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SPRING 2016

Boston Children's Hospital

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Magnet Moments

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In this issue

As all of us at Boston Children's Hospital gear up for our Magnet re-designation process, individual nurses describe what's meaningful to them about the Magnet journey by sharing their experiences at the recent Magnet Conference. Their essays impart insight on everything from leadership lessons and nurse empowerment, to how they've been inspired to elevate the profession of nursing and improve patient care at Boston Children's.

In this issue, you'll also find stories about the ways that Patient Care Operations team members have been pushing the envelope when it comes the patient experience and safety: improving health-literate communications; making the hospital safer for LGBTQ people; trainings for holding difficult conversations; putting High Reliability principles in action—and much more.

—Laura J. Wood, DNP, RN, NEA-BC

Senior Vice President, Patient Care Operations, and Chief Nursing Officer

Freedom of Information: OpenNotes®

Partnering with families to improve visit notes can bolster quality and safety

At Boston Children's Hospital, we always encourage patients and families to participate in their care, and promoting communication and transparency is an ongoing priority. OpenNotes,® a platform that gives patients and their families access to clinicians' notes about their visits, is a meaningful example of this.

The first few clinics to implement OpenNotes® at Boston Children's went live in late 2014, and every area officially came on-board in January of 2015. Now, with a year's worth of usage under its belt, Boston Children's is helping to ensure that OpenNotes® not only becomes the national standard of care, but also that the platform is as family-friendly as possible.

Having found that with the introduction of transparent records comes the need for transparent communication skills, an interprofessional team from Boston Children's is partnering with Beth Israel Deaconess Medical Center on a quality improvement project to enhance the usability of OpenNotes® for families. During the one-year pilot that begins in March, a notification will alert parents or patients when a physician's note is available. There will be an embedded tool for families and patients to use in reporting inaccuracies or potential mistakes in the notes.

"Working with Beth Israel is important because we have very different patient populations—adults vs. children and adolescents—who will use OpenNotes® differently," says **Fabienne Bourgeois, MD, MPH,** pediatric hospitalist, who is the Boston Children's principal investigator for the project.

Another facet of this new pilot is soliciting patients' and parents' responses to the structures of the notes themselves, as well as the language used in the notes. Because these notes are written for medical professionals, the language that doctors and nurses use is often abbreviated and contains medical terms familiar to them; however, these can

be hard for lay people to decipher. The pilot study will assess the ability of patients and parents to understand the notes. Families will also offer feedback on medical terms they find off-putting. From preliminary feedback, this includes words and phrases families find offensive ("obese") or implicitly accusatory ("the patient denies drug use").

A final part of the project entails petitioning the hospital's Institutional Review Board for clearance to conduct a longer survey to see how access to OpenNotes® has affected patients' and families' interactions with doctors and nurses at Boston Children's. "We want to find out answers to questions, such as: Are they more likely to speak up about issues they're having? Are they more likely to be aware of information, such as why tests were ordered, or the next steps to take?" says Bourgeois.

Use of the new reporting tool will likely go beyond the yearlong study period, allowing researchers to modify the process and make sure they're asking families all the right questions. The team ultimately hopes to make the reporting tool a permanent part of OpenNotes® to give providers ongoing feedback.

"It is exciting not only because this helps our effort to be transparent with families, but also because we are partnering with them to improve the quality of care," says Bourgeois. The project's impact is meant to be felt well beyond the two collaborating Boston institutions. Part of the goal is to share the findings nationally and help others learn from the hospitals' process of partnering with families to improve the quality of the notes and their overall health care experience. Groups from both hospitals plan to present these findings at conferences, publish papers and disseminate findings on the OpenNotes® website.

The importance of projects like OpenNotes® has been noted by the Joint Commission. As it points out in an article in *The Joint Commission Journal on Quality and Patient Safety (August, 2015)*, this kind of effort—to determine the feasibility of an online OpenNotes® patient reporting tool—goes a long way toward "developing better understanding of patient attitudes about safety and participation in care, preferences related to reporting possible mistakes in notes, and barriers to speaking up about possible errors in notes." ♦

"Examining the effects of OpenNotes® on missed follow-up appointments and referrals, incomplete diagnostic tests and procedures, delayed laboratory or test result notifications and patient likelihood of speaking up about persistent but undiagnosed symptoms can help establish a body of evidence linking OpenNotes® to safety measures."

–The Joint Commission Journal on Quality and Patient Safety, August 2015, Volume 41, Number 8

SUPPORTING PATIENTS AND FAMILIES

Reading their provider's notes strengthens families' communication with their care team and helps keep families healthy. Boston Children's is committed to supporting patients and their families in using these notes to help them:

- Fully understand their child's condition
- Make sure they are following the most current treatment plan
- Remember to follow up on procedures, tests or appointments
- Stay up to date with visits
- Prepare for their next visit
- Feel connected with doctors and nurses

Inspiring Talk on Addressing Nurses' Moral Distress Leads to a Guest Lecture

By Michele DeGrazia, PhD, RN, NNP-BC, FAAN, director of Nursing Research, Neonatal Intensive Care Unit

Michele DeGrazia, PhD, RN, NNP-BC, FAAN

Pediatric critical care nurses encounter difficult and challenging patient care situations while delivering care to critically ill patients and their families; this is fundamental to the work they do. At times, however, nurses are asked to deliver care that they believe is not in their patient's best interest. When a nurse believes that the care they deliver will lead to a poor quality of life, or is futile, it can lead to moral distress.

Moral distress develops when the nurse feels the tremendous responsibility of caring for the patient but has little authority over decisions about the care that is delivered. It occurs when the nurse cannot carry out what she perceives as ethically appropriate care due to internal or external constraints. It is said to arise "from inaction in the face of an ethical question or conflict that compromises both personal and professional values" (AACN, 2008).

When nurses experience moral distress, they feel powerless. It is a serious problem that is associated with impaired communication, disengagement from caring practices, job dissatisfaction, job retention issues, as well as diminished patient advocacy and safety.

The concept of moral distress is discussed in the literature dating back to the 1980s and the causes of moral distress are becoming well understood. However, little has been done to address this problem—that is, until recently. Attending the 2015 ANCC National Magnet Conference left me optimistic that things were about to change.

Corinne Haviley, PhD, MS, RN, of Central DuPage Hospital in Winfield, Ill., presented her work on moral distress, which consisted of a three-pronged approach for addressing the problem. The multifaceted interventions to address moral distress include counseling, ethics committee consult and cognitive learning. Counseling by the Employee Assistance Program (EAP) and/or spiritual care allowed staff to recall the event in a private setting and to have time to reflect on their experience to promote healing.

Managers encouraged their staff to contact EAP or spiritual care for confidential support. Ethics Committee consults were established to support ethical decision making around ethically challenging situations. Cognitive learning provided physician and nursing education on assessment and treatment of patients receiving provocative care. And these educational resources were advertised to staff by posting flyers throughout the units.

From Dr. Haviley's work, nurses:

- Learned how to recognize moral distress and give it a name
- Identified ways to deal with situations in which they found difficult to reach closure
- Changed the culture of the work environment to one that does not require the nurse remain silent when these types of conflicts arise

Following the conference, I reached out to Dr. Haviley, asking her to share her findings with our Intensive Care Unit (ICU) Staff Support Working Group, and she has accepted the invitation. We look forward to meeting with Dr. Haviley soon and hope to utilize what she has learned as we develop a similar program of staff support at Boston Children's Hospital. ♦

Best Practices Based In Best Evidence

A new immersion training program launches this spring

What should a nurse do when she hears, "That is the way that we have always done it," but thinks there could be a better way? In March, Boston Children's Hospital launched a novel Evidence-Based Practice (EBP) Mentor Development Program to train nurses to scientifically and methodically answer their clinical practice questions that arise from moments like these.

EBP is a problem-solving approach that integrates best evidence from past research, clinical expertise, and patients' preferences and values. Rather than conducting new research, it's a matter of examining the best existing evidence and translating it into practice.

Beginning this spring, a group of Boston Children's nurses will become the first cohort to begin the yearlong program. The project is being launched by the EBP subcommittee of the Nursing Research Council (NRC), which is chaired by **Fiona Paul, DNP, RN, CPNP,** nurse practitioner, Gastroenterology and Nutrition, and **Carole Atkinson, MS, PPCNP-BC, CNRN,** nurse practitioner, Neuroscience Programs. The EBP subcommittee has been creating new ways to more deeply integrate evidence-based practice into the work of bedside nurses, and according to Paul, this program emerged from the subcommittee retreat held in May of 2015.

"After the retreat, I went right to work, helping the subcommittee identify resources that would help bring the project to fruition," says **Michele DeGrazia, PHD, RN, NNP-BC, FAAN,** chair of the NRC. **Ethan Schuler, MSN, RN, CPNP-PC/AC,** the newest member of the EBP subcommittee, will be leading program evaluation efforts.

The Mentor Development Program, which received overwhelming support from the Nurse Executive Committee for Research and Inquiry, will pair nurses with EBP experts. These mentors, many of whom belong to the EBP subcommittee, will walk participants through the steps of answering their clinical practice questions. "This process begins by asking, Is there a scientific basis for what I am doing, is there a better way to do it and how can I put it into practice?" explains Ashley Waddell MS, RN, professional development specialist, Clinical Education & Informatics, and a lead member of the program.

Throughout the program, nurses will follow the

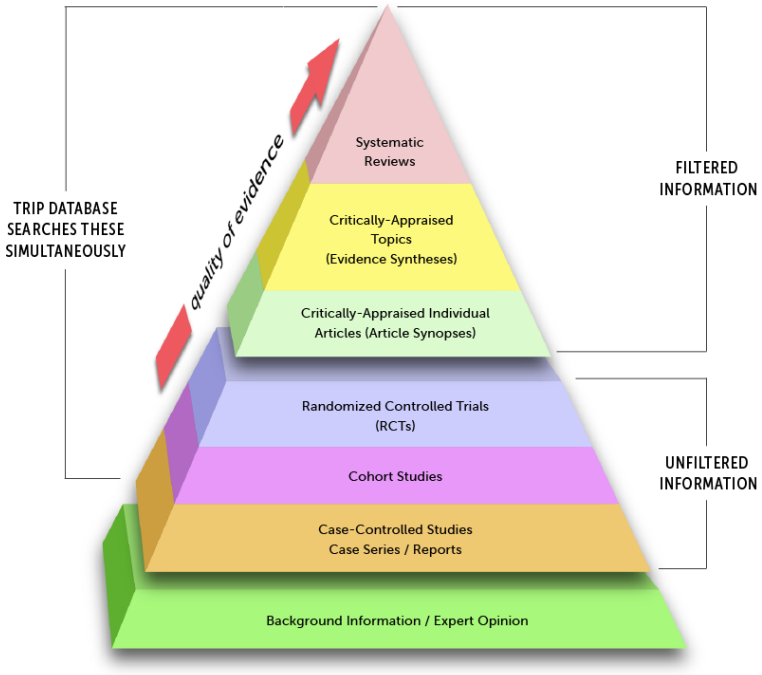

Image Courtesy of the Trustees of Dartmouth College and Yale University

steps of EBP, which include identifying an important clinical practice question, searching for and critiquing current evidence and integrating clinical expertise and patient preferences with the evidence. They will follow through with an evaluation of current practice, and provide recommended changes based on evidence. Participants will then share their projects during the annual Nurses' Week celebration. What's more, the mentors will encourage participants to share their findings externally at national conferences and in journal publications.

The EBP subcommittee hopes to make the program available to all nurses seeking to further their professional development while contributing to the quality of care they deliver. Another goal is to foster a culture of EBP by developing system-wide EBP expert mentors. "We envision that each nurse who goes through the program will complete a project and then serve as mentor," says Waddell. "There will be an ever-growing number of nurses with the knowledge and skills to carry out EBP and support the development of their colleagues." ♦

WHY EVIDENCE-BASED PRACTICE?

- Ability to translate research into bedside practice
- Improved patient outcomes
- Justification for standards of care
- Evidence of practice standards for patients
- Evidence of practice standards for regulatory agencies and other stakeholders

Veteran Conference Attendee Inspired to Bring Aromatherapy Into Her Practice

By Pam Lundergan, BSN, RN, staff nurse II, Post Anesthesia Care Unit

I have been a Magnet Champion for about five years. I've attended three magnet conferences before this most recent conference in Atlanta. Each time I attend the Magnet Conference, I gain more insight and knowledge about the Magnet process.

At the 2015 ANCC National Magnet Conference, I was excited to attend a session on aromatherapy, called "Common Scents: Using a Placebo-Controlled Research Study in Aromatherapy to Drive Practice." And I was eager to view the poster, "Nurse-Delivered Aromatherapy in a Large Healthcare System." I've begun using essential oils in my own daily life, and I have read articles discussing how they are being used in hospitals in the United States. I was interested to learn more and find out how I could possibly incorporate them into my practice.

In my 16 years in the PACU, I have seen how patients can have problems recovering from sedation, such as experiencing pain, nausea and vomiting after surgery. We give pain and anti-nausea medications, but sometimes the treatment for pain can make nausea worse. When I saw the aromatherapy poster, I was excited to see data showing how the researchers reduced nausea, anxiety and pain by incorporating essential oils. Of the three areas I mentioned above, nausea had the most reduction after incorporating the essential oils.

I felt inspired to bring this knowledge back to my own practice. I came back to Boston Children's excited to discuss with my peers all the things I'd learned. I even talked to my nurse manager about the possibility of doing a study using aromatherapy in our PACU.

At a debriefing after the conference, I discovered that we have access to essential oils at Boston Children's. I have identified this as a goal for myself: to become certified in the use of aromatherapy and begin using them in my practice for my patients. I would like to look into studying the efficacy of using essential oils in the PACU setting to reduce nausea, and possibly pain and anxiety, and plan to incorporate this practice into our care delivery system. ♦

Dispatch from Yangon: Changing Nursing Care in Southern Myanmar

By Marilyn Moonan, MSN, RN, CPN, educational coordinator for surgical programs and nursing fellow in the Global Pediatrics Program

As I walked into the inpatient pediatric oncology waiting area at Yangon Children's Hospital—a relatively modern, well-equipped hospital in Yangon, Myanmar—a beautiful young woman approached me. She was holding her son, a 15-month-old boy who had Down syndrome. In English, she repeatedly sobbed, "Please help me."

An interpreter explained that she and her husband were farmers from rural northern Myanmar (more than 700 miles from Yangon, an urban area of more than five million people) and that recently their son had not wanted to breast feed, had been sleeping a lot and had developed lumps in his neck. They had previously traveled to Thailand, where their son was diagnosed with acute lymphoblastic leukemia. The parents had sold their farm to travel to Yangon so their son could receive chemotherapy.

I put my arm around her but could not think of what to say that would give her comfort. It was my first day at Yangon Children's, where I traveled as part of my yearlong Global Health Nursing Fellowship with Boston Children's Hospital's Global Health Program. With this single, chance meeting in the waiting area, it took all of 15 minutes for me to begin to understand the challenges that families and medical staff in Myanmar face in providing quality, consistent health care.

Morrissey with members of Yangon Children's health team

The challenges of care

Normally, I'm the educational coordinator for Boston Children's surgical programs. But in June 2015, my colleague **Lisa Morrissey, MPH, MSN, RN, CPHON,** nurse manager of 6 Northeast (Hematology/Oncology/Research), and I traveled 28 hours on three flights for a unique opportunity. We were to be catalysts for positive change in how nurses care for families and children in a region of the world where so many factors keep quality health care from being achieved with any regularity.

There are many distinct health care system challenges in Myanmar. The nation allocates only two percent of its gross domestic product (GDP) to health care, the lowest amount in all of Southeast Asia. Nursing is task-oriented, and nurses are only paid about $100 per month. Nurses are not specifically trained for pediatric oncology and rotate throughout the hospital every six months. One nurse and one resident are together responsible for a ward of as many as 50 pediatric oncology patients at night.

Despite these challenges, the nurses we worked with were extremely caring and clinically competent. They were thirsting for knowledge and enjoyed learning about any topic that we presented.

Forces of nature

My visit to Yangon lasted just over a week. I checked in on that mom and her baby each day that I was in the hospital. The baby had responded well to the treatments. I found out that the mom had

taken on the role of comforting other mothers with children on the unit, often carrying their babies through the unit while hers slept, so they would have some relief.

I saw her one more time, when it was time for me to fly home. We exchanged smiles, hugs and well wishes, but there was finality in our goodbyes. I knew there was little, if any, chance that our paths would ever cross again. There was no way that we could stay in touch; she did not have access to the Internet in her remote village.

Several months after I returned home, I began hearing about devastating flooding in northern and other areas of Myanmar. Nurses we had met in Yangon shared horrifying photographs—a dead infant floating in a flooded village, a toddler chest-deep in mud, holding a dead, mud-covered snake. More than 100 people died, and thousands were displaced as mudslides wiped away their homes. Water sources were contaminated, power sources were cut and roads and bridges washed out. I thought about that beautiful family and wondered if they had escaped the fury of Mother Nature. I also worried about the storms' effects on the oncology patients I'd met. How do they maintain their fluids when their water was contaminated? How do they avoid infection? How can they possibly even think about making it to a follow-up appointment? The overall rate of oncology treatment abandonment in Myanmar is thought to be about 25 percent. I am sure that this extreme flooding only exacerbated the problem.

The Myanmar government held elections in November of 2015, and many wonder if there will be a change in how the Ministry of Health approaches health care. As we continue our work in Myanmar, we hope to continue building strong partnerships with interprofessional teams at Yangon Children's, working for positive and sustainable change. ♦

This was Moonan's first trip to Myanmar, but she has also traveled extensively with Operation Smile over the past 15 years to Asia, Africa and South America. She is returning to Yangon for another fellowship visit in February 2016.

Boosting Health-Literate Communications

Patient & Family Education team leads initiative to meet health literacy needs

The health care setting is rife with medical terminology and jargon, leading to communication barriers that can have serious effects on patients' health and safety. Limited literacy skills are one of the strongest predictors of poor health outcomes for patients: They know less about their chronic diseases, are worse at managing their care and less likely to take preventive measures for their health.

The problem is widespread, as only 12 percent of adults have "proficient" health literacy, according to the National Assessment of Adult Literacy. In fact, research shows that patients only understand about half of what a provider tells them, and many patients do not feel comfortable asking providers to repeat or clarify information.*

To reduce the complexity of health care and to increase patient and family understanding of health information, Boston Children's Hospital's Clinical Education & Informatics Department (CEI) has formed a Patient & Family Education team made up of staff with a range of expertise—from plain language writing to the use of health communication theory to graphic design. Their goal is to make Boston Children's a "health literate organization"—a term coined by the Institute of Medicine for an organization that makes it easier for people to navigate, understand and use health information and hospital services.

There are 10 attributes to a health literate organization:

1. Ensuring easy access
2. Leadership promotes
3. Including consumers
4. Meeting needs of all
5. Designing easy to use materials
6. Targeting high risk
7. Explaining coverage and costs
8. Communicating effectively
9. Preparing workforce
10. Planing, evaluating and improving

To meet these attributes, the Family Education team is leading several initiatives (described below) in partnership with the Family Advisory Council, clinicians and hospital staff.

"As an organization committed to patient- and family-centered care, the need for a clear strategy to meet the health literacy needs of our patients and families is crucial," says **Kristin Erekson, MA, CHES,** health education project manager and editor in Clinical Education & Informatics, and a certified health education specialist. "Not only is it important to provide the best possible care, but it is also important for Boston Children's to provide an experience that empowers patients and families to confidently manage their health both inside and outside of our hospital."

"Health literacy is the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."

— *U.S. Department of Health and Human Services*

Designing easy-to-use materials

Boston Children's provides a plethora of family education materials for its patients and families, including handouts, videos and mobile applications. According to the Institute of Medicine, a health literate organization "designs and distributes print, audiovisual and social media content that is easy to understand and act on." As a starting point, the Family Education team assessed the literacy of its library of Family Education materials, which contains more than 1,000 handouts on diseases and treatments, procedures and tests, and home care instructions. With an increasingly diverse patient population, the team felt it was imperative to create new materials that use easy-to-understand language as well as illustrations and photos to demonstrate step-by-step instructions for families to follow at home.

The team identified priority diagnosis-specific materials to rework, including asthma and diabetes, and partnered with clinicians from those areas to rewrite and redesign their Family Education Sheets. For **Jean Potter, BSN, RN, CPN, CDE,** an inpatient diabetes nurse educator in Medicine Patient Services, the timing of the project was ideal. She had recently encountered an incident where a child was readmitted to the hospital a day after she was discharged home. Through discussion with the mother via an interpreter, Potter discovered that the mother struggled to understand the home care instructions she was given.

"Based on my assessment after readmission, it was evident the current diabetes education materials used in our Inpatient Diabetes Program were not going to work for this mother," says Potter. "In my 28 years of nursing, this was my first encounter with an extreme level of illiteracy and I identified an immediate need for the development of suitable teaching tools to help this mother learn how to manage her child's new diagnosis."

Brendan Whipple, BFA, graphic designer in Clinical Education & Informatics, is working with Potter to create diabetes handouts that are almost entirely image-based and customizable. Potter says that these illustrated Family Education Sheets have made a marked difference in her patients' and families' self-efficacy.

To date, the Family Education team has revamped more than 200 Family Education Sheets, all of which now read at a seventh grade reading level or lower. Newly revised materials include those on asthma device use, central line care, ostomy care and AED device use. Visit Boston Children's Family Education eLibrary here: *http://chbshare.chboston.org/elibrary/ptsvc/educate/famed/default.aspx*.

Need help with your Family Education Sheets? Contact family.ed@childrens.harvard.edu

Including consumers

Boston Children's offers many initiatives that allow patients and families to engage with the hospital beyond their clinical care experience. From the Family Advisory Council to a peer-mentoring program, the hospital aims to have families at the center of every decision made that affects quality of care, safety or patient experience.

According to the Institute of Medicine, a health literate organization "includes populations served in the design, implementation and evaluation of health information and services." Families now play an integral role in the assessment of Boston Children's patient and family education, particularly Family Education Sheets. One out of every 10 sheets is reviewed by a committee of families who have had experiences at the hospital. These families' use an education assessment form to assess the sheets' content, understandability,

reading level, writing style/tone and design. The form is modeled after the Suitability Assessment of Materials, an instrument that offers a systematic method to quickly and objectively assess the suitability of health information materials for a specific audience.

Katie Litterer, family partnerships coordinator and a Family Advisory Council member, has been a champion for Family Education, working in partnership with Erekson to build a roadmap to make Boston Children's a health literate organization. Litterer and Erekson have presented on the topic of health literacy and patient and family education in a variety of venues, including Planetree's 2015 International Conference on Patient-Centered Care, the 2015 Health Care Education Association Conference and a recent webinar for the Massachusetts Association for Healthcare Quality.

"Family Education is important to me, as a parent, for two major reasons," says Litterer. "First, being educated about what challenges my child is facing enables me to be the parent that my child needs, asking the right questions and advocating for her while helping manage her expectations." She adds, "Second, an educated parent/family member and a clinician can engage in a true collaborative effort to find the best solution for a child when both parties hold the information that they need to do so." ♦

RED FLAGS FOR LOW LITERACY

According to The Permanente Journal and the American Medical Association, some red flags that could indicate a family's low literacy are:

- Incompletely filled out forms
- Frequently missed appointments
- Poor compliance
- Inability to identify the name, reason or timing of a medication
- Not asking questions
- Reactions to written materials such as, "I forgot my glasses" or asking the physician to read the materials aloud

**Schillinger, D., Piette, J., Grumbach, K., Wang, F., Wilson, C., Daher, C., et al. (2003). Closing the loop: Physician Communication with diabetic patients who have low health literacy. Archives of Internal Medicine, 163, 83-90.*

Image Courtesy of the Institute of Medicine

Consistency on Cooling Blankets

'Speaking up for safety' regulates policy

For **Grace Leblanc, BSN, RN, CPN,** nurse manager in Inpatient Medicine, using the High Reliability principle of Speaking Up for Safety is second nature, due to her role managing safety events. She works closely with staff to identify the root causes of safety-compromising events by asking, "What could be done differently?" and taking steps to prevent them from happening again.

Recently, Leblanc had occasion to use this High Reliability principle after noticing that a staff nurse on her unit had requested a cooling blanket from the hospital's Centralized Equipment Pool (CEP), and one had been sent to the floor. This wasn't in line with what she'd understood to be hospital policy based on work she'd done several years ago as part of a small group of nurse investigators who examined the hospital's use of water-cooling blankets.

They had noticed a lack of consistency in how, when and where hospital staff used them. Taking a step back, the group posed the overarching question: Are cooling blankets, in fact, an effective fever treatment in hospitalized pediatric patients?

The group examined consistency within the hospital on the blankets' use and conducted evidence-based practice research by reviewing existing literature, outside institutions' policies and American Association of Critical-Care Nurses (AACN) guidelines. In the studies they reviewed, cooling blankets did decrease fever—but the safety and efficacy of this practice was questionable when used outside of intensive care units.

The team's benchmarking survey established a need for more research on fever management and the use of cooling blankets in non-critical pediatric patients, as well as evidence-based policies. And in soliciting expert opinions, they discovered that some experts argue that fever is an adaptive mechanism and therefore they suggest not using cooling blankets to treat fevers outside of intensive care units.

After bringing these findings to the Nursing Practice, Quality & Outcomes Committee, it was decided that the cooling blankets were not recommended in non-intensive-care inpatient areas. "Because there is natural turnover in every department, not everyone is aware of every policy change," says Leblanc.

Seeing an opportunity to re-educate staff, she brought the matter to nurse leaders' attention and suggested a simple solution: Connecting with CEP

to make sure each cooling blanket is tagged with a laminated sign to remind everyone they aren't to be sent to—or used on—floors outside of the ICUs. "Creating a visual barrier is a good physical reminder for staff to stop and check what they're doing," she says. Leblanc is happy to set a good example by pointing out this opportunity for communication improvement. "I encourage others to speak up for safety whenever they notice something like this," Leblanc says. "We're working to have everyone feel like they're empowered to say something." ♦

Nurse Gets Eye-Opening Perspectives About Other Hospitals

By Stephanie Cantlin, SNS, RN, staff nurse I, Neonatal Intensive Care Unit (NICU)

I started at Boston Children's Hospital as a student nurse, and I quickly realized how the environment differed here from other local hospitals where I had done clinical rotations. I was impressed with the ability of nurses to advocate for their patients and how complex multidisciplinary teams were able to work together to create care plans for patients. I knew at that time that I wanted to work here. I started as a new graduate nurse four years ago, and I have been learning what the Magnet process is all about through the lens of Boston Children's.

When I was invited to go to the 2015 ANCC National Magnet Conference, I was excited to connect my impressions of the roles we play as nurses—our autonomy and how the hospital utilizes us—with what it means to be a Magnet hospital.

It was eye opening to see how most other hospitals are so different from one another. After every talk at the conference, I was struck by the fact that we are already doing what other hospitals are just starting to implement, for examples models of collaboration and Program to Enhance Relational and Communication Skills (PERCS) rounds. I was devastated to learn that at some hospitals there continues to be lateral violence among nursing staff. It made me appreciate the care that experienced nurses here at Boston Children's take in welcoming new nurses and making us feel comfortable and part of the team. Through the six-month preceptorship and beyond, we are supported and guided to grow into strong nurses who are able to provide high-quality care and advocate for not only our patients but also ourselves. It is clear that Boston Children's promotes a culture of investing in nurses.

A young professionals group was recently started in the NICU for newer nurses to come together once a month to talk about their stressors and feelings, and to work through them as a group. We also have monthly PERCS rounds run by one of our level II nurses to provide a forum for talking about topics that might be causing moral or ethical distress. Both of these sessions ensure confidentiality and provide a time for us to learn from each other's experiences, support each other and learn new ways to cope with the different stressors that come with our job. At the Magnet conference, this sounded like it was a new concept for many hospitals. I found it impressive that we have a well-developed program here.

Broadly speaking, what I heard at the conference made it sound like nurses at other hospitals are trying to figure out systems to be more nursing-focused, which made me realize how much nurses' opinions are valued here. We are able to advocate well for our patients due to the high degree of multidisciplinary collaboration, and we are given opportunities to advocate for ourselves.

The experience of attending the Magnet Conference is sure to give anyone a good sense of perspective. For me, this was especially true since I have never worked anywhere other than Boston Children's. It has made me much more appreciative of the supportive environment we have here, and I am proud of everything we do to take care of one another. ♦

Grand Opening of Community-based Acute Treatment Program

High Reliability infuses Waltham's new community-based behavioral health care operations

There is high demand for intensive behavioral health services, both within Boston Children's Hospital and the larger region. Over a period of several years, nurses, physicians and behavioral health team members at Boston Children's have studied how to meet this need.

As a result, acute behavioral services expanded this winter, with the opening of a new, 12-bed, intensive, community-based treatment facility (CBAT) at Boston Children's Hospital at Waltham. The CBAT is designed specifically for children who require 24-hour care and who have moderate psychiatric and behavioral needs.

In establishing many of the operations for the 24-hour community-based acute treatment unit, **Martha Butler, RN, PMHCNS,** nurse director of Boston Children's Inpatient Behavioral Health Unit, in collaboration with CBAT Nurse Manager **Amy Alleman, PNP,** saw the opportunity to incorporate High Reliability principles into the unit's policies, operations and communication structure from the very beginning.

Alleman and Butler, along with the program's Nurse Educator **Lisa McCordic, RN, PMHCNS,** and **Cheri Sinclair, BSN, RN,** Bader 5 clinical coordinator, looked to High Reliability to design the orientation classes and simulations for the new staff. Alleman and Sinclair are members of the hospital-wide High Reliability training team.

"High Reliability is organized around a set of guiding principles that we used in our planning for this new program and in planning the care we deliver," says Butler. "These principles apply to all operations of a 24-hour care setting, whether it's the way we answer the door, how we orient patients to our safety guidelines on the unit or how we de-escalate high-risk behavior."

For example, the new unit designed operational communication structures (such as nursing staff hand-offs and reports at change-of-shift) using High Reliability principles (like closed-loop communication). During orientation training, nurse leaders encouraged all staff, regardless of their position, to use the High Reliability "Speak Up for Safety" technique. They're also using the STAR (Stop-Think-Act-Review) approach to ensure that an intervention or process is done thoroughly.

Alleman points out another element that has been incorporated into the CBAT's operational structure in order to establish a reliable and extremely safe care environment. "From the program's inception, we've created a standard of relying upon the High Reliability method of cross-checking," she says. "Staff can easily say to one another, 'Don't forget to do this,' and ask, 'Did we make sure we did that?' "

To promote the efficient patient flow and referral to these beds, a nurse (and when available a doctor) from the new CBAT program will join the existing Psychiatry departmental Daily Huddle, which was instituted during the first phase of the institutional High Reliability initiative. This interdisciplinary meeting focuses on facilitating the referral and placement of behavioral health patients being cared for in the ED and as inpatient boarders. "CBAT staff will join Psychiatry colleagues in ongoing efforts to improve the efficiency of care for all of our behavioral health patients and families," says Butler. ♦

Construction of the new CBAT program in Waltham

Safe Zone Success

Training for LGBT patient-centered Care

For the past several years, staff from across Boston Children's Hospital have been working on grassroots efforts to promote equitable and inclusive care for our LGBT (lesbian, gay, bisexual and transgender) patients and families. Two keys groups at Boston Children's committed to these goals are the LGBT & Friends Committee and the Rainbow Health Consortium for Gender and Sexual Diversity.

Last year, various employees from these two groups donated their time to bring Safe Zone trainings to the hospital. They worked with the national organization The Safe Zone Project to become trained in facilitating Safe Zone educational workshops. These workshops began in colleges around the country to teach students and staff about gender and sexuality diversity, and these groups had a vision to adapt the training to the hospital setting.

"Our goal is to support our LGBT patients, families and co-workers by fostering a respectful community—one in which all patients and employees feel welcome and valued," says **Katharine Thomson, PHD,** attending psychologist on the Psychiatry Consultation Service and co-leader of the Safe Zone initiative at Boston Children's.

Last June, nearly 30 staff from across disciplines, including Social Work, Psychiatry, Chaplaincy, Adolescent Medicine and Nursing attended a full-day workshop to become Safe Zone trainers. A core group of those trainers took on the work of consolidating and adapting the curriculum to fit the hospital setting, and Boston Children's in particular. They have now created a two-hour workshop (including an option for a one-hour version) that focuses on:

>>story continues on next page

LGBT LEADERSHIP STATUS

The Healthcare Equality Index (HEI) is the national LGBT benchmarking tool that evaluates health care facilities' policies and practices related to the equity and inclusion of their LGBT patients, visitors and employees.

The HEI evaluates more than 1,500 health care facilities nationwide. It's not easy to be a HRC-designated Leader in LGBT Healthcare Equality. Policies, employee training and patient care must reflect a commitment to truly comprehensive and fair treatment for LGBT patients.

The organization recently reviewed a survey submission filed by **Laura Wood, DNP, RN, NEA-BC** senior vice president, Patient Care Operations and chief nursing officer, on behalf of the hospital. The HEI reviewers established that the hospital has met the four foundational criteria for LGBT patient-centered care known as the Core Four and has achieved 2015 and 2016 Leader in LGBT Healthcare Equality status.

The Core Four areas are:

Patient non-discrimination

- Patient non-discrimination policy (or patients' bill of rights) includes the term "sexual orientation" and the term "gender identity"
- LGBT-inclusive patient non-discrimination policy is communicated to patients in at least two documented ways and is communicated to staff

Equal visitation

- Visitation policy explicitly grants equal visitation to LGBT patients and their visitors
- Equal visitation policy is communicated to patients in at least two documented ways and is communicated to staff

Employment non-discrimination

- Employment non-discrimination policy includes the term "sexual orientation" and the term "gender identity"
- Employment non-discrimination policy is communicated to the public in at least one documented way

Training in LGBT patient-centered care

- Staff receive training in LGBT patient-centered care to staff at all levels
- All staff involved in patient care services must be informed of the free LGBT training opportunities available through the HEI

As a result, Boston Children's will be featured as an Equality Leader in the HEI 2016 report, which was released in March of 2016 during LGBT Health Awareness Week.

- Understanding differences and diversity in sex, sexuality and gender
- Learning about respectful and current terminology
- Discussing department-specific scenarios to help employees brainstorm approaches to promoting safe and welcoming environments for LGBT patients, families and coworkers

The overarching aims of the training are to expose people to concepts and terms that will increase their ability to respond to LGBT patients and colleagues with respect and sensitivity. "Ultimately, this will serve as a launching off point for continued learning, which we are certain will create an improved patient, family and employee institutional culture and experience for all," says **Allison Scobie-Carroll, MBA, LICSW,** director of Social Work, who is one of the Safe Zone trainers.

The committee has already been invited to lead Safe Zone workshops for several groups across the hospital, including Staff Nurse Council, Human Resources, and Psychiatry Administration. The goal is to train 100 employees per month and eventually provide CME/CEUs for the training. The committee is also looking to recruit new trainers in the months ahead.

"The reaction among participants has been very positive thus far, with most participants reporting increased knowledge and comfort with LGBT issues and appropriate language to use in clinical and other professional contexts," says Scobie-Carroll. The committee is capturing pre- and post-training data to illustrate whether trainees have achieved increased awareness in key areas and whether overall comfort in addressing the needs of LGBT patients or employees has improved as a result of the training. Thomson and the core committee are hoping to publish their results in order to assist other hospitals in creating similar programs. ♦

The Safe Zone committee (safezone@childrens.harvard.edu) can also provide ongoing support and resources for employees wanting to learn more about the LGBT community.

Optimizing Patient Flow

An integrated platform introduces a new level of efficiency

More than a year's worth of planning came to fruition when the new hospital-wide bed management system by Cerner, CareAware Capacity Management for Patient Flow, rolled out on January 18, 2016. The existing platform had become outdated, and a core planning group took the opportunity to seek ways to improve patient flow by adopting a new bed management system.

Members of Nursing and Patient Care, Administrative Staff, Environmental Services, Clinical Education & Informatics, Information Services and subject matter expert (SME) groups worked together to identify and evaluate criteria that support the smooth flow of patients through clinical areas. They also studied how to reduce impediments to the efficient flow of patients. Armed with that information, the team collaborated in developing a system to improve hospital-wide performance in areas such as:

- Completing a transfer on patient arrival
- Transferring a patient out of a unit
- Switching a patient's bed
- Assigning patient's attributes
- Planning a discharge
- Canceling a discharge

The resulting platform has been customized to serve Boston Children's Hospital's unique needs, reflecting key planning requirements that affect patient placement and capture acuity, such as care companions and security measures. Several features that were not present in the previous system will reduce delays, enabling better attention to a wide range of patient throughput and capacity management challenges. Some of these customized improvements are:

- Pages are sent immediately to physicians when a patient is placed on their service, alerting them of the admission
- Infection prevention precautions enter directly from doctor's orders into the flow (reducing the need to obtain additional clarification and to move

patients to precaution-friendly rooms)

- Environmental Services use iPod touch technology instead of being notified by pager to clean a room
- The platform connects with Epic, enhancing reporting capabilities
- Administrative associates have access to PowerChart, where requests for transfers take place

"This platform is going to help place patients more smoothly, because it's one-stop-shopping—there aren't so many moving pieces," says **Suzanne Reidy, MS, RN, NE-BC,** director of Patient Flow and Staffing, and member of the planning group. "It's all on one system that you can rely on, so it will be a big time-saver for everyone." ♦

Inspired to Improve on Excellence

By Lynne Hancock, MSN, RN, NE-BC, project manager, Patient Care Operations, Magnet program director

The role of the Magnet Program Director (MPD) is a unique role. As the MPD for Boston Children's Hospital, it is my responsibility to shepherd the organization through the Magnet re-designation process and keep us on track. One way in which I keep current on what's going on in the world of Magnet is to attend the annual Magnet Conference. I have attended it every year since 2008, and each year the presentations get better and there are more take-away ideas than ever before. It is stimulating to be surrounded by 9,000 nurses all aiming for the same thing: to elevate the profession of nursing, improve patient care and continue to achieve higher degrees of excellence. Magnet is not a competition, and this is made clear at the conference. Everyone wants each other to succeed. That doesn't happen too often, but in Magnet it does.

The conference gives me the opportunity to network with other MPDs and to find out how they address new Magnet requirements and lessons they have learned over the last year for either achieving or maintaining designation, as it is always a work in progress. This year, there were many presentations about how organizations have redesigned their shared governance structures, clinical ladders (professional advancement) and peer review process. This is very similar to several discussions going on currently within Nursing at Boston Children's.

I come back from the conferences able to confer with leaders and staff that we are heading in the right direction, and bring back some ideas that perhaps were not considered previously. One lesson that I always take from the conference is that Magnet is not about being the perfect nursing organization; it is about how we stretch in order to continue to achieve a higher level of excellence.

Coming back re-energized it what the Magnet conference does for many nurses. Motivated. Empowered. These are some of the words that staff share with me after returning. What one finds out by attending the conference is that Magnet is not just a recognition program, a plaque or trophy. It is a culture.

The Boston Children's Nursing "tag line"—Dedicated to Excellence—exemplifies the mindset of an organization that maintains a culture that supports the achievement of Magnet status. Magnet recognizes the impact of direct care nurses (staff and advanced practice) on practice and the practice environment. It is not about how the work gets done, but what difference did nurses make. It's about the positive impact nurses make on patient care, which is visible across our organization.

Currently, we are in the documenting phase, and over the next few months, I will be reaching out to find evidence of how nurses actualize the tenets of Magnet. These months are one of the most rewarding periods for someone in my role. I get the privilege of seeing all the great work nurses have been driving and participating in across the organization. Many times, I think, "This is fantastic!" (and I will admit that I clap, too).

One could look at achieving Magnet status as the Academy Awards for Nurses. The award is not presented to individual stars but to an ensemble cast of our nurses. ♦

Advancing Pediatric Care in Haiti

By Alexis Schmid, MS, RN, CPNP-PC/AC, CPEN, CCRN, nurse practitioner, International Services & Emergency Department

I'm writing this looking out over the mountains of Haiti's central plateau. Children's laughter is in the air as they play a soccer game barefoot with a deflated ball. A small fire crackles nearby as garbage burns. Goats mew, chickens cackle, a cow ambles nearby. The University Hospital of Mirebalais is in the foreground, a crown jewel in the midst of utter destitution. People live in huts with no doors, children run barefoot, food can be scarce; however, singing is abundant and constant in the air.

Class started in March 2016 for the 24 week Pediatric Intensive Care Course and Neonatal Intensive Care Course in Mirebalais, Haiti, a collaboration between Boston Children's Hospital and the NGO Partners in Health. Approximately 45 nurses from the Emergency Department, the Medical Intensive Care Unit, the Medical/Surgical Intensive Care Unit and the Neonatal Intensive Care Unit at Boston Children's Hospital will be volunteering their time to advance pediatric care in one of the poorest countries in the western hemisphere. Nurses will be traveling in groups of four per week (two to teach the PICU component, two to teach the NICU component) to teach this course. The course is two didactic days per week and two clinical teaching days per week. During the clinical sessions, Boston Children's nurses precept Haitian nurses at the bedside, mentoring patient care. Nurses from different wards at Boston Children's are travelling together, drawing from one another's expertise and strengths.

The Haitian nurses are incredibly smart, driven, resourceful, compassionate and excited to learn; however, I have a feeling Boston Children's staff will be learning quite a lot from them as well as they work by their side. ♦


MEBIOTECH LABORATOIRE MEDICAL

My Journey to Becoming a Nurse Scientist

By Jennifer Baird, PhD, RN, MSW, pediatric health services fellow, Cardiovasular and Critical Care Nursing

Jennifer Baird, PhD, RN, MSW

I started my career as a social worker—not a nurse. While I did my practicum for my master's in Social Work, I worked with kids in the foster care system with chronic conditions. I took them to medical appointments and helped figure out their health care plans. That's when I first realized that nurses had an amazing role—they were attending to kids' health, often using many of the skills I had learned as a social worker.

I had an "aha" moment: Maybe I was meant to be a nurse! It seemed like an empowering role in a lot of ways, because there are so many challenges to working in the foster care system, especially in terms of the limits placed on which kids can stay with their families and which ones have to be removed. In contrast, the nurses' focus was on restoring kids to health and teaching families how to help keep their children healthy—for me it all came together. My grandmother was a nurse. She worked as a visiting nurse in people's homes, and growing up I thought that was interesting, but I hadn't given it much consideration in relation to my own plans. But once I started working alongside nurses, I realized that there is so much within nursing that I could do. I loved that nurses are at the center of a lot of the efforts toward reforming health care and have many opportunities to have an impact. My grandmother's experiences helped to highlight the wide variety of roles that nurses have, and talking with her helped to convince me that it was something that I could do.

That changed my career trajectory entirely. After going to nursing school, I worked in the PICU at UCLA for two years, then did a doctoral program at University of California, San Francisco. While earning on my doctorate, I worked on a pediatric oncology unit, taught nursing students in the hospital, and eventually returned to working in the PICU. After completing my PhD, I came to Boston Children's Hospital for the Harvard-wide Pediatric Health Services Research Fellowship, which provides additional, post-doctoral research training.

Working in the ICU was an eye-opening experience for me. I saw how nurses are front-and-center in partnering with physicians on quality improvement and evidence-based practice. I realized there was a whole other side of nursing that was shaping care. It was really exciting to me because it puts nurses in more of a "driver's" position. As nurses, we know what needs to be changed and we can use systematic methods to drive that change.

That's what I love about my work here with my mentor, **Jean Connor, PHD, RN, CPNP,** director of Nursing Research, Cardiovascular & Critical Care in Patient Services, and her Nursing Science Fellowship team. There aren't many post-doctoral fellowships in pediatrics, and few in health services research; what exists for nurses is more often focused on clinical research. The research fellows in the Pediatric Health Services Research Fellowship are primarily physicians, and in fact, I'm just the second nurse to go through the program—

Connor was actually the first, 10 years ago! So my colleagues in the fellowship are all physicians and one psychologist.

For the current research study I'm working on, Enhancing Informational Continuity of Nursing Care, I'm building from my dissertation findings on communication and interaction between nurses and parents of children with chronic conditions, specifically in ICUs and in an ambulatory procedural area. This study is tremendously exciting to me because it has the potential to directly address an unmet need identified by patients and families and improve their satisfaction with the nursing care delivered here.

The goal of our study is to design, implement and evaluate a tool for communication of patient/parent preferences and priorities of nursing care in an ICU and in a procedural setting. I'm working to build the content of the tool based on parent and nurse focus groups. Later phases of the study will focus on evaluating the feasibility and usefulness of a paper-based tool, building and transitioning to an electronic version of the tool, evaluating the extent to which the electronic version enhances usefulness over the paper form, and assessing the broader impact of the tool through in-depth parent interviews.

This work builds a lot on my dissertation, which came directly out of my experience in the PICU. I had gone into my PhD thinking about how we support families during end-of-life care. Then I realized that we haven't laid the groundwork ahead of time to create a system of support based on how families want care delivered. My dissertation work showed a need for more continuity of care—an issue that isn't easily solved by having the same nurses caring for the same family. We need a mechanism to enhance continuity that is not dependent on individual nurses.

Full-time nurses might work three long days a week, and it can be difficult for nurses to care for long-term patients. It's emotionally challenging if a family is in crisis, for example, some nurses want to practice their wide range of skills on different patients. So I am looking for approaches that embrace continuity in ways that resonate with families by enhancing informational continuity—by communicating important things that can get lost, such as nurses' or social workers' notes, for example—in a way that parents want.

Personally, I love taking care of the same patient over a long time. I thrive on that connection, and it's calming for me if I know I'm taking care of "Johnny" today and I know his parents well. But I realized as I talked with nurses that not all of them feel the same way. That's part of the fun of doing qualitative research. I ask other nurses and families questions and find out what kinds of things they value. In talking to nurses, I've come to understand how some are like me, while others passionately love the excitement of caring for different patients and always learning from those experiences.

Some people thrive on getting kids better and then moving on to the next very sick kids. I want to make sure nurses have the important information they need about a patient so they can jump into the care plan for that day, while creating a sense for patients and for their families that everyone caring for a particular child really knows that child—and to make the care truly holistic.

Boston Children's is such a phenomenal environment. Working with Connor and other nurse scientists has opened my eyes to even more roles in the nursing field—this time around, for doctorally prepared nurses. I've been so fortunate to work with several of the nurse scientists here, and I'm continuously amazed at the quality of the work that they produce. Boston Children's has hands-down the most robust nursing science program I know of, and we have such a unique environment of collaboration.

While the role of the hospital-based nurse scientist is still relatively new, Connor and the other nurse scientists at Boston Children's have quickly made incredible contributions to improving care for children and families. They have also focused on ensuring that our work is interprofessional, and I've been excited to work with colleagues from a variety of disciplines, including working closely with physician researchers. It's exciting to help break down traditional barriers in disciplines—it feels a bit cutting edge. I feel so fortunate to be able to join these teams and contribute to a hospital that gives so much attention to family-centered care, and to thinking about what questions we need to be asking in order to improve care to support families.

I love seeing nurses throughout this hospital doing independent clinical and quality improvement research. A lot of nurses think they can't do research; in my own role as a mentor, I like to help them understand they can! They just need to have questions they want to ask, the skills to do assessments and a structure for answering those questions. So now when I mentor nursing students or those considering becoming a nurse, I ask them, "What do you want to do?" And I tell them, "Whatever it is, there is a place for it in nursing." ♦

Sharing Social Media Expertise

Boston Children's Hospital's best-practice model for real-time patient relations responses

Hospitals across the country are navigating how to best use social media when dealing with unexpected publicity, especially during coverage of high-profile cases followed in the national media. Questions they are addressing include, "How should a hospital react to individuals expressing their passionate perceptions online?" and "How can social media support transparent, open communication and improve patient relations?"

While high-profile incidents may be rare, hospital administrators are eager to prepare for them, as well as for lower-profile cases that may require similar strategies. In response to this demand, the insurance carrier CRICO identified Boston Children's Hospital as a thought leader in this area and asked representatives to present on this subject at its annual event this past fall. CRICO, a group of companies owned by, and serving, the Harvard medical community, is a recognized leader in evidence-based risk management.

"They recognized Boston Children's experience with highly publicized patient cases and felt that our process was well established," says Patient Relations Specialist **Dianne Arnold, MSN, RN.** Arnold teamed up with **Lily (Albin) Vautour,** a social media specialist in Boston Children's Marketing Department, to present a talk called "Embracing the Influence of Social Media" at the CRICO event. They gave a similar presentation again at the Planetree Conference in October 2015.

"Patients and their families are very active on social media and joining them in these online communities has many benefits," says Arnold. "Of course, there are concerns that it also opens the institution up to some risk but we've developed several best practices to address these risks."

When an incident on one of its social media channels takes place, Boston Children's Patient Relations and Marketing teams identify the risks and benefits of responding to the negative feedback in real-time through social media. For example, the social media team may respond by publicly posting an apology for someone's negative experience and provides contact information for Patient Relations, encouraging the dissatisfied person to call. If the dialogue does continue, the team sends a private message and asks for contact information, and Patient Relations reaches out to the person with the complaint.

Arnold believes social media presents an opportunity to engage families—both those with positive and negative feedback—in a completely new way. "We need to meet families where they are, and they're online," she says. "We have a very organized and effective process to manage all kinds of situations, and we're glad that other institutions are looking to us for our leadership in managing their own responses." ♦

Leadership Lessons and Empowerment Examples Drive Magnet Principles Home

By Catherine Curro-Harrington,
BSN, RN-BC, CPN, staff nurse II, Neuroscience

I was able to attend the Magnet Conference this year, and it was exciting to see all the different information sessions offered for various nursing specialties, as well as general nursing subjects. The keynote speaker, Captain L. David Marquet, author of "Turn the Ship Around!" was one of the best I have ever heard. He was sincerely invested in linking his story to nursing and he was mesmerizing as a speaker. He explained his passion for surrounding yourself with the best staff to do the job, and then let them do it.

He supports the objective of a leader to create more leaders and foster that process in others, so the cycle continues. His idea is to find the best people and train them well and bring them along, helping them advance up the leadership ladder. If he could do this in a military environment and succeed, it certainly can be done with hospital staff.

There were many interesting speakers in the breakout sessions I attended, too. Several of them were involved in best-practice changes through data collection at their facility and I noticed, in looking at their goals, that Boston Children's Hospital was light years ahead of them. We have certainly championed best practice, the updating of standard policies, evidence based practice fellowship and support, clinical ladders and recognition like the Daisy Award. I truly felt that Boston Children's could supply the speakers for many of these topics and provide the latest evidence to support the subjects.

I am lucky to work for a state-of-the-art, family-friendly, Magnet-certified hospital. For us to be recognized by Magnet, nursing leaders must value staff nurses, encourage nurses to advance in education and nursing practice, involve them in evidence based nursing research and data collection. Magnet nurses have a high level of job satisfaction and deliver excellent patient outcomes and partner in patient care. Teamwork and open communication among different departments/disciplines encourage us to flourish as professionals. We focus on professional autonomy, decision-making at the bedside, involving nursing in determining the nurse work environment and promoting leadership. I work in a culture that supports nurses to be the best nurse you can be.

I love that I am encouraged by my manager to problem-solve any issues that come along. It is empowering to shape change in hospital policy with our contributions. I have seen mnay examples of "change starting at the ground level" firsthand. Nurses on the Pain Committee advocated to take into consideration our complex patients who are developmentally not on target in orders to modify pain management policies. And a nurse looked into best practices of infection control for MRSA patients and modified the existing hospital policy. Staff nurses collaborated with psychiatric nursing to come up with a computer flag announcing the arrival of behavioral patients in the waiting room so they could swiftly be moved through registration process to an exam room, decreasing stimulation.

I am inspired each May during Nurses Week by the hundreds of posters and presentations shared throughout the hospital. This shows the level of commitment our nurses have to finding an answer to a question or looking at a problem. Our nurses always look for a better way to do things in a way that is best for the patients and families. ♦

Captain L. David Marquet

Teaming Up for Staff Safety

Coordinated employee injury prevention and mitigation projects yield results

Boston Children's Hospital has a range of employee health and safety programs designed to prioritize and prevent employee injury and illness. As part of this effort, the departments of Environmental Health and Safety (EH&S) and Occupational Health Services (OHS) have partnered with several groups working to coordinate efforts to mitigate risks to employee safety. "On-the-job injuries can result in chronic pain and disability for employees and are costly in terms of lost time from work and medical bills," says **Nicolas Kielbania, MS,** director of EH&S.

"All must be mindful of health and safety for both the patient and the health care worker in any setting providing health care to promote a sense of safety, repsect, and empowerment for all persons."

–American Nurses Association

In particular, Boston Children's is working to move the dial toward zero overexertion injuries. EH&S has worked with the Clinical Education & Informatics and Physical Therapy departments to research and develop Safe Patient Handling (SPH) assessment methods, and has developed training in both inpatient and ambulatory settings.

EH&S and OHS collaborated to deliver SPH training to all perioperative nurses, along with assessments focused on manually handling heavy procedure kits and linens. Work is also underway to expand the injury and illness prevention program to help staff stay safe, healthy and productive.

Reducing sharps injuries

Since 2009, EH&S and OHS have been analyzing and reporting sharps injury dashboards to clinical leaders to drive hazard awareness and prioritize sharps injury risk reduction projects. Sharp incidents are a frequent cause of employee injuries at Boston Children's, especially in the perioperative setting. A Six Sigma project resulted in local Nursing, Anesthesiology and Surgical work groups coming together to improve perioperative safety device usage, communication and sharps disposal practices.

EH&S and OHS have partnered with Infection Prevention & Control and Perioperative Nursing under the sponsorship of **James Kasser, MD,** Orthopedic surgeon-in-chief, to strategize about creative solutions. At monthly meetings, this group reviews all sharps injuries to identify any patterns. They have implemented a plan for multidisciplinary improvements in the culture of reporting sharps injuries, focusing on the quality of root cause investigations, work process changes and new audit processes. For one intervention, the team is working with Purchasing to create a system that flags the option of ordering a safety needle, when appropriate. As a result of these efforts, there has been a 20 percent reduction in sharps injury rates compared to 2014.

Slips, trips & falls

The teams will use similar methods as its sharps injury projects to reduce employee risks from slips, trips and falls, working with a new committee dedicated to identifying the biggest hazards related to each area. While these injuries aren't as frequent as overexertion or sharps injuries, they are more impactful.

"Slips, trips and falls often cause injured staff to spend weeks or months away from work, having surgery or rehab," says **Lucinda Brown, MA,** director of OHS. In a pediatric setting, this is particularly noteworthy, since pediatric specialists are harder — sometimes impossible — to replace on a temporary basis.

At the request of hospital leadership, a new Employee Fall Prevention Committee has formed under the sponsorship of **Henry Tomasuolo,** vice president of Support Services. These injuries often result in significant lost time, suffering and operational disruptions. The committee focuses on specific high-priority cases that are most disruptive to clinical, support and research operations. During a monthly facility walkthrough, team members survey the campus and proactively identify risks that could contribute to employee injuries. These cases each undergo a deep-dive investigation to determine their root cause and the committee formulates a corrective action plan. Outcomes are shared at the

Daily Operations Briefing as progress is made. (See Figure 1.)

Some of these planned interventions engage the whole hospital in the High Reliability principle of Speaking up for Safety. For example, the group is working on a pop-up cone alert system that empowers employees to flag a spill until Environmental Services is contacted to clean it up.

Another effort to protect workers from slips and falls is retrofitting existing ice machines located in several patient care areas. Due to inadequate tray design, ice frequently spills from the machines onto the floor and melts, creating slippery surfaces. With the help of **Paul Williams,** director of Engineering, Boston Children's Engineering staff are able to retrofit existing trays with wider and deeper catch trays, eliminating the problem of ice landing on the floor. The installation of slip resistant flooring enhances this solution.

Recently, an area of concern was identified involving employee head injures due to bumping into boom-mounted display monitors in the operating rooms. Kielbania and **Jon Boyer, SCD, MS,** risk manager for EH&S, worked with perioperative partners to investigate and purchase protective padding for all boom-mounted display monitors in the operating rooms. No head injuries from impact to monitors have occurred since this intervention.

Fostering national support for employee safety

As workgroups endeavor to eliminate all preventable harm to staff, they are also collaborating with many outside institutions to share information and establish metrics.

For example, Brown and Boyer presented with a colleague from the Cleveland Clinic at the Solutions for Patient Safety (SPS) Conference in 2015, a nationally recognized forum focusing on employee and patient injury prevention. Together, they submitted a proposal to the Children's Hospitals' Solutions for Patient Safety (SPS) for the creation of a Healthcare Acquired Condition (HAC) on Employee Safety. Creating a HAC by SPS means that bundles of care, safety and data sharing are created by, agreed-upon and standardized across more than 80 hospitals in the United States and Canada. The shared goal is minimizing harm to children and staff. Kielbania and Brown will represent Boston Children's on the SPS HAC leadership team.

The teams are working with the newly formed Children's Hospital Association Employee Health, Safety and Well-Being forum created by the Occupational Health departments of Boston Children's and Seattle Children's Hospital. The goal of this group is to share best practices and benchmark employee health and safety data to drive collective improvements. As part of this forum, the hospital is making strides toward its goal of having employee health and safety be methodically studied and corrective actions designed and implemented, similar to best practices in patient safety and quality improvement. ♦

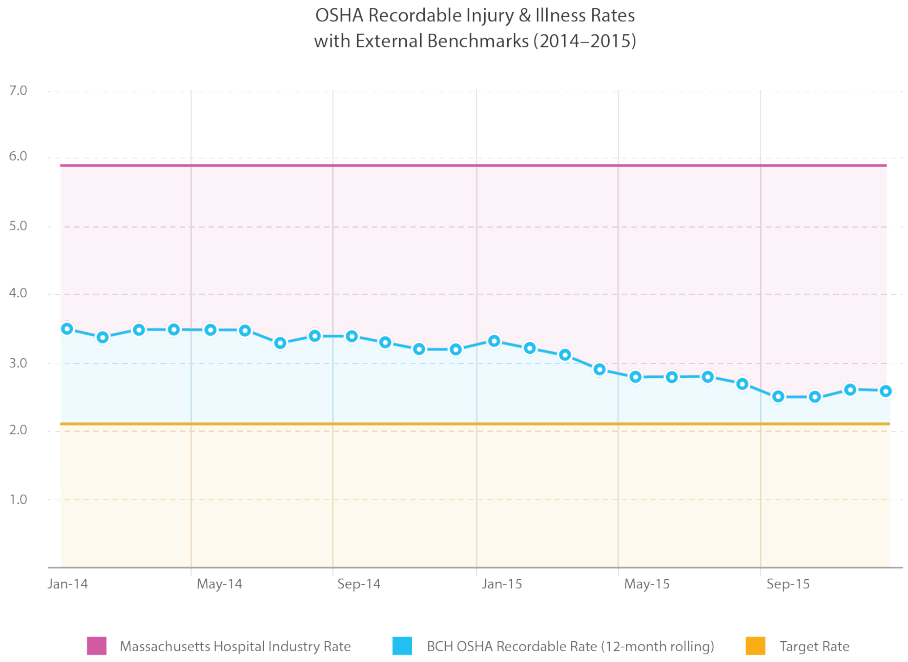

Figure 1

Hacking Pediatrics for Patient Impact

Through innovative teamwork, a social worker's inspiration comes to life

The concept of hacking has made its way from the world of software programs and internet codes into the everyday world, as "hacks" to streamline processes or make tasks more tolerable are embraced by everyone from cooks to commuters and beyond.

In the past few years, hacking tactics have become an innovative way to push health care forward. Hacking Pediatrics, now in its third year, is an event that brings together physicians, designers, coders and entrepreneurs from the Boston Children's Hospital community with world-class technology professionals. The hackathon's overarching goal is to foster a movement of collaborative innovation with the clinicians, patients and parents at Boston Children's and the brilliant minds outside of health care that, working together, can build ways to help children and families.

During this past November's invitation-only event, multidisciplinary teams formed to pitch their pediatric prototypes and solutions to a panel of judges. The judges issued nine awards, including the Best Patient Impact award given to Inpatient Cardiovascular Clinical Social Worker **Alyssa Chrobuck, MSW, LCSW.** For her project, called "A Clear Improvement," the team used a sewing machine to prototype new protective masks for health care personnel that would be less scary for young patients. These proposed masks were designed so that children can see their providers' faces. The Boston Children's SIMPeds program, Boston Scientific, CVS and Mad*Pow lent their expertise to the hack.

Chrobuck was inspired to contribute the psychosocial and neurological perspective on the hack by her longstanding passion for exploring the intersection of medicine and mental health. "When children are admitted to the hospital, whether they are admitted medically or psychiatrically, the two worlds collide, as the hospital setting brings up new stressors," she says. "Viewing the two worlds together is much more dynamic. With improvements to basic medical approaches and equipment like this, pediatrics will be able to reduce the rates of medical traumatic stress."

"I had wonderful team members to collaborate with," Chrobuck adds. "As a social worker, I can have an idea like this—but have *no* idea how to physically build a new mask. But some good quality engineers and designers sure do."

The next step for Chrobuck's team is to find the most breathable, pliable, transparent material to use in these masks. As the project meets milestones, she will have the potential to receive additional resources and opportunities, including the Mad*Pow Prize of $10,000 in design services. ♦

Every Patient Tells a Story

By Maureen Beath, RN
staff nurse II

I had the pleasure of attending the Magnet Conference. The enormity of the conference was overwhelming at first, but because of its organization I was able to focus on my needs.

I attended several sessions and was impressed by the achievements of other hospitals around the country. Suffice to say that we here at Boston Children's Hospital are on the leading edge of health

care advancements. That being said, some of the best sessions I attended were given by staff members from small community hospitals.

One session that I found especially inspiring was "The Magic of Storytelling to Improve the Patient and Family Experience." This nurse who led the session shared with us the importance of learning the story of those you are caring for. To do that, you need to be observant and to be aware of the cues you are receiving from the patient or family.

For example, walking into a room and seeing the curtain closed does not necessarily mean that a patient or parent wants privacy. It could, in fact, mean something completely different, such as they are feeling frustration, fear or exhaustion. Opening up a dialogue at this time could be beneficial to the patient, the family and yourself. It is one thing to hear what they are saying, but it is most important to really listen to what they say.

Factors like family dynamics and work demands play a part in all of our lives. When you compound that with illness that requires a hospital stay, stress levels increase and caregivers can experience get overwhelmed and wonder, "How am I going to handle this?" We as caregivers need to be aware that we don't just care for a patient's health needs. In order for us to have the best patient outcomes, our care needs to encompass all facets relating to that patient and family. Connecting with social workers and nurse case managers can take maybe five minutes of your time, and can completely change that feeling of helplessness to one of calmness and control.

This is just a glimpse of something that impressed me enough that I have incorporated it into my daily work experience. Asking yourself a simple question about your approach, and taking the time to listen, can lead you to a wealth of information that can make a patient and family's day that much better. ♦

Nurse's Personal Experience Underscores the Power of Empathy

By Karen White, BSN, RN, CPN, CCRN, staff nurse II, Cardiac Catheterization Lab

At the last minute, I decided to attend a different presentation at the 2015 ANCC National Magnet Conference. The one I had signed up for was too far away and I worried that it would be full by the time I arrived. So I stepped into the nearby presentation, called "Magic of Storytelling to Improve the Patient and Family Experience," by Michelle Clements, BSN, RN, clinical manager, Special Care and Well Baby Nurseries, Rex Healthcare, Raleigh, N.C. She began with this story, paraphrased here:

The man in the pay booth at the hospital, well, he must have been in his 70s. He was a constant fixture. He took my ticket every day I was there to visit my daughter, and he always smiled and wished me well. But I kept my head down or I just looked straight ahead.

This went on for several days in a row. Then, one day—it was a particularly bad day—when I handed him my ticket, he said to me, "Are you okay?" And, of course, I wasn't. I averted my gaze, avoiding eye contact. We didn't know each other. He was kind to me. He wished me well again. He said, "It will get better. You'll see; it will get better." I looked up to thank him, and he smiled. I drove off that day feeling cared for, and my spirit lifted, just for that moment.

Clements connected with the nurses in her audience with that story. And she went on to tell similar stories that revealed that when we judge people too quickly—"Oh, that family" or "Oh, this father..."—we deprive them of our empathy. And this hurts our ability to form a therapeutic relationship.

After telling the stories of others, Clements shared a personal story about her daughter's hospitalization experience. Clements admitted she was worried we might pass judgment, but after having seen how the nurses in the audience received her so warmly, she revealed the details behind her family's traumatic experience. Clements' 11-year-old daughter had

attempted suicide, but had survived and was receiving psychiatric care. This story brought me — and others in the audience — to tears. Clements used her own story to teach us that not only are our patients and families vulnerable, but we are, too.

Despite her discomfort, Clements also felt more connected to us and supported after she told her story. After lengthy applause, more than half the audience lined up to the podium to hug her. In this talk, I learned that we are all on a journey, each one of us—our patients, their families and our coworkers.

The nurses at Boston Children's Hospital endeavor to provide family-centered care. When we go even further to engage families by showing empathy, a connection can be made. It requires us to be vulnerable and be willing to "lean in to discomfort." Clements called this "relationship-based care."

When a nurse is able to establish a personal connection with a patient and family, and we do it with a non-judgmental narrative, we can truly give superior care—meaningful care. ♦

Train to be Present, Not Perfect

With Elaine C. Meyer, PhD, RN, director, Institute for Professionalism & Ethical Practice

Meyer has recently given several talks, nationally and internationally—including a TED Talk, called "On Being Present, Not Perfect"—that draw on her professional and personal experiences to illustrate profound gaps in health care communication. A YouTube video of her talk averages more than 1,000 hits monthly and has been incorporated into nursing and medical school curricula across the country and abroad. She has published several peer-reviewed papers on this subject.

Elaine C. Meyer, PhD, RN

What kinds of communication are you most interested in improving?

The conversations that matter most in health care are often the most difficult. From conveying serious diagnoses and disclosing medical errors, to ethical quandaries surrounding end-of-life care, these conversations are the bedrock of the patient-health care provider relationship. In addition to these big conversations, the everyday conversations at the bedside matter greatly. When they go well, patients' health outcomes, trust and satisfaction with care can be enhanced. But initiating and holding difficult conversations can be challenging for clinicians who often feel unprepared and learning opportunities are limited.

Which conversations are the most difficult?

The first conversation is often the beginning in a cascade of conversations, especially when a serious illness has been diagnosed. As difficult as the first conversation might be, subsequent conversations can be even more challenging and dreaded by clinicians, as when the laboratory results are confirmed, the treatment has failed to bring about the hoped-for response or when time has simply run out. These conversations matter deeply.

What inspired you to work to improve this kind of communication?

As a nurse and psychologist, I have devoted my career to holding challenging conversations in the Pediatric Intensive Care Unit and teaching others to feel capable and confident when talking with families and shepherding them through their darkest, most stressful times. I came to understand the profound value and healing that can reside in holding genuine conversations with our patients and their families. I learned that a year, five years or 10 years down the road, it's not the medications, treatments or surgeries that people remember, but rather the words we utter, the looks we share and the relationships we dare to establish. And in this work, we are called upon to be present, not perfect.

What is the idea behind being present, not perfect?

Difficult conversations can be life altering for patients and families, and clinicians want to "get it right." Just when patients and families need their care providers most, clinicians' words and confidence can seemingly fail them. This yoke of perfection and pressure can amplify anxiety and erode a practitioner's confidence. When clinicians try so hard during conversations, their authenticity and gestures of kindness can be diminished. Similarly, when clinicians hide behind medical jargon or cling to scripts, the treasured moments of real human connection with patients can be sacrificed.

What is the most challenging part of having these conversations?

Even seasoned clinicians who are confident in their areas of expertise can find themselves uncomfortable, at a loss for words or even reluctant to seek out patients and their families. Practitioners worry about their own display of emotions, plaguing themselves with second-guessing, self-doubt or admonitions to "be professional." The myth prevails that there are some people who are simply gifted in the art of holding difficult conversations, so others might feel inadequate or not up to the task.

You recommend a *Wizard of Oz* analogy for caregivers to use during difficult conversations?

Yes, in our Program to Enhance Relational and Communication Skills (PERCS) workshops, we like to share the *Wizard of Oz* metaphor—courage, brains and heart—to highlight the core ingredients of honest, effective conversations.

The approach offers practitioners an advantage by focusing on generalizable principles rather than specific skills, being easy to recall "just in time" and promoting communicative and relational engagement. And as the wizard revealed, these abilities typically lie within each of us, waiting to be fully realized.

How can practitioners summon "courage?"

Never underestimate the importance of courage, confidence and leadership ability to convene and hold challenging conversations. Even seasoned practitioners describe feelings of heightened anxiety before high-stakes conversations, but with courage they can steady themselves to push past the initial fear, hesitancy and sense of inadequacy. The goal is to move beyond being at the mercy of one's anxiety—and to be energized, empowered and focused during conversations. Remember, teamwork and practice makes one better.

How can caregivers best convey their knowledge and "brains?"

Patients and families highly value practitioners who can effectively communicate their full range of clinical knowledge, experience, decision-making processes, treatment recommendations and accumulated wisdom. Pay attention to word choice, clarity of explanations, use of drawings and educational visual supports and adapt information to best meets the priorities and needs of families. Offer meaningful examples to families and check in regularly to see that they understand.

Think creatively about ways to explain clinical procedures and situations that commonly arise in your practice, from radiographic imaging to inserting intravenous lines and chest tubes.

And how can they draw on "heart?"

Practitioners who bring their compassion and full humanity to conversations naturally boost the trustworthiness and therapeutic capacity of their professional relationships. The willingness to express genuine emotions makes the difference between a good practitioner and a great one. Practitioners can take the time to sit down, listen carefully, notice emotional cues, inquire gently and acknowledge the complexity of emotional responses that can surface during challenging conversations—sadness, anxiety, guilt, frustration, anger.

What other advice do you have for improving these conversations?

Adjust to their rhythm and calibrate your style to the patient and family's emotional needs and expressiveness. By slowing down your rate of speaking, honoring natural pauses, granting silence and "speaking in sentences, not paragraphs," you can create favorable conditions for healthy emotional expression. Be sure to ask about and honor the patient and family's agenda for these conversations, and remember that not everything necessarily needs to be discussed all at once.

By recognizing a patient's emotions with comments such as, "I can see that you are disappointed with the latest test results," you can effectively invite patients to share their emotions and create opportunities for them to share according to their wishes. Asking patients and families to share what they are hoping for and what they are worried about can have profound influence not only on the conversation, but also on your entire relationship with them as well. ♦

Learn more: www.childrenshospital.org/clinician-resources/education-and-training/percs

New Nurse Learns Lesson on Transparency and the Meaning of Magnet

By Oanh Vu, BSN, RN, staff nurse I, Inpatient Medicine

I started as a nurse at Boston Children's Hospital in September of 2014, and every day I come to work, I feel blessed and amazed to be a part of the No. 1 leading pediatric hospital in the world. As a young nurse, having the opportunity to attend the Magnet Conference was a true honor and privilege. I had learned about Magnet in college and I knew is was a status given to a hospital for nurses, from nurses. I also knew that it measured nursing job satisfaction in the hospital and statistics in nursing regarding patient care.

Attending the conference, I learned so much more not only about what Magnet was, but also what Magnet means. Walking into the conference, I could the feel the excitement and inspiration all around me and it continued during an opening session for all attendees on the second day. Cole Edmonson, DNP, RN, FACHE, NEA-BC, the chief nursing officer of Texas Presbyterian Hospital, the first hospital to diagnose and treat an Ebola patient in the United States, spoke about how his hospital responded to the case. The hospital had to quickly learn how to not only treat the patient, but also how to ensure the safety of the other patients and staff.

There were no guidelines or policies on how to care for an Ebola patient, but the nurses, doctors and health care workers came together to work through this health scare. They added more protective gear and developed new protocols to contain the infectious disease. Edmonson showed the audience a video of nurses rallied together expressing how proud they were to be a part of an organization that cared for them and genuinely appreciated their input. The events that occurred at Texas Presbyterian Hospital embodies what Magnet is: a status that signifies how great an institution is in making its nurses proud to come to work every day and feel empowered to advance health practices to improve outcomes.

Texas Presbyterian Hospital later released an article that openly discussed what the hospital did, including the mistakes they made. This open knowledge sharing helped make the Ebola scare what it is a today, a mere memory. It allowed other health organizations improve their infection control policies and become better prepared for any future infectious disease outbreaks that may arise. Knowledge sharing occurred all throughout the Magnet Conference and being able to listen to these presenters, my respect for nursing grew and grew.

Attending the conference showed me just how advanced Boston Children's is compared to other hospitals in the United States. I was shocked to hear that not all hospitals had the same resources as we do. I walked away from many sessions amazed at how advanced Boston Children's Hospital is as an institution.

The conference gave me greater appreciation and increased pride for being a nurse at Boston Children's. I realized how important it is to continue research in evidence based practice and to share data and outcomes with the world. One of the many valuable lessons of the conference, I believe, was the idea that by sharing problems, research and outcomes of other health organizations, all nurses can improve practices at their own institutions, and all nurses can become leaders. ♦

Cole Edmonson, DNP, RN, FACHE, NEA-BC

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