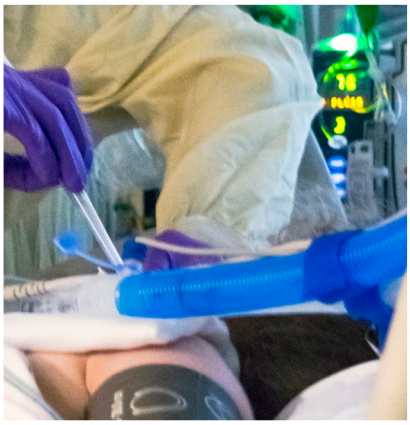
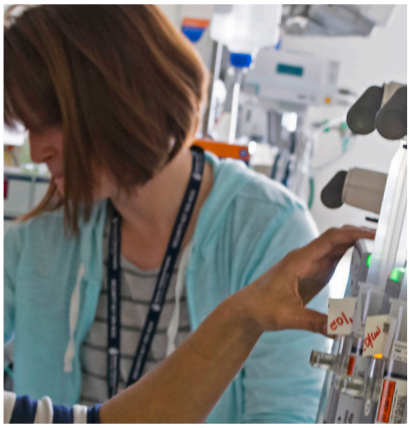






NURSING/PATIENT CARE BIENNIAL REPORT 2016-2017




Boston Children's Hospital
Until every child is well™

Hospital Mission & Values

Our mission

To provide the highest quality health *care,* be the leading source of *research* and discovery, *educate* the next generation of leaders in child health and enhance the health and well-being of children and families in the *communities* we serve.

Our values

Communication

Speak and listen respectfully, communicate clearly and respond thoughtfully and promptly **to all patient, family and staff needs.**

Collegiality

Work toward a common purpose **in concert with interprofessional colleagues.**

Excellence

Achieve the **highest standards of performance and quality** throughout the care experience.

Accountability

Hold ourselves and each other to high standards of performance and **maintain responsibility for our own actions.**

Teamwork

Foster interprofessional collaboration and synthesize clinical and non-clinical perspectives.

Innovation

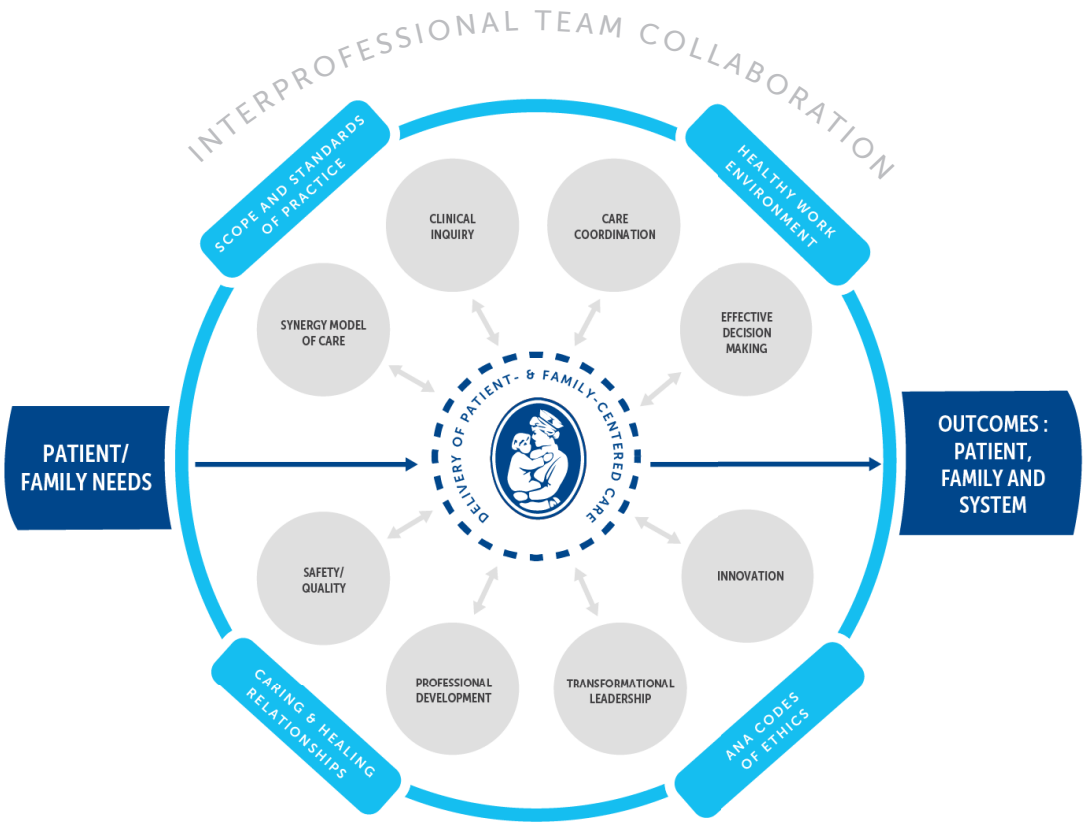
Create novel and interprofessional approaches to **advance the care and experience of patients and families.**

Nursing Vision & Care Model

Our vision

Through relationship-based care and powerful partnerships with patients and families, Boston Children's Hospital nurses and interprofessional teams serve as local, national and global leaders in shaping the science and delivery of safe and high-quality pediatric health care, while nurturing healthy work environments.

Our professional practice model



Nursing/Patient Care Goals

Translating Organizational Priorities to Our Work: 2016–2017

ORGANIZATIONAL PRIORITIES	AMERICAN NURSES CREDENTIALING CENTER (ANCC) MAGNET® DOMAINS & NURSING/PATIENT CARE GOALS
Research & Innovation Leadership	**INNOVATIONS IN CARE DELIVERY** - Disseminate key nursing and patient care research, inquiry and innovations to advance practice - Support formal opportunities for staff to participate and lead governance, science and quality improvement initiatives - Advance relationship-based practices to strengthen full participation in the delivery of high-quality care
Complex Patients & Accountable Care	**EXCELLENCE IN PRACTICE/QUALITY OF CARE** - Advance system-wide evidence-based practice standards to guide clinical practice - Promote health education and literacy via interactive patient care technologies - Ensure greater access to expert clinical resources to improve support and throughput
Operational & Administrative Effectiveness	**TRANSFORMATIONAL LEADERSHIP** - Define standard workflows for care coordination - Improve care coordination for patients and families via technologies to enhance engagement and support - Disseminate innovative practice initiatives that demonstrate a positive cost-value equation
Staff & Employee Engagement	**EMPOWERMENT & PROFESSIONAL DEVELOPMENT** - Design and implement models to strengthen staff participation in clinical/operational decisions and promote engagement - Recognize nursing/interprofessional team members for their collegiality and contributions to the patient, their work team, the hospital and the community - Strengthen relationship-based leadership practices

Table of Contents

LAURA HOLDWAY, BSN, RN, CPN, WITH THOMAS AT BOSTON CHILDREN'S AT WALTHAM

Introduction from the Chief Nursing Officer

Dear Friends and Colleagues,

Through relationship-based care and powerful partnerships with patients and their families, Boston Children's Hospital nurses and interprofessional teams continue to serve as local and global leaders to shape the science and delivery of care. As the external health care delivery system continues to adapt to rapidly shifting public policy and broad mandates for change, the importance of nursing and the primacy of caring as a cornerstone within Boston Children's has never been clearer.

Boston Children's Nursing and Patient Care teams completed their most recent strategic plan refresh in 2016. Organized through an interactive planning process blending staff nurse, patient care leadership, and patient and family voices via a facilitated work session and survey process, this next iteration of our strategic plan intentionally focused on the needs and priorities of front line nurses and care team members and intentionally aligned with the hospital's strategic direction.

The priorities set through this process have guided our own ambitious agenda to advance nursing excellence and quality patient care over the past two years and into the future. Through exceptional nursing science, clinical inquiry and evidence-based practice, Nursing continues to prioritize the achievement of outcomes to substantiate the impact and value of nursing to patients and families, the organization and to the professional communities we serve.

In 2016, Boston Children's identified four key organizational priorities: 1) Research and innovation leadership, 2) Care of patients with complex and rare health challenges, including readiness to manage populations within accountable care delivery systems, 3) Operational and administrative effectiveness, and 4) Staff and employee engagement. A year later in 2017, the hospital completed a strategic refresh of the organization's mission, strategies, priorities and values, as reflected in this report.

This 2016-17 Nursing/Patient Care Biennial Report connects nursing and patient care contributions and empirical outcomes with hospital priorities described within the framework of the American Nurses Credentialing Center's (ANCC) key model components noted below. Each story in this report links nursing/patient care contributions and outcomes to one of these components:

- Innovations in Care Delivery
- Excellence in Practice/Quality of Care
- Transformational Leadership
- Empowerment and Professional Development

Nurses and patient care team members are central to value-creation within health care and clearly throughout Boston Children's. We look forward to continuing on the pathway ahead as we strengthen the health of communities and health care locally, nationally and around the world.

Each and every day, Boston Children's nurses contribute as caregivers, innovators, policymakers and leaders who serve at the heart of all we do.

With appreciation to all,

Laura J. Wood

Laura J. Wood, DNP, MS, RN, NEA-BC
Chief Nursing Officer
Sporing Carpenter Chair for Nursing
Senior Vice President, Patient Care Operations
Boston Children's Hospital

“When you’re a nurse, you know that every day you will touch a life or a life will touch yours.”

—Author Unknown

LYNNE PUTNEY, RN, CPN, WITH DANLEY AND MOTHER AT BOSTON CHILDREN’S AT LEXINGTON

Innovations in Care Delivery

AMARA GERARDEN, BSN, RN, WITH NEWBORN IN THE NEONATAL INTENSIVE CARE UNIT (NICU)

100%

Inpatient units utilizing Distraction Free Zones

47%

Ambulatory clinics utilizing Distraction Free Zones during first year spread-and-scale rollout

Medication Safety from the Hospital to the Home

Distraction Free Zones Increase Mindfulness and Safety Among Staff and Families

Clinical environments are at high risk for interruption and distraction-related errors. This poses threats to clinical performance and can impact patient safety during high-risk patient care. Interruptions and distractions may originate from many sources, including clinical staff, patients and families, medical devices and phones. While these interruptions cannot be fully eliminated, there are ways to create safer environments to reduce preventable errors. Distraction Free Zones allow clinical staff to be more mindful and focus on the task at hand.

Recognizing that distractions are not limited to the hospital environment, and in fact may be more prevalent at home, Boston Children's Hospital is now integrating Distraction Free Zones into discharge teaching to empower families to reduce their risk of medication errors at home.

"Sometimes, it just takes a passionate nurse, a bold idea, a supportive work group and simple supplies to make an impact."

Jamie Harris, MSN, APRN, CPNP

Reducing Distractions During Medication Administration

Cardiovascular nursing leaders at Boston Children's recognized the vulnerability of distractions in the critical care setting. While the Cardiac Intensive Care Unit's (CICU) medication error rates were low, an interdisciplinary team developed a distraction free medication safety initiative. This initiative included the following four key components:

- Delineation of **DISTRACTION FREE AREAS** within the unit for staff to utilize for critical tasks
- Creation of **COMMUNICATION MATERIALS**, including floor decals and signage, to serve as visual aids to denote Distraction Free Zones
- Development of **PLAIN LANGUAGE SCRIPTS** to assist staff in explaining to patients and families the purpose of Distraction Free Zones
- **MONTHLY FORUMS** with nurse ambassadors, leaders and interdisciplinary teams to monitor progress and share new ideas

Since the implementation of Distraction Free Zones, the CICU has reported a sustained reduction in medication-related events, both averted and actual. Distraction Free Zones are now utilized in all inpatient areas at Boston Children's.

Beyond the front line staff, the interprofessional Adverse Drug Event (ADE) committee—which includes physicians, nurses and pharmacists—reviews all medication- and fluid-related events with the goal of further reducing the number of ADEs reaching patients. Working subgroups are divided by discipline and focus on risks related to ordering, dispensing and/or administration, respectively. Each group looks for trends and patterns to suggest where additional education, increased awareness or system improvements may be possible. Observations and recommendations are then reviewed by the entire ADE committee.

Reducing Distractions in the Home

The National Patient Safety Foundation identified the home environment as the next frontier for patient safety. Jamie Harris, MSN, APRN, CPNP, nurse practitioner, Cardiac Electrophysiology Program, noted an increase in the reporting of liquid antiarrhythmic medication errors occurring at home. Harris conducted a Failure Mode and Effects

Analysis (FMEA) with quality improvement consultants in Cardiology.

The analysis revealed multiple issues that could lead to an error, such as prescriptions from multiple providers, changes in medication concentration, use of multiple medications, drug interactions, inconsistent medication labels, variation in teaching practices, uncertainty about how and when to take medications and use of the wrong size syringe. Harris and colleagues found that multiple care providers in the home, as well as involvement of multiple households, were contributing factors.

A Distraction Free Zone Toolkit for the Home

Harris extended Boston Children's proven internal distraction free practice to patients discharged after hospitalization for a cardiac arrhythmia. An interprofessional team convened to integrate strategies from the hospital-wide initiative with evidence-based patient education techniques to assist parents and caregivers with identifying Distraction Free Zones and safely administering liquid medications.

The team created toolkits for families to take home with their children after a stay on the cardiac floor. The toolkit contains medication patient education material, directions on how to create a distraction free space and Distraction Free Zone signage to display in the home when performing medication administration. Using the toolkit, parents can quickly designate any area as a Distraction Free Zone.

The team began following a group of 10 patients and families to collect feedback on the intervention. Harris conducted telephone interviews with parents who received the toolkit 24–96 hours post-discharge to evaluate its effectiveness. During follow-up phone calls, parents gave positive feedback overall and emphasized the concept of dedicated space for limiting distractions as especially helpful. All families advised Harris to continue providing the toolkit to other patients and families.

Future directions for this initiative include maximizing the impact of Distraction Free Zones in the home and determining how best to educate families about this technique during discharge teaching.

Translating the Practice to Other Areas

Boston Children's ambulatory areas are presently implementing a distraction free practice. Currently 47% of clinics, including satellite locations, are using Distraction Free Zones. These zones may be used during a range of patient care activities as noted in the infographic to the left. Interprofessional teams—including nurses, clinical assistants, nurse practitioners, physicians and allergy technicians, among others—all participate in a Distraction Free Zone environment.

The Hematopoietic Stem Cell Transplant Unit implemented a Distraction Free Zone to enhance the practice of blood product administration. Transfusion of blood products is a high-risk task requiring a multi-step process to minimize the risk of an adverse reaction.

Barbara Cuccovia, MSN, RN, CPON, BMTCN, nurse manager, Hematopoietic Stem Cell Transplant Unit, worked with her staff to identify three distinct Distraction Free Zones: a dedicated computer for blood product administration, a distraction free second check space at the patient's bedside and a designated area to set infusion pump rates.

Impact of Distraction Free Zones

The practice of addressing distractions has proven to be an effective, cost-efficient and sustainable intervention. "It doesn't always take a high-tech innovation to make a positive impact on patient outcomes," says Harris. "Sometimes, it just takes a passionate nurse, a bold idea, a supportive work group and simple supplies."

YRAG DAPHNIS, BSN, RN, CPN, AND JOCELYN LUND-WILDE, BSN, RN, ON THE SOLID ORGAN TRANSPLANT UNIT

Amplifying the Patient and Family Voice

1,700+

Number of responses to a new "How did we do today" survey prompt on inpatient TVs over a five-month pilot

16.9%

Pre-intervention: Families who responded to a paper-based experience survey post-discharge

↓

71.7%

Post-intervention: Families who responded to an electronic tablet-based experience survey

A Journey to Co-Design Care Processes with Patients and Families

Boston Children's Hospital has a long history of incorporating the voices of its patients and families into care and operational processes. Over the past few years, Boston Children's has been reinvigorating its patient experience improvement and measurement strategy to garner more patient and family feedback across all care settings.

Leveraging Technologies to Engage Families

The hospital receives more than 9,000 completed paper-based experience surveys per quarter. Despite these large numbers, survey response rates at Boston Children's—and nationally—are not as high as the organization would like. Response rates vary between 18-26% based upon survey type. Two pilot projects were undertaken in order to improve the inpatient survey response rate.

One of the pilots tested the administration of the Child Hospital Consumer Assessment of Healthcare Providers and Systems® (Child HCAHPS)—a tool developed by Boston Children's—on the day of discharge using an electronic tablet. Two medical and two surgical inpatient units participated. The tablet was equipped with audio computer-assisted self-interview software, which allowed families to listen to the questions. Clinical staff identified patients being discharged. Next, administrative or research staff gave the family the tablet and later downloaded the results. The research staff followed up with the families post-discharge by email, mail and phone to request the family complete the discharge questions of the survey.

The use of tablets led to a dramatic improvement in the survey response rate—the response rate increased to 71.7% compared to the baseline response rate of 16.9%. In addition, a more demographically diverse group of families participated, including families of color, fathers and participants who were not college graduates.

"It is important that we continue to implement mechanisms for patients and families to provide feedback on their experience," says Sara Toomey, MD, MPhil, MPH, MSc, chief experience officer.

Utilizing Technology to Measure the Pediatric Patient Experience

Another early-stage pilot aims to improve response rates and streamline the administration of the Child HCAHPS tool by administering the survey on inpatient units using the hospital's blended education and entertainment platform. The system provides patients and families with accessible health videos, on-demand entertainment options and service requests via the bedside television. Since the system is interactive, surveys can be completed electronically before discharge.

Early data show that it takes families just under 10 minutes to complete the Child HCAHPS survey using this platform. Approximately 19% of patients who participated in the pilot completed the survey.

Lisa Rubino, MBA, program manager, Patient/Family Experience, has been impressed by how the system—traditionally used for education and entertainment—can also be used to generate real-time patient experience data. "It is our hope that our adaptation of this platform will help us gain a clearer understanding of the patient and family experience," she says.

"Patient and family engagement in our experience improvement efforts is accelerating our ability to meaningfully redesign systems of care."

Lisa Morrissey, MPH, MSN, RN, CPHON

Garnering Real-Time Feedback Electronically

Starting in 2017, the hospital began using the same platform for an initiative called Question of the Day to ask, "How did we do today?" The use of this question on three inpatient pilot units provides staff with in-the-moment feedback to better understand the extent to which patients and families perceive their most essential needs are being met each day.

Every afternoon, the following statement appears on patients' TVs on the pilot units: "Today Boston Children's gave us the care we wanted and needed." Families can choose a "yes," "neutral" or "no" answer. Negative responses prompt a notification to unit-based nursing leaders who in turn check in with families to address concerns that same day. Since beginning the pilot in early spring, there have been more than 1,700 queries. Only 2% of patients and families have responded negatively.

Lisa Morrissey, MPH, MSN, RN, CPHON, nurse manager of inpatient Hematology/Oncology, has seen the "How did we do today" question improve communication. An adolescent patient who had been hospitalized for many months responded unfavorably to the survey prompt. "When I visited the patient and her mother, the patient expressed that she missed her family," says Morrissey. The mother was also struggling with the isolation of a long hospitalization and had trouble sleeping.

"I notified the social worker of the situation, and the entire team put a plan forward," says Morrissey. "Nurses made a focused effort to cluster care at night so the family could get more uninterrupted hours of sleep. The response to this quick survey helped our team to better meet this family's needs and improve their experience."

Collaboration with Patients and Families

Boston Children's is committed to helping transform the care experience by ensuring patients and families are fully engaged as partners. The hospital's Family Partnerships Program provides avenues for families to collaborate on projects that influence patient and family experiences before, during and after their hospital stay or ambulatory visit.

The Family Advisory Council, led by a parent co-chair and senior Nursing and hospital leaders, collaborates to:

- **Advise/Share:** Provide feedback via council meetings and focus groups.
- **Partner/Support:** Serve as family representatives on hospital committees focused on strategic goals.
- **Drive/Lead:** Direct initiatives prioritized by the council, including collaboration with numerous hospital departments and staff members.

"Our families are so committed to giving back to the hospital because staff really listen. It's amazing to know that my family's medical journey may affect the way staff care for families."

Katie Litterer, mom and family partnership coordinator

19 FAMILY ADVISORY COUNCIL MEMBERS

20 TEEN ADVISORY COMMITTEE MEMBERS

74 VIRTUAL ADVISORS

The Family Wellness Program offers a variety of free services just for families, including reiki, mediation, gentle yoga, massage and Zumba.

The Family-to-Family Program provides a short-term peer-mentoring program that connects patients and families who are facing similar, health-related challenges. Family-to-Family mentors are trained on how to listen, share experiences and provide comfort by phone to other family members.

The Teen Advisory Committee is made up of adolescents and young adults who receive their care at Boston Children's. They strive to enhance the quality and quantity of programs and practices that affect the hospital's teen patient population and their families.

The Virtual Advisors Program provides a mechanism for families to join a secure online forum where they can share insights and feedback on important projects and initiatives from their own homes.

Excellence in Practice

KELLY FECTEAU, BSN, RN, CCRN, WITH TIMMY AT BOSTON CHILDREN'S AT WALTHAM

$26B

Estimated cost of readmissions to hospitals in the U.S. annually

18%

Reduction in hospital-wide seven-day readmissions from October 2014 through September 2017

$5.3M

Estimated health care expenditures saved due to averted readmissions at Boston Children's over a four-year period, based on national pediatric safety consortium estimates

PAIGE WILCOX, BSN, RN, WITH NE-QUAE ON A GENERAL MEDICINE UNIT

Mitigating Care Transition Risks

Improving Patient Discharge and Reducing Hospital Readmissions

One out of seven patients is readmitted within 30 days to U.S. hospitals each year, at an estimated cost of $26 billion. Beyond the cost, readmissions strain societal resources and serve as a major stressor for patients and families. Readmissions have become a key quality focus and a measure Boston Children's Hospital is continuously striving to improve through innovative process and technological solutions. Readmissions have decreased hospital-wide by 18% from October 2014 through September 2017, resulting in an estimated $5.3 million in averted health care expenditures and a reduction in patient and family burden.

"Discharge is a vulnerable time. With improved problem-solving and communication, we can ensure a safer transition home."

Kelly Dunn, MSN, RN, CPNP

Phase I: Implementation of a Communication-Focused Discharge Bundle

As a member of Children's Hospital's Solutions for Patient Safety (SPS)—a network of more than 100 children's hospitals—Boston Children's is part of a national collaborative that has established a goal to reduce preventable seven-day readmission rates 20%

by the year 2018. To meet this goal, an interprofessional Readmissions Committee—led by Nursing Director, Surgical Services Herminia Shermont, MSN, RN, NE-BC, and Chief of Inpatient Services/ Department of Medicine Vincent Chiang, MD—formed a working group in 2015 to evaluate hospital-wide readmission trends and evidence-based solutions. Their research showed a link between avoidable readmissions and the use of reliable discharge planning and transition processes.

Discharge is a complex process that requires clear communication, attention to detail and engaged families as partners in care. With this in mind, the committee embarked on a quality assurance and performance improvement (QAPI) project in all inpatient areas. They aimed to close communication gaps between patients, families and their care providers and improve readiness for discharge through education and standardization.

"Many reasons for readmissions have been identified," says Shermont. "Recent evidence suggests that multifaceted interventions are more promising than individual interventions."

The team developed a multi-pronged discharge bundle—effectively a series of patient safety interventions—to be utilized by clinical and administrative staff on inpatient units. The bundle included the use of the following elements:

- A **STANDARDIZED HAND-OFF** between staff
- The **TEACH-BACK METHOD:** Asking families to recall, demonstrate and restate the information they were taught
- A **ROOT CAUSE ANALYSIS (RCA)** process to review potential contributors to all readmissions

At the end of phase I, use of this discharge bundle resulted in an 8% reduction in seven-day readmissions and 10% reduction in 30-day readmissions over 16 months.

Phase II: Implementation of a Patient- and Family-Focused Discharge Bundle

Following the success of a communication-focused discharge bundle, the Readmissions Committee spearheaded a second intervention aimed at standardizing care and improving families' understanding of managing care at home. Clinical staff utilized the following bundle elements on all inpatient units: 1) Confirming that the discharge instructions contained a self-management plan; 2) Ensuring scheduling of follow-up appointments, tests and/or labs prior to discharge; and 3) Identifying high-risk patient populations.

Via the RCA process, staff noticed a trend in formula errors made at home. To mitigate readmissions caused by these errors, Nutrition staff led an intervention to engage with families to fill in gaps of home care knowledge.

Their intervention showed that many of these errors occurred because families did not have measuring cups and spoons at home. Clinical nutritionists reinforced the importance of using these devices through use of the Teach-Back Method.

Expansion of Follow-Up Tests and Appointment Scheduling

Research indicates that timely outpatient follow-up after an inpatient stay can help to reduce unplanned readmissions. In an effort to consistently translate this evidence into practice, a surgical floor partnered with ambulatory schedulers, clinicians and members of the Family Advisory Council to launch an initiative to ensure follow-up tests and appointments were scheduled prior to discharge.

The pilot included more than 400 families being discharged post solid organ transplant procedures. The success was evident—100% of Transplant outpatient appointments were scheduled, compared to 87% of appointments scheduled prior to the pilot's implementation. In addition, the outpatient appointment cancellation rate for the Transplant unit pilot was 15%, compared to the 27% hospital-wide cancellation rate.

"With all the unknowns you face after an inpatient stay, having your next visit confirmed before discharge gives a peace of mind and ensures that you will get the care that you need," says Sarah Morris, parent and member of the Family Advisory Council and Readmissions Committee.

Improving Communication Post-Discharge via a Nurse-Designed Platform

As a part of the care continuum, it is imperative that communication and education continue with families once they are home. Kelly Dunn, MSN, RN, CPNP, nurse practitioner, inpatient General Pediatrics, spearheaded an interprofessional effort aimed at sustaining communication with families in their home environment.

"Discharge plans are meant to provide patients and families with tools to safely transition care management to home," says Dunn. "Care transitions can be complex and expose patients to gaps in care."

Traditionally, post-discharge follow-up is conducted by Nursing staff via a phone call to the family at home. However, nurses found that many families were not voicing any post-discharge concerns. Therefore, the team sought out another way for families to easily communicate if they needed help via a text and e-mail messaging platform.

Thanks to a technology grant, Dunn and her colleagues created DisCo (**dis**charge **co**mmunication), a messaging platform that disseminates pre-populated, post-discharge follow-up questions. Families choose whether they prefer to receive these messages by text or e-mail. The questions sent

via DisCo were designed to be brief and were based on evidence found in literature: 1) Did you fill your prescriptions? 2) Do you have a follow-up appointment? and 3) Is there anything that concerns you that was not anticipated or discussed?

Responses track the patient's name, caregiver name, contact information and if follow-up is needed. Nurse practitioners monitor the responses daily and contact the family to evaluate their concerns and provide triage. The nurse practitioner, consulting with the attending physician as needed, also determines if the child requires urgent Emergency Department follow-up or if they might benefit from a visit to their primary care provider.

During an initial test, more than 550 families from General Medicine inpatient units enrolled in DisCo. Approximately 99% of the families who utilized the DisCo system reported that it was helpful.

"Continuity of care is a valuable part of the program," says Dunn. "Discharge is a vulnerable time. With improved problem-solving and communication, we can ensure a safer, more highly reliable transition home."

The Neonatal Intensive Care Unit (NICU) also piloted the use of DisCo to improve medication teaching and increase communication with families post-discharge. One hundred percent of discharged families consented to use DisCo in the first three months of its use. The average response rate of families at 24 hours was 69% and the average response rate at seven days was 23%. The current target goal is to improve communication via DisCo by 20% above baseline.

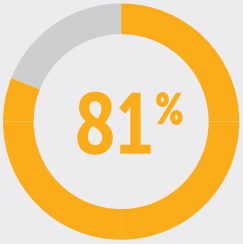
"All families transitioning home can experience confusion, have unexpected questions and feel overwhelmed," says Cheryl Toole, MS, RN, CCRN, NEA-BC, director, Nursing Patient Services, NICU. "This discharge improvement work is meaningful in that it directly affects the patient and family experience—discharging a child home is a hallmark event for families."

Discharge Communication Platform Outcomes (DisCo)

Enrollment, response rates and rates of return to care (being seen in the Emergency Department or being readmitted) were tracked. In the two pilot phases, parents and caregivers also received a survey about how helpful they found the process. Qualitative data were recorded by nurse practitioners, including the reasons for phone follow-up and what assistance was provided to the patient and family after discharge.

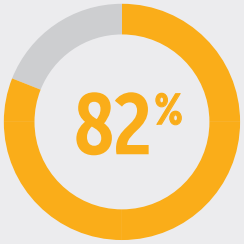
DisCo Phase I Preferred Method of Communication

Tool Usability



81% OF USERS REPORTED NO USABILITY-RELATED TOOL CONCERNS

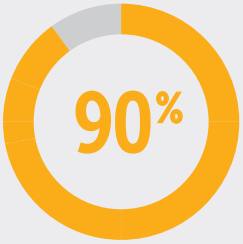
Helpfulness



82% FELT THE TOOL WAS HELPFUL

DisCo Phase II Preferred Method of Communication

Tool Usability



90% OF USERS REPORTED NO USABILITY-RELATED TOOL CONCERNS

Helpfulness

>99% FELT THE TOOL WAS HELPFUL

Hardwiring High Reliability

70

Number of clinical areas leadership visited to reinforce High Reliability principles and tools over a two-year period

100%/15,500

Percent and number of eligible Boston Children's team members who completed High Reliability error prevention training, 2016–2017

276

Number of patient/employee safety and operational concerns identified in the Daily Operations Brief and resolved over a two-year period, 2016–2017

Departments, Teams and Families Unite to Advance a Culture of Safety Using High Reliability Principles

Boston Children's Hospital is on a journey to becoming a High Reliability organization—one where zero preventable harm impacts any patient, visitor, family or team member. Several years into the effort, Boston Children's is sustaining this culture change by embedding it within the hospital's fabric through the commitment of leadership and an emphasis on safety and process improvement tool use.

Commitment of Leadership to High Reliability

The Daily Operations Brief (DOB) has become an invaluable patient and staff safety communication tool. Leaders supported its expansion in 2017 from weekdays to also include weekends and holidays.

During the DOB, clinical and operational leaders from across the organization meet for 15 minutes each morning to discuss potential risks to patients and team members that could impact safety, quality or the patient and family experience. There were 276 issues identified and resolved during the DOB over a two-year period ending September 2017.

Leaders also participate in Rounding to Influence, where they meet with frontline staff to discuss specific safety topics. By strategically scheduling these sessions to occur immediately following the DOB, senior leaders can round in areas that may have specific safety concerns in real time.

Leadership, including Laura Wood, DNP, MS, RN, NEA-BC, chief nursing officer and senior vice president, Patient Care Operations, has fully committed to Rounding to Influence at least twice a month with front-line staff to reinforce High Reliability principles and tools. Wood and other senior leaders have rounded in 70 areas throughout the organization over a two-year period.

Preventing Mistakes and Learning from Failure

Collective mindfulness improves the ability to sense something is not quite right. It is part of a foundation used to catch and prevent potential patient harm. This happens thanks to concerted efforts to create an environment in which all team members are utilizing high reliability methods, including "speaking up for safety," "having a questioning attitude" and "paying attention to detail."

One such example comes from Sharon Collier, M.Ed, RD, LDN, clinical nutrition director, Center for Nutrition. A dietitian was doing morning rounds when a nurse told her that a patient had orders not to eat because she was going have a gastro-jejunal (G-J) tube placed. When the dietitian questioned why the child needed a G-J tube instead of a less invasive G-tube, the nurse took note.

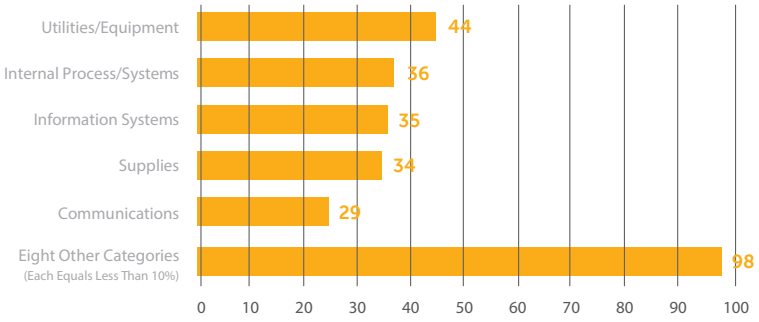
"It turned out that the child would do well with just a G-tube, and the dietitian's questioning attitude—and the nurse's response—got the question escalated to a surgeon and cardiologist, who modified the treatment plan," says Collier.

Focusing on Employee Safety

A recent effort has focused on employee overexertion injuries, specifically from manual patient handling, which are one of the top causes of employee injuries. An intervention was initiated to create a sustainable safe patient handling and mobility program. The goal is to ensure that employees have the patient handling equipment, tools, training and decision-making algorithms that they need.

To appropriately meet patient care needs, a quantitative modeling project was undertaken to supplement the qualitative information gleaned from interviews, observations, simulations and benchmarking. Staff from Nursing, Physical Therapy, Environmental Health and Safety, and Facilities, together with architectural, logistics and equipment industry partners, are involved

Safety Concerns Identified in the Daily Operations Brief by Category (n=276)



Utilities/equipment and internal process/systems issues account for approximately 30% of all concerns identified in the Daily Operations Brief.

in conducting historical reviews, simulations, site visits and best practice research.

A second effort focused on safely and effectively caring for a growing population of patients with behavioral health needs. Boston Children's established an interprofessional Behavioral Subject Matter Expert (SME) group. Led by Cheri Sinclair, BSN, RN-BC, clinical coordinator, inpatient Psychiatry, the SME group sought to assess the feasibility of using the electronic health record (EHR) to pro-actively identify patients with potential behavioral issues and needs.

After months of collaboration with key stakeholders, including families who are members of the Psychiatry and Developmental Medicine Family Advisory Councils, the workgroup developed a "Precautions B" order, which creates an alert and links to a plan in the EHR. The clinical team works with the patient and family to develop a behavioral plan, which describes the patient's triggers, behaviors and needs for special accommodations.

After the Precautions B initiative launched hospital-wide, the workgroup collaborated with families and clinical teams in clinic and inpatient settings to brainstorm strategies to increase utilization of the new behavioral plan workflow. As a result of the effort, the organization has experienced an improved ability to plan and more effectively deliver care to this complex patient population with a decreased need for emergency response.

Improving Pre-op Flow

In Perioperative Services, teams regularly come together to improve outcomes and safety. A highlight of this collaboration included a project to re-engineer perioperative flow and communication to eliminate patient holds from the Operating Room (OR) to the Post Anesthesia Care Unit (PACU). Guided by leadership sponsors Yolanda Milliman-Richard, MSN, RN, NEA-BC, vice president and associate chief nurse for Surgical Services and clinical director, Radiology, James Kasser MD, surgeon-in-chief, and Lynne Ferrari, MD, chief, Perioperative Operations, an interprofessional team identified system-level constraints in the management of patient movement across the perioperative care continuum.

A surgical flow pathway was developed, implemented and evaluated. As a result of this project, OR to PACU holds have decreased by 99%. The team has identified additional opportunities to refine processes to improve safety outcomes for patients, families and staff, including a project to next reduce OR to ICU holds.

Employee Training

Over the past two years, Boston Children's made a commitment to educate every team member in core High Reliability principles, tools and behaviors in an effort to reduce errors and harm throughout the organization. In addition, training also emphasizes the importance of reporting both patient and employee safety concerns in order to improve systems. The trainings are led by certified Boston Children's trainers, with senior leaders serving as affiliate trainers at some of the sessions. In December 2016, 100% of eligible Boston Children's staff completed High Reliability error prevention training, reaching 15,500 team members. The training is now integrated within the orientation process for all new employees to sustain and spread high reliability as a standard work process.

Family Partnership

A core takeaway from the staff error prevention training was that "safety is everybody's concern." This led to Boston Children's inviting family members to participate in the development of one of the first known patient and family High Reliability partnership initiatives, which mirrored the staff toolkit. Two family representatives from the hospital's Family Advisory Council (FAC) joined the High Reliability Safety Leadership Core team.

"Family members and guardians have a keen sense of what is normal for their child, and their ability to spot and notify care team members of a potential risk or error can widen the culture of safety," says Serena Hadsell, a parent, FAC member and family representative on the High Reliability Safety Leadership Core team.

Through a continuous feedback and review process, the family partners suggested language that suited a non-medical audience while also ensuring that the overall concepts were consistent with the employee toolkit.

"The hospital understands that parents are integral to a High Reliability organization," says William O'Donnell, a parent, co-chair of the FAC and family representative on the High Reliability Safety Leadership Core team.

Staff members of the team found the experience eye-opening as well. "Working with Bill and Serena has been a huge enhancement to the design of this program," says Milliman-Richard.

Quality of Care

SHEVONNE LINNANE, BSN, RN, WITH AYLIN AT PRIMARY CARE AT LONGWOOD (PCL)

50%

Decrease in urgent care visits among 141 high-risk patients in a two-year coordinated asthma care program

54%

Decrease in inpatient hospitalizations among 141 high-risk patients in a two-year coordinated asthma care program

70%

Decrease in emergency department visits among 141 high-risk patients in a two-year coordinated asthma care program

JENNIFER WAYSHVILLE, MSW, BSN, RN, WITH HARRY IN THE EMERGENCY DEPARTMENT (ED)

Promoting the Health of the Community

Programs Benefit At-Risk Children via Coordinated Asthma Outreach, Immunization Initiative and Suicide-Risk Screening

Boston Children's Hospital is dedicated to enhancing the health and well being of children and families in the local community. Staff throughout the system of care champion this mission by finding innovative ways to meet the needs of patients and families in the communities they serve, including identifying and treating at-risk children.

"Staff in our ED and outpatient clinics are committed to offering the highest level of care for patients living in the community."

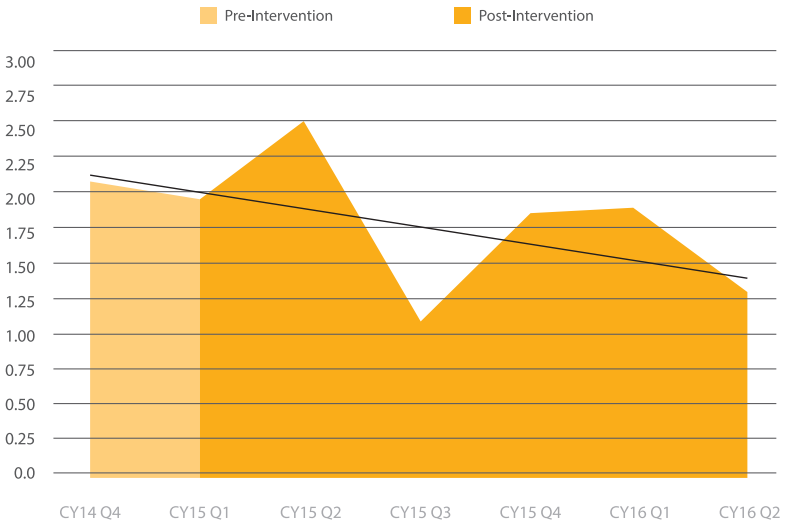
Pam Schubert-Bob, MHA, RN, NE-BC, CPN

Coordinated Asthma Care

Boston Children's launched its Community Asthma Initiative to improve the health and quality of life of children with asthma and their families. The program serves children who live in Boston, are 2–18 years old and have been either seen in Boston Children's ED or hospitalized for asthma. Clinicians work with each family to understand their child's asthma, the medications used to treat it and to identify and reduce asthma triggers.

While this effort has been successful, Boston Children's Primary Care at Longwood (PCL) staff took note that innovative approaches were needed

Percentage of Boston Children's Emergency Department Visits for Asthma as Primary Diagnosis: October 2014–June 2016



Since the intervention, there has been a decline in ED visits for asthma patients, from 2.1% in CY14 Q4 to 1.3% in CY16 Q2, with an average reduction of 0.12% per quarter.

to reduce care fragmentation, increase continuity of care and improve asthma outcomes. PCL provides care for an ethnically diverse, underserved and medically complex patient population with historically high rates of ED visits and asthma-related admissions.

As part of a quality assurance and performance improvement (QAPI) initiative, an interprofessional team developed and evaluated the impact of coordinated, team-based asthma care on urgent care visits, ED visits and inpatient hospitalization stays. An Asthma Action Team (AAT) was formed to provide coordinated care to high-risk asthma patients.

The AAT now includes physician and nurse practitioner champions, a certified asthma nurse educator, a social worker, a community resource specialist and a research/administrative assistant.

The AAT was available to see patients in a designated "asthma clinic" within Primary Care. Patients received an in-depth diagnostic and family needs assessment, asthma education and coordinated referral to social and community services. The AAT established continuity of care through the asthma clinic within the practice and regular supplemental visits with asthma clinicians.

Nurse-Led Care Management

Nurses began calling parents and caregivers whose child's Asthma Control Test (ACT) indicated that asthma was not well controlled. They discussed medications and reviewed when to contact the clinic. If the nurse assessed that the patient needed to be seen or had not been seen in the past year for a well-child visit or an asthma visit, the nurse set up an appointment for the patient with the primary care provider.

In addition, Linda Haynes, MS, RN, PPCNP-BC, AE-C, nurse practitioner, and Sheila Petrosino, MSN, RN, AE, staff nurse II, Asthma Care Program, called families of the most fragile asthmatics at established intervals. The initiative demonstrated that coordinated asthma care is associated with significant decreases in asthma-related urgent care visits, ED visits and inpatient hospitalizations. Over a two-year period, 141 patients were included in the study. Following the intervention, there was a significant decrease from pre-intervention rates in urgent care visits (50%), ED visits (70%) and inpatient hospitalizations (54%).

"Staff in our ED and outpatient clinics are committed to offering the highest level of care for patients living in the community," says Pam Schubert-Bob, MHA, RN, NE-BC, CPN, nurse manager, Boston Children's Primary Care at Longwood (PCL) and Martha Eliot Health Center. "These programs are just the tip of the iceberg."

Improving Immunization Rates in Primary Care

Despite current immunization schedule recommendations from the American Academy of Pediatrics and the American Academy of Family Physicians, many children are missing much-needed vaccines — and it is a problem that PCL staff took note of among their patients. Using a series of multifaceted interventions, PCL nurses led efforts to improve immunizations by 7% between 2016 and 2017.

An interprofessional team, including Christine Doherty, BSN, RN, CPN, staff nurse II, PCL, and Schubert-Bob, formed to identify barriers in vaccination and study at-risk age groups. They took into account PCL's unique patient population: About 70% of families are living at or below the poverty level and receive financial support. Acute life stressors, such as homelessness, domestic violence, transportation issues and single parent status, often cause patients and families to miss appointments.

In reviewing immunization data, the group developed multi-year QAPI projects to improve influenza and Human Papillomavirus (HPV) vaccine rates, as well as vaccines for patients in their first year of life.

In their research, the work group identified a significant number of 11- and 12-year-old patients who had not received the full HPV vaccine series and found health care disparities, with black and Latino teens being less likely than white teens to complete the vaccination series. They set out to identify perceived barriers to immunization and to create clinic-based interventions to improve overall immunization rates.

By educating families, using motivational interviewing, creating bundles to improve education, and developing protocols that enable nursing to take the lead to identify vaccine needs for each patient, immunization rates improved for the entire clinic population. They especially improved for patients starting at age 9 who should begin receiving the full three-dose series of HPV.

Suicide Risk Screening in the ED

Suicide is the third leading cause of death for youth between the ages of 10 and 24, according to the Centers for Disease Control and Prevention (CDC). In February 2016, The Joint Commission issued a Sentinel Event Alert advising the implementation of suicide screening for all patients, especially in Emergency Departments (EDs). Studies show that most individuals who die by suicide have visited a health care provider three months to one year before their death; many victims were seen in the ED for an unrelated health concern.

Many families use the ED as their sole contact with the health care system, according to Lisa M. Horowitz, PhD, MPH, staff scientist and pediatric psychologist at the National Institute of Mental Health (NIMH). Horowitz served as a consultant on the implementation of a suicide screen risk tool in Boston Children's ED. "Most people don't show up to the ED and say, 'I want to kill myself,'" Horowitz adds in an interview with NIMH. "Rather, they show up with physical complaints and do not discuss their suicidal thoughts. But studies have shown that if you ask directly, the majority will tell you. Nurses and physicians need to know what questions to ask."

Meeting this Joint Commission regulation—and knowing what questions to ask—required resources and process changes across all clinical environments. An interprofessional team—including key stakeholders from the ED, Psychiatry, Social Work, Nursing and the Program for Patient Safety and Quality (PPSQ)—formed to develop and implement an appropriate screening process. A gap analysis was conducted to target areas that needed to screen patients for depression and suicide. The team concluded that a brief suicide screening should also be piloted in the ED. They opted to use the Ask Suicide-Screening Questions (ASQ)—a fast, easy-to-administer screening instrument developed by NIMH.

> **"What is impressive about this effort is the truly interprofessional nature of the work from start to finish, the tenacity required to see it through and the impact it has had on children who otherwise may not have disclosed their suffering."**
>
> ***Allison Scobie-Carroll, MBA, LICSW***

Horowitz and Elizabeth Wharff, PhD, LICSW, chief of Social Work in Psychiatry, set forth to launch the use of this tool in the ED. Trainings were offered to nursing staff and social workers guiding them how on to utilize the tool and manage results. To date, no patients who screened positive required inpatient care. Rather, staff provided one of the following:

- Connected family with **BOSTON EMERGENCY MEDICAL SERVICES** to provide follow-up
- Shared information for **EMERGENCY SERVICES** providers in patient's local area
- Delivered **PSYCHOEDUCATION** to families
- Outlined **MENTAL HEALTH SERVICES** in patient's area (such as partial hospitalization programs and therapy providers)

The success of the pilot has led to a plan to expand the screening to non-English speaking patients and to work with interpreters to understand the cultural implications of asking the questions.

"What is impressive about this effort is the truly interprofessional nature of the work from start to finish, the tenacity required to see it through and the impact that it has had, particularly on children who otherwise may not have disclosed their suffering," says Allison Scobie-Carroll, MBA, LICSW, senior director of Social Work and Family Services.

Fran Damian, MS, RN, NEA-BC, director of Nursing/Patient Care, ED, also credits the success to Boston Children's culture of high reliability and safety practices. "Tremendous progress has been made regarding attitudes about screening and compliance with screening," she says. "Every nurse in the ED now considers it to be important and best practice."

The ASQ screening tool is now an expectation for use for all ED patients ages 12 and older.

Standardized, Evidence-Based Central Line Care

$50k

Average cost of a CLABSI episode per hospitalized child

480+

Number of clinical staff members who contributed to an evaluation of existing baseline CVC practices

Interprofessional Effort Bolsters Organization's Commitment to Reduce CLABSI Occurrences

Central venous catheters (CVCs), also known as central lines, are vital medical devices. They provide intravenous access for life-saving medications, chemotherapy, nutrition and other treatments for pediatric patients. Despite the many benefits these lines provide, they also contribute to potential health-related complications, such as central line-associated bloodstream infections (CLABSIs).

CLABSIs are the most frequent health care-associated infection in hospitalized children. Prior studies noted an increase in hospital length of stay by 19 days and estimated a cost of more than $50,000 per episode[1].

As a member of Children's Hospital's Solutions for Patient Safety (SPS) network, Boston Children's Hospital has committed to contributing to SPS' goal of reducing the national CLABSI rate by 40% by 2018. Through a series of unit-based interventions and an enterprise-wide standardization effort, Boston Children's is steadily reducing complications associated with CVC use.

"The hospital's evidence-based prevention bundle has been incredibly successful, resulting in substantial reductions in CLABSI occurrences."

Jennifer Ormsby, BSN, RN, CPN

Unit-Based Successes Treating High-Risk Conditions

Historically, individual areas across the enterprise have been responsible for investigating modifications to CVC care to benefit their patient populations. In her former role as a staff nurse III in Surgical Programs, Jennifer Ormsby, BSN, RN, CPN, recognized that intestinal failure and esophageal atresia patients are one of the high-risk populations for CLABSIs.

An interprofessional group comprised of staff nurses, nurse managers, physicians, Infection Prevention and Control specialists, pharmacists and phlebotomists developed an educational and practice strategy focused on reducing the risk of CLABSIs when caring for this high-risk patient population. Six key practices—which the workgroup called an "enhanced CLABSI prevention bundle"—were identified for parenteral nutrition-dependent intestinal failure patients. These practices are in addition to standard CVC maintenance bundle practices. Elements of this bundle include:

- **APPLYING** chlorhexidine gluconate (antimicrobial) impregnated dressings to CVC insertion sites
- **CHANGING** parenteral nutrition and intralipid tubing every 24 hours
- **CONDUCTING** peripheral venipuncture for labs
- **ENSURING** two trained staff members are present for all CVC care activities (dressing, needleless connector and line changes) and lab draws in a Distraction Free Zone
- **GIVING** daily baths
- **USING** ethanol locks on eligible patients

"The prevention bundle has been incredibly successful, resulting in substantial reductions in CLABSI occurrences," says Ormsby.

Boston Children's Infant/Toddler Surgical Unit implemented the enhanced bundle and did not have a CLABSI for the entire 2016 calendar year. In addition, the Transplant Unit, in partnership with the Infant/Toddler Surgical Unit, saw a combined 87% decrease

[1] Goudie, A., Dynan, L., Brady, P. W., & Rettiganti, M. (2014). Attributable cost and length of stay for central line-associated bloodstream infections. Pediatrics, 133(6), e1525-e1532. doi:10.1542/peds.2013-3795

in their CLABSI rate from February to December 2016.

Enterprise-Wide Standardization

In 2016, an interprofessional workgroup, led by nurses from Clinical Education and Informatics (CEI), Infection Prevention and Control (IPC), the IV team, and unit-based nursing representatives, spearheaded a six-month evaluation process to understand CVC practices across the enterprise. Their goal was to standardize CVC care and maintenance through policy and education, and ensure that all patients received the same CVC care no matter their setting of care.

A survey analyzing CVC practice was distributed and completed by more than 480 staff across the institution. Results revealed variability in CVC practice between units, and underscored the need for consistency and re-education.

"Good prevention techniques are most successful when they are conducted in the same way," says Patricia Pratt, MA, BSN, RN, CPN, NE-BC, nursing director, Medicine Procedure Units, and team lead of the interprofessional CVC workgroup. "Standardized care is also incredibly beneficial to our patients and families. It is imperative for them to see our clinical staff practicing and teaching the same CVC care."

The project began with a comprehensive literature review and a line-by-line assessment of the hospital's existing CVC policies—there were 17 in total. After 10 months, a single, evidence-based CVC patient care policy was published and approved by the Nursing Policy and Procedure Committee.

"While national organizations offer general guidelines on central line care, they often do not take into account the intricacies around these procedures," says Ashley Renaud, BSN, RN, professional development specialist, CEI. "Our new standard of practice integrates a deep level of expertise and evidence-based standards for CVC care into every care setting."

As a part of the standardized CVC care rollout, the workgroup created a mandatory, four-part educational requirement for all staff nurses who care for patients with CVCs. The competency requirement included two online modules, a post-test and a live workshop, where participants conducted a live demonstration of a needleless connector change. Additionally, prescribers completed a web-based module focused on specific practices to employ to reduce a patient's CLABSI risk.

> **"Reliable and standardized CVC care will remain at the forefront of our quality assurance and performance improvement efforts to eliminate health care-associated infections."**
>
> ***Gail Potter-Bynoe, BS, CIC, FAPIC***

As of October 2017, more than 95% of nursing staff completed the four-part CVC competency. One hundred percent of nursing staff are required to complete the competency by end of 2017.

New Clinical Products

Under the guidance of Boston Children's Infection Prevention and Control (IPC) program and the leadership of several infection prevention committees, the Clinical Products Committee (CPC) researched and evaluated the evidence for devices used to decrease the risk of CLABSIs. The CPC is an interprofessional group responsible for the evaluation of all products and supplies that are used in patient care. Boston Children's trialled and implemented the use of a neutral displacement needleless connector to replace prior positive displacement connectors, based upon recommendations from the Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America.

In June 2016, Boston Children's also implemented the use of an antiseptic-impregnated cap that is used on needleless connectors to protect CVC ports from contamination when not in use. The caps are saturated with 70% isopropyl alcohol. The sponge continuously releases the isopropyl alcohol while in place and also acts as a physical barrier to touch and airborne contamination.

Use of the Kamishibai Card

In June 2017, three inpatient areas participated in a Kamishibai card (K-card) launch for CVC care. A K-card is a visual management tool used to improve performance in a specific task. Staff from CEI and IPC used the K-card to engage nursing staff in face-to-face conversations about their patient's CVC to consider why the patient had a CVC and to assess compliance with dressing changes and line access procedures.

The goal of the trial was to measure nurse's policy compliance in CVC care. The trial was conducted over two weeks and included 112 audits. Of these 112 audits, 100% were compliant with the CVC policy for dressing change frequency.

The K-card implementation was expanded to include all additional inpatient units in August 2017. A full implementation of K-cards is now in progress and will replace current CVC maintenance bundle audits.

"Reliable and standardized CVC care will remain at the forefront of our quality assurance and performance improvement efforts to eliminate health care-associated infections," says Gail Potter-Bynoe, BS, CIC, FAPIC, manager, IPC.

Transformational Leadership

MICHELLE SOURIS, MSN, RN, CPNP, CNRN, WITH KATE IN THE CENTER FOR AMBULATORY TREATMENT AND CLINICAL RESEARCH (CAT/CR)

50+

Number of spinal muscular atrophy patients currently being treated with Nusinersen at Boston Children's

7

Average number of days from scheduling new patients to Nusinersen treatment initiation

DEBORAH SHIERS, MSN, RN, CNRN, NE-BC

Coordinating Care for Patients with Spinal Muscular Atrophy

Nursing Contributions to a System-Level Strategic Response Upon FDA Approval of a Life-Changing Drug

On December 23, 2016, the U.S. Food and Drug Administration (FDA) approved the drug Nusinersen (Spinraza)—the very first treatment for Spinal Muscular Atrophy (SMA). For families of children with SMA, the news was momentous. The disease is characterized by a loss of motor neurons, resulting in severe and progressive multi-muscular atrophy, which in its most severe stage often leads to either paralysis or early childhood death. Children may experience multiple infections, difficulty swallowing and breathing, and may also require respiratory support.

"Because this was a potentially life-changing therapy option for many patients, the team anticipated many families would be eager to obtain treatment quickly," says Deborah Shiers, MSN, RN, CNRN, NE-BC, Nursing director, Medicine Patient Services, Neuroscience Nursing. Given that the estimated cost of medication and treatment was extremely high, many care coordination challenges surfaced quickly.

Boston Children's Hospital's Spinal Muscular Atrophy Program offers a subspecialty clinic within the Department of Neurology, allowing patients to be seen by many specialists in a coordinated care setting that includes neurologists, nurses, nurse practitioners, pulmonologists, physical therapists, genetic specialists, gastroenterologists, nutritionists and orthopedists.

Jennifer McCrave, BSN, RN, CNRN, clinical coordinator, Neurology Clinic, says, "Coordination of care is a fundamental aspect of nursing practice, requiring skilled guidance to patients and families as they navigate multi-specialty care over time."

Within two weeks, the nursing team, guided by Michelle Souris, MSN, RN, CPNP, CNRN, nurse manager, Neurology Advanced Practice Nursing and provider in the SMA Program, identified the existing patients followed in the SMA Program to gauge their level of interest in this new treatment and estimate the appointment capacity likely to be needed in the clinic. The list quickly expanded to include families beyond those known to the clinic who reached out directly to Boston Children's requesting evaluation and treatment.

Access to treatment required clinical expertise and care coordination across multiple subspecialty areas to ensure safe and effective care to support intrathecal Nusinersen administration for this fragile population. These areas included Neurology, Nursing, Nutrition, Pulmonary, Orthopedics, the Center for Ambulatory Treatment and Clinical Research (CAT/CR), Interventional Radiology, Pharmacy and Anesthesia, among others.

Team members quickly began working within their respective clinical and administrative areas to schedule patients, coordinate care, obtain the drug, and mitigate financial risk for both families and the organization. Other key support areas joined clinical team members to address myriad known and potential challenges related to access, clarification of insurance approval, patient and family advocacy, as well as ethical considerations.

Conquering Logistical Challenges

The launch of novel therapies often presents specific challenges. For example, the administration of Nusinersen is complex. It is given by injection into the spinal canal, and the first three doses must be timed to be given at 14-day intervals.

Given the high cost of this medication, the working group formed a sub-team spanning Pharmacy, Patient Financial Services, Nursing, Neurology, Government Relations, and Patient Relations to establish a review and approval process to expedite timing to first treatment.

A Huddle Approach and Team Communication

Over the following five months, huddles involving stakeholders from clinical and administrative departments across the organization were implemented. Together, the team reviewed clinical benefits, coordinated care needs, identified a communication plan in collaboration with each family, and coordinated efforts to reduce the complexity of insurance approval and prior authorization. The partnership across departments mitigated delays in care to ensure timely treatment for SMA.

"The huddles were incredibly helpful to remove redundancy, provide clarity in communication and improve resource utilization," says Shiers. The group was challenged to guide both referring physicians and patient inquiries from regional, national and international families, summarize clinical chart reviews, determine optimal treatment locations, and to support family concerns related to timely access to treatment. Information sharing was supported across the team via the creation of a secure database.

In collaboration with the Patient/Family Education and Marketing and Communications Departments, the team created a workflow process map to ensure all parties involved provided consistent communication and guidance to families.

Taking Action to Advocate for Families

The commitment to provide this novel therapy to patients quickly moved beyond the clinical intervention itself, and soon highlighted numerous family requests to support advocacy efforts for their own children. Boston Children's Government Relations and Patient Relations teams facilitated family communication with public and private insurance providers to support treatment approvals. As the SMA community is well connected to one another, families noted the benefit of Boston Children's coordinated approach.

Key Outcomes

The results of this supportive, team-based approach were improved utilization of resources with direct impact on patient care access. The team was able to see new patients within two weeks and, when applicable, procedures were scheduled within seven days of insurance approval. More than 50 patients are now being treated with Nusinersen at Boston Children's.

"It was an opportunity to come together in a new way to provide access to treatment across specialties," says Shiers. In particular, close collaboration between Nursing and Patient Financial Services highlighted how important it is for these teams to work hand-in-hand for streamlined communication between families, clinical teams and external groups as novel therapies are introduced.

This work effort increased the hospital's ability to care for patients with complex conditions by establishing system-wide standards to guide a tightly coordinated care process. There are anticipated FDA approvals of more high-cost breakthrough therapies for a variety of conditions on the near horizon. This process will be replicated given its success in delivering timely treatment.

The team's perseverance continues to pay off. Souris says, "There is no greater feeling of accomplishment than to know the entire team has made a profound, lasting impact on so many children and families. The work will continue to positively impact the community."

Spinal Muscular Atrophy (SMA) Patient- & Family-Centered Team: Roles and Responsibilities

Interprofessional SMA/Neurology Team

(including neurologists, nurse practitioners, nurses, gastroenterologists, genetic specialists, nutritionists, orthopedists and pulmonologists)

to identify patients who may benefit from novel therapies and to facilitate treatment sequencing

Pharmacy

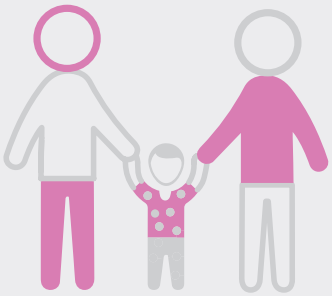
to facilitate authorized medication purchases and distribution, and monitor responses to therapy

Center for Ambulatory Treatment and Clinical Research (CAT/CR)

to facilitate the safe and efficient intrathecal administration of Nusinersen to patients

Marketing, Communications & Family Education

to facilitate internal and external communications



PATIENT- & FAMILY-

Centered Care

tailored to individual circumstances

Physical Therapy

to conduct evaluation to establish baseline and ongoing functional status

Patient & Family/ Government Relations

to provide responses to family questions regarding care, and support families as they advocate for their children

Office of Ethics & General Counsel

to engage with clinical teams to eliminate potential areas of concern when initiating novel therapies

Patient Financial Services

to collaborate with public and private insurers to confirm benefit eligibility in alignment with access and treatment plans

Evolving Professional Governance

4.24/74th

Registered nurse (RN) and clinical assistant (CA) engagement score and percentile rank*

4.28/82nd

Advanced practice registered nurse (APRN) engagement score and percentile rank*

4.52/99th

Nurse manager engagement score and percentile rank*

*Employee Engagement Survey, Press Ganey National Healthcare Database, 2017

Advancing Nurse Engagement and Professional Governance

Nursing's Professional Practice Model (PPM) is a unique framework designed to affirm shared values and beliefs about professional nursing practice at Boston Children's Hospital. The PPM serves as a guide to evaluate and evolve care delivery processes to advance professional nursing and team-based practice.

A key tenet of the PPM is the importance of the direct care nurse as a leader in decisions that impact patient care. The evolution of shared and professional governance is a means to ensure that voice is heard. Boston Children's recently modernized its governance model and the impact was clear. Since the new model's implementation, staff nurse engagement increased, outperforming the academic medical center national comparator data, according to the 2016 National Database of Nursing Quality Indicators (NDNQI) RN Satisfaction Survey results.

"We are well on our way to strengthening staff nurse leadership through our professional governance practices."

Greg Durkin, M.Ed, RN-BC

Shared Governance and Impact on Nurse Engagement

Shared governance has been part of the fabric of Nursing at Boston Children's since the mid-1980s. Shared governance is a strategy that provides direct care staff with greater control and autonomy over practice by strengthening voices in decision-making. Participative governance structures are positively associated with the healthy work environment, nurse engagement and retention.

Boston Children's Nursing's governance model organically grew to include 25 councils, committees, workgroups and taskforces within an increasingly blurred governance structure. This led to duplication of efforts and confusion as to which council or committee was responsible for a project or task. This model was no longer efficient or effective in providing direct care staff with a voice to be part of the decision making. It was also noted that staff attendance at meetings was inconsistent.

Evaluating Nationally-Recognized Professional Governance Models

Greg Durkin, M.Ed, RN-BC, senior professional development specialist and program manager, Nursing, Clinical Education and Informatics, and Lee Williams, MSN, RN-BC, director, Clinical Education and Informatics, were charged with investigating contemporary governance models via a review of the literature and interviews with senior leaders within leading health care delivery organizations who had previously advanced this work.

Based upon the evidence, Durkin and Williams put forth a proposal to simplify the model to amplify the staff nurse voice, increase staff nurse engagement, and progress toward a blended nursing/interprofessional governance model.

Changes to the model were proposed in late 2015. The first steps were introduced in 2016 to simplify the model and create a coordinating council to guide Nursing/Patient Care collaborative decision-making. The new model's coordinating council, the Nursing/Interprofessional Practice Council (NIPC), became the central organizing council. Its goal is to nurture staff nurse contributions to programs and processes that reflect the priorities of those delivering care—often well beyond the requirements and obligations of staff nurse practice.

The NIPC created new guidelines for the councils, including membership structures, term limits and

member expectations. A formal membership application process was established and nurses from all specialties and practice settings are encouraged to discuss with their nurse leaders and apply to be selected as a member of one of the governance councils.

The creation of a formal application process for NIPC membership yielded a strong response, according to Williams. "It showed that people want to be part of the new structure," she says. One of the early NIPC accomplishments was to establish a common monthly meeting day for the councils and to test time of day meeting options. The objective was to garner commitment of both staff nurses and directors/managers to support individual and work team staffing on a given day to encourage full participation in the NIPC councils.

Simplifying Professional Governance

The structure was simplified to include four councils—Practice, Quality and Outcomes, Professional Development, Informatics and Dissemination. Each of these councils functions independently and seeks to work collaboratively to move change. In late 2017, more than 100 membership applications for these councils were received, 67 of which were from staff nurses.

Boston Children's nurse engagement scores remain strong, according to employee engagement survey outcomes in the Press Ganey National Healthcare Average Database, 2017. Nurse engagement scores for staff, including registered nurses, clinical assistants, APRNs and nurse managers, rank in the upper quartile among thousands of nationally benchmarked hospitals.

"We are well on our way to strengthening staff nurse leadership through our professional governance practices," says Durkin.

Professional Governance Framework

The Nursing/Interprofessional Practice Council (NIPC) serves as the governing body for professional governance.

Functions of the NIPC

COMMUNICATE between councils to maintain activity & effectiveness

DIRECT groups to prioritize efforts and prevent duplication

REWARD and provide recognition for councils

COORDINATE chairs, membership and council goals on an annual basis

Professional Governance Council Structure

Interprofessional team members: Nursing, Pharmacy, Social Work, Clinical Nutrition, Child Life, Physical Therapy/Occupational Therapy, Chaplaincy, Respiratory Care, Laboratory Medicine and Radiology

Empowerment & Professional Development

FIONA PAUL, DNP, CPNP, WITH CONNOR AND LOGAN IN THE GASTROENTEROLOGY CLINIC

140

Number of APRNs employed at Boston Children's in 2007

375+

Number of APRNs employed at Boston Children's in 2017

Nurturing APRN Professional Development

Professional Advancement Model Based on Progressive Skill Acquisition

In alignment with the Institute of Medicine's 2010 landmark *The Future of Nursing: Leading Change, Advancing Health* report, Boston Children's Hospital created its first clinical ladder for Advanced Practice Registered Nurses (APRNs) in October 2016.

Advanced practice nursing is based on educational preparation (graduate degree in nursing), practice preparation (specialty certification) and core competencies. APRNs practice in defined roles, such as nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist or certified nurse midwife.

Boston Children's APRN Workforce

In 2007, Boston Children's employed a total of 140 APRNs. Over the last 10 years, the number of APRNs in the hospital's workforce has grown to more than 375. As the APRN workforce has grown, so have the professional development needs of this key portion of Boston Children's nursing workforce. Boston Children's views clinical advancement as a means to recognize and reward APRN practice expertise and leadership as well as a tool to strengthen APRN professional development and engagement. Members of the APRN Council, including nursing leadership, nurse practitioners and clinical nurse specialists, designed an APRN advancement model to:

- **NURTURE** novice to expert APRN development
- **RECOGNIZE** APRN clinical experience, academic preparation, professional accomplishments, research/evidence-based practice contributions and impact to both nursing and patient care

"This is about recruiting, retaining and developing exceptional APRN practice," says Terry Saia, DNP, CPNP, nurse manager, Cardiology Clinic, who co-chaired the workgroup with Fiona Paul, DNP, CPNP, nurse practitioner, Gastroenterology and Nutrition. "We have a lot of high-performing APRNs at Boston Children's, and we want to recognize the specific contributions they continue to make to the science and practice of nursing."

Saia and Paul led weekly workgroup meetings over the course of a year to develop the model and implementation plan. The group worked closely with Laura J. Wood, DNP, MS, RN, NEA-BC, chief nursing officer and senior vice president, Patient Care Operations; Marcie Brostoff, MS, RN, NE-BC, associate chief nurse and vice president, Nursing/Patient Care and Clinical Operations; and Karen Conwell, MSN, RN, CPNP, professional development specialist in Clinical Education and Informatics, to develop the model.

> **"We want to recognize the specific contributions [APRNs] continue to make to the science and practice of nursing."**
>
> ***Terry Saia, DNP, CPNP***

Shared Decision-Making

The workgroup examined the existing Boston Children's staff nurse clinical ladder, and reviewed leading practices at other hospitals, including professional development, performance evaluation, clinical practice excellence, job satisfaction and APRN retention. The workgroup also completed a systematic review of the literature.

Three Progressive Levels of APRN Professional Practice

Adapted from "Novice to Expert" stages of clinical competence by Patricia Benner, PhD, RN, FAAN.

The group also sought interprofessional feedback from numerous colleagues, including collaborating physicians.

"We wanted representatives from across the spectrum, from our CNS to our NP colleagues, to give feedback and share ideas before moving forward," says Paul. "We invited every APRN in the institution to join our working group, share ideas and participate in the creation and implementation of the new model."

Many nurses attended the first few meetings, and over time it grew into the "Wednesday Night Club." The core group, representing areas from ambulatory to inpatient units to Intensive Care Units (ICUs), provided feedback related to the translation of the draft APRN Practice Model across both primary and multi-specialty care settings.

The Ideal Professional Advancement Model

The proposed APRN model integrated the work of Dr. Patricia Benner, who applied the Dreyfus Skill Acquisition Model to clinical problem solving within nursing. This work also aligned their proposed model with Boston Children's Staff Nurse Professional Advancement Model.

The new model purposefully mirrored The American Association of Critical-Care Nurses' (AACN) Synergy Model for Patient Care. This model describes the nurse and patient relationship, in which the needs or characteristics of patients and families influence and share the characteristics or competencies of nurses. The integration of Synergy concepts into the APRN advancement model led to the development of three model domains: Clinical Practice and Outcomes, Impact and Leadership.

The next step was to identify competencies aligned with the knowledge and skills required within each domain through an extensive literature search of national, academic and organizational guidelines.

The group identified hundreds of competencies. The process to synthesize and distill to a small subset was daunting. The group of APRNs took a studied approach and conducted a competency validation process by sending the competencies to be reviewed to internal and external experts for validity testing. The competency list was further validated by the associate chief nursing officers and the chief nursing officer.

Codifying APRN Practice

The workgroup presented the advancement model to senior nursing leadership during its development. Changes were made based upon stakeholder feedback to strengthen the final product. The APRN Professional Advancement Model was approved in June 2016.

"It's really been a labor of love," says Conwell. "But it's something we feel really strongly about because we are confident this model will contribute to APRN professional development and patient care outcomes."

Paul agrees: "It has really united APRNs throughout Boston Children's in a way many of us haven't experienced in the past. It's been very exciting to formally codify the evolution of our work."

Implementation and Implications

The focus on the development and implementation of the APRN Professional Advancement Model is not only to recognize those who excel, but also to provide key support to novice staff. Programs have been established to nurture professional development across all experience levels.

APRNs across the organization see the opportunity to study the impact of the APRN Advancement Model on nurse engagement and retention, as well. "APRNs may now think differently about their careers, and can choose to move up the clinical ladder or remain where they are and do a great job," says Saia. "Now this highly motivated group has options across their career horizon."

The new model was operationalized in October of 2016. To date, 24 APRNs have been promoted to Level II. A workshop for APRNs interested in pursuing advancement has been established. This workshop is facilitated by APRNs who have been promoted to Level II.

"Experienced APRNs are leading nursing and shaping the future of health care at Boston Children's locally and around the world," says Conwell.

2,000+

Number of nurses tracked using a NetCompetency toolset spanning 75 different competency domains

44%

Pre-intervention: Staff nurse satisfaction with the competency assessment/ management process

↓

68%

Post-intervention: Staff nurse satisfaction with the competency assessment/ management process

DENISE MOLLOY, BSN, RN, CCRN, AND KAREN MURPHY, RN, CPN AT BOSTON CHILDREN'S AT LEXINGTON

Evolving the Competency Assessment Process

New Process Increases Awareness and Perceived Influence Among Interprofessional Clinical Staff

Health care delivery organizations are required to assess and advance the competence of clinical nurses and interprofessional team members. Competency assessment is more than a one-time test.

"This process is now fully integrated into the daily practice, and staff nurses have found this process to be very meaningful."

Jennifer Engel, BSN, RN

Rather, it is a continuous process. Boston Children's Hospital recognized the need for a more consistent approach to competency management and evaluation across clinical professions. Greg Durkin, M.Ed, RN-BC, senior professional development specialist and program manager, Nursing, Clinical Education and Informatics, saw the opportunity to evolve the competency assessment and management process to make it more relevant and meaningful.

In order to standardize across disciplines, and to make the process more relevant to each practice setting, every clinical area was involved. An interprofessional Competency Steering Group convened. This group included staff nurses, unit educators, clinical coordinators and Child Life specialists. They met monthly from 2014 to 2016, and continue to

Competency Assessment Survey: Staff Nurse Pre- and Post-Feedback

Staff nurse rate of satisfaction to all survey questions increased post-process revision.

meet two to three times per year as needed. These efforts have proven worthwhile. Following the launch of the new process, staff awareness of and satisfaction in the competency assessment process has increased significantly.

No More One-Size-Fits-All

The Competency Steering Group began their efforts by mobilizing staff spanning 75 different clinical practice areas, including Nursing, Child Life, Respiratory Care, Physical Therapy/Occupational Therapy, Pharmacy, Social Work and Clinical Nutrition across the main campus and satellites. Within each practice environment, they developed competencies needed and suggested modifications to the current education and evaluation processes.

This individualized competency creation approach resonated with Colleen Nixon, MSN, RN, CPHON, staff nurse III and education coordinator, Hematology/Oncology, who was involved in the competency program since its early stages. Nixon served as a member of the Competency Steering Group. "What this meant to me was finding out from the staff what they thought was important in order for them to be able to do their job competently," she says.

Every clinical area developed their own competencies and staff became accountable for bringing forth evidence of their competences. Each department committed to operating on one schedule and to ensure staff were signed off on their competencies annually.

As a part of this new process, all areas have a competency "lead." The Competency Steering Group conducts forums each November to help staff better understand and embrace the process. At the forum, they discuss results, ensure deadlines are met and competencies are completed. "In every area, staff learn and are evaluated on competencies that are appropriate to their practice, so it's no longer one-size-fits-all," says Durkin.

Jennifer Engel, BSN, RN, staff nurse III, Cardiac Intensive Care Unit (CICU), is the competency lead on her unit. Over the last year, her area's Competency Committee has grown as the initiative gained momentum. The group is now 15 members strong, and helps to verify and track competencies. The committee provides staff with regular education and updates on the committee through emails, at daily huddles and staff meetings. "This process has been integrated into the daily practice in our unit. Our staff has found this process to be very meaningful," she says.

A Digital Tracking Process

Once the competency process was revised, there were new challenges with record keeping. Keeping track of records on paper for more than 2,000 staff in 75 areas led to the implementation of an electronic solution to efficiently track competency verifications. Over the past year, the hospital has been transitioning all 75 areas into NetCompetency, a subsection of the NetLearning staff online training portal that allows for automated assignment, verification and reporting of competencies.

The transition involved a subset of areas acting as "early adopters" to test and pilot the system. Most areas received support from the hospital's nursing education team in the Department of Clinical Education and Informatics, which built 52 competencies for 23 different clinical areas, in addition to traveling to satellites to help units get up and running.

Measures of Success

This initiative spurred several measures of success. First and foremost, the effort supported the professional development of staff. Nurses have created posters, given presentations and shared case studies with peers about the competency process at Boston Children's and how it pertains to the patient population they care for.

For example, two lead competency nurses in Hematology/Oncology created and presented a poster at the Association of Pediatric Hematology/Oncology Nurses conference (APHON), marking the first time one of the authors had ever created a poster and attended a national conference. After the conference, *APHON*

Counts newsletter staff asked these nurses to write about the competency process at Boston Children's—and again, it was the first time either had a published piece. Other measures of success included:

- Involvement of 75 clinical areas
- Depth and variety of competencies selected in each clinical area
- Incorporation of competencies into an online platform
- Completion of competencies

As of today, 93% of clinical areas have reported competencies; 82% are live in NetCompetency and completion tracking processes have been established.

A pre- and post-implementation survey with staff, educators and managers was also conducted. The results showed a significant improvement for all levels of staff. One question asked staff if they were familiar with competencies. The responses improved from 44% being familiar in 2014 to 79% being familiar in 2016.

Overall satisfaction with the competency process also increased significantly. A goal was to give staff more influence in the competency process. Educators and managers had the biggest change in perceived influence, with an increase among staff, as well.

The Road Ahead

The Competency Steering Group is discussing whether to focus next on orientation competencies or to expand the annual competency process to other roles, such as clinical assistants or advanced practice clinicians. The group is also completing a publication to disseminate the learnings from this innovative competency assessment program.

Joint Accreditation for Continuing Education™

Anyone in the health care field understands the challenges of planning a continuing education course. The accreditation process requires hours of paperwork and effort, and most course directors struggle with having to complete it. Since patient care is being increasingly provided by teams, the need for continuing education courses to address team-based learning—with participants from different professions—has become more important than ever.

With this collaborative learning mission in mind, Boston Children's earned Joint Accreditation for Interprofessional Continuing Education™ and was named the **first pediatric hospital in the country to achieve this accreditation.**

"If Pharmacy is able to learn in a collaborative manner with Medicine and Nursing, it will further strengthen our teams' abilities to speak up and ask questions of one another."

Crystal Tom, PharmD, MHA, BCPS

This initiative supports Boston Children's goal to provide continuing education to its pediatric providers and specialists. Joint Accreditation allows the hospital the opportunity to provide accreditation in a more simplified process across three disciplines — Medicine, Nursing and Pharmacy. Other disciplines may decide to join the Joint Accreditation organization in the future. The accreditation is offered with one review process by global leaders, including:

AMERICAN NURSES CREDENTIALING CENTER

ACCREDITATION COUNCIL FOR PHARMACY EDUCATION

ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION

Durkin sees benefits, including the ability to provide continuing education for teams of physicians, nurses and pharmacists, as a first step to having health care teams of the future learn together. "Our work in Nursing is not performed in isolation," he says. "While we all have specific approaches to care, we are ultimately working together for patients and families. Moving to Joint Accreditation accelerates our shared goal of providing continuing education by the team, for the team."

DAISY Award® for Extraordinary Nurses

The DAISY Award® is awarded monthly to an outstanding nurse at Boston Children's Hospital. This program is in place in more than 2,800 health care facilities around the world. DAISY Award® recipients are nominated by patients, families and coworkers to recognize and celebrate compassionate care. The narratives submitted with nominations describe the impact of compassionate nursing practices on patients, families and fellow caregivers.

The program is part of Boston Children's commitment to foster healthy work environments, nurture nurses and to advance the patient and family experience. Since the program's inception, more than 100 Boston Children's nurses have been awarded this important honor recognizing extraordinary nurses for their individual contributions. This is a list of Boston Children's DAISY Award® winners from January 2016 to October 2017.

January 2016
Corrie Howe, MSN, RN, CPN
General Medicine

February 2016
Mary Trahon, RN
Surgical Programs

March 2016
Ava Mauriello, BSN, RN
Inpatient Cardiology

April 2016
Abigail Sparrow, BSN, RN
Cardiac Intensive Care Unit

May 2016
Molly Armstrong, BSN, RN, CCRN
Neonatal Intensive Care Unit

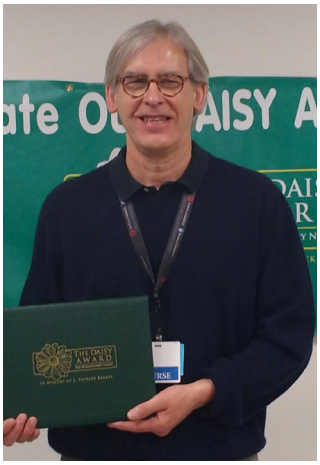
June 2016
Genevieve Ohemeng, BSN, RN
General Medicine

July 2016
Joeann Guerrero, BSN, RN, CCRN
Medical Surgical Intensive Care Unit

August 2016
Christina Ireland, MS, RN, CFNP
Pulmonary Vein Stenosis Group

September 2016
Oanh Vu, BSN, RN, CPN
General Medicine

October 2016
Jennifer Fleming, BSN, RN, CPN,CPHON
Hematology/Oncology



November 2016
Christopher O'Rourke Friel, BSN, RN, CPHON
Hematopoietic Stem Cell Transplant Unit

December 2016
Seth Metayer, BSN, RN
Intermediate Care Program

January 2017
Jill Dattilio, BSN, RN, CNRN
Therapeutic Apheresis Unit

February 2017
Alyssa Lurie, BSN, RN, CPN
General Medicine

March 2017
Jeanne Richard, RN
Main Operating Room

April 2017
Tami (Babineau) Anderson, BSN, RN
Medical Surgical Intensive Care Unit

May 2017
Emily Powell, BSN, RN, CPHON
Hematology/Oncology

June/September 2017
Paige Wilcox, BSN, RN
General Medicine

July 2017
Molly Klinka, BSN, RN
General Medicine

August 2017
Alicia Cline, BSN, RN
General Medicine

October 2017
Judie Jackson, BSN, RN, CNOR, CPN, CNRN
Main Operating Room

BOSTON CHILDREN'S AT MARTHA ELIOT HEALTH CENTER

Nursing/Patient Care Contribution to Organizational Recognition

U.S. News & World Report Ranking

In the 2017-18 *U.S. News & World Report* "Best Children's Hospitals" survey, Boston Children's Hospital was ranked as the nation's #1 pediatric hospital.

The *U.S. News & World Report* rankings are based on four key elements: reputation, patient outcomes, patient safety and care-related factors, such as the adequacy of nurse staffing and the breadth of patient services. These rankings rely heavily on patient outcomes and nurse-sensitive measures.

American Nurses Credentialing Center Magnet® Designation

The American Nurses Credentialing Center (ANCC) Magnet Recognition® is considered the most prestigious institutional distinction a health care organization can receive for quality patient care, nursing excellence and innovation in professional nursing. Only 8% of hospitals across the nation have achieved this designation. Consumers rely on Magnet designation as the ultimate credential for high quality nursing.

Boston Children's Hospital first achieved Magnet designation in 2008 and was awarded redesignation in 2012. In October 2017, Boston Children's hosted appraisers from ANCC as a part of Boston Children's next redesignation process.

Emergency Nurses Association Lantern Award

Boston Children's Hospital's Emergency Department first received Lantern Award designation in 2012, followed by redesignation in 2015 from the Emergency Nurses Association.

The award is a symbol of an emergency department's commitment to quality, leadership, cultivation of a healthy work environment and evidence-based nursing and interprofessional practice.

Beacon Award for Excellence

The Beacon Award for Excellence was established by the American Association of Critical-Care Nurses (AACN) to recognize individual hospital units that demonstrate evidence-based practices to improve patient, family and staff outcomes.

Since 2010, all four Boston Children's Hospital's intensive care units (Cardiovascular Intensive Care Unit, Medical Surgical Intensive Care Unit, Medicine Intensive Care Unit and Neonatal Intensive Care Unit) have received gold Beacon Awards. The Cardiovascular Inpatient Unit has also received a silver Beacon Award for Excellence.

These awards are evidence of positive work environments, stellar leadership structures, evidence-based practice, improvement science and positive outcomes for patients, families and staff.

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NURSING/PATIENT CARE
BIENNIAL REPORT
2016-2017

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Scan this QR code to visit Boston Children's Nursing website and to download a copy of this biennial report.

Boston Children's Hospital
Until every child is well™