PATIENT-CENTERED CARE CASE STUDY

A Picker Institute Series

South Miami Hospital Focuses Resources on Pain Management and Physician Communication

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Organization Profiled

South Miami Hospital, Miami, Florida

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For 30 years, Picker Institute has been dedicated to developing and promoting a patient-centered approach to healthcare. For more information about our services, please call toll free at (800) 388-4264.

Organization Profile

South Miami Hospital opened in 1960 as a 100-bed hospital in what was then a small suburban community. Today it is licensed for 452 beds and houses innovative programs such as the Center for Robotic Surgery, the Center for Women & Infants, Miami Cardiac & Vascular Institute, and a Level III Neonatal Intensive Care Unit. The hospital opened a new Emergency Center and Surgical Suites in January 2013.

The hospital was recognized as a Magnet Hospital for Nursing Excellence in 2004, 2008, and again in 2014. The medical staff includes about 1,300 physicians and physician assistants. Of those, about 60 physicians have a direct contractual relationship with the hospital (hospitalists, anesthesiologists, and intensivists).

South Miami Hospital is part of Baptist Health South Florida, the largest not-for-profit healthcare organization in the region. The system also includes Baptist Hospital of Miami, Baptist Cardiac & Vascular Institute, Baptist Children's Hospital, Doctors Hospital, West Kendall Baptist Hospital, Homestead Hospital, and Mariners Hospital.

Statement of Interest

Hospitals today strive to meet patient needs on many levels. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey documents hospital performance in eight areas of patient-centered care: nurse communication, physician communication, discharge information, pain management, communication about medications, cleanliness, quietness, and responsiveness of hospital staff. The survey also asks how patients rate the hospital overall, and whether they would recommend the hospital to family and friends.

In each of these areas certain hospitals are excellent performers, with consistent high scores on specific HCAHPS measures. Picker Institute case studies explore the ways hospitals achieve these outstanding results, and share examples of best practices.

The Picker Institute has selected South Miami Hospital as a high performer in delivering patient-centered care based on its exemplary performance in HCAHPS publicly reported data for pain management and for physician communication among hospitals of its type and size.

The HCAHPS survey questions on pain management are:

During this hospital stay...

A. How often was your pain well controlled?
B. How often did the hospital staff do everything they could to help you with your pain?

South Miami Hospital: Deep-Rooted Commitment to Controlling Pain

Pain management poses challenges for any hospital. It requires a firm grasp of technical details about the benefits and side effects of various methods of reducing pain. Just as much, it requires clear communication with patients about the hospital's commitment to offer pain relief, and each individual's personal experience of pain. Nurses and physicians must find ways to offer support for patients who have difficulty communicating, and also cope firmly but compassionately with drug-seeking patients.

For more than 20 years, South Miami Hospital benefited from the services of Patricia M. Collins, RN, M.S.N., ACCN, an oncology nurse specialist with a passion for understanding and controlling pain.

She was a coauthor of evidence-based practice tools related to pain, and she created the pain tool in current use at South Miami Hospital, which has been shared with many other organizations. Collins presented many times at local state and national programs, educating professionals and the public on cancer and pain issues.

"Many people respected Pat Collins. She earned that respect through the knowledge she accumulated over years about managing pain," recalled Milly Selgas, M.B.A., M.S.N., RNC, CPHQ, Assistant Vice President of Performance Improvement and Quality. "She wasn't an advanced practice nurse, but physicians would call her in to consult about the best combination of drugs to manage pain

appropriately; they knew she had become an expert in this area."

Collins retired about two years ago, but thanks to her efforts over many years South Miami has developed an exceptionally strong commitment to managing pain effectively, and to offering patients and practitioners the resources they need to understand and manage pain. "She created a series of classes called 'Pain 101,' and trained other nurses in the details of pain management so they can serve as resource specialists on this subject," Selgas said. "Even though she has retired, there are so many people here who learned pain management from Pat, and now they teach other nurses as they arrive."

In 2001, the South Miami Pain Council was created, an interdisciplinary group that meets monthly to discuss a wide range of issues related to pain management in the hospital. The group has about 20 members, including nurses, physical therapists,

pharmacists, respiratory therapists, care partners, and lay members of the community.

"This is a very active group," said Aimee Green-Blumstein, B.S.N., RN, CCRN, Nurse Manager of Critical Care Services and Chair of the Pain Council. "We've organized educational sessions for nurses; we send out emails and posters about important issues related to pain. Several members are staff nurses who work directly with patients, so the council serves as a useful channel to communicate important issues directly to senior leadership."

For example, staff nurses noticed that many times prescriptions were written for an initial Dilaudid dosage of two milligrams, which is a strong dose for someone who hasn't already developed tolerance to the medication. At that time the hospital formulary only carried one- and two-milligram doses of Dilaudid. "Actually, for people who have not developed tolerance, 0.5 milligrams is an effective starting dose," said Green-Blumstein. "The Pain Council brought this issue to senior leadership, which supported our request, and the pharmacy department added a 0.5-milligram dose of Dilaudid to the formulary." In order to do this, the pharmacy department searched for a while to find a specialized pharmacy that could supply Dilaudid in this particular dosage.

Physician-Founded and Team-Centered

South Miami was founded as a community hospital in the 1960s by a group of physicians. "They wanted a small hospital where they could pamper and care for their patients in a very homey way," Selgas said. "No matter how large the hospital has grown, it's still able to maintain a familial relationship with patients. The idea of talking with patients, meeting and exceeding their expectations, and empowering staff so they have the ability to provide excellent care, has been part of our culture from the very beginning, and those ideas are still ingrained in our daily activities."

Even though the hospital was founded by physicians, it offers nurses authority to jump in so that patient care needs are met. Nurses play a large role in patient advocacy and are empowered to speak up on the patient's behalf. For example, nurses are authorized to call the vice president of quality whenever they have concerns about a patient care issue. Or they can request a consult from the ethics committee, which is available day and night without a doctor's order.

"We encourage our nurses to speak up whenever they feel their patient is not being advocated for, or when the physician isn't giving the patient all the information they need," Selgas said. "They know we are there to support them at all levels of this organization, from the CNO to the leaders to the CEO. We have zero tolerance here for lateral violence; if physicians start acting up and screaming, they will get written up. We expect collegiality and civility from all members of our team."

Training for South Miami staff emphasizes that responding to pain, as the patient reports their experience of pain, is an essential responsibility. "Our staff understands that pain is pain," said Lindsay Hindin, M.S.N., RN, Director of Emergency Services and the Clinical Decision Unit. "Over the years it's been engrained in our staff that it is not up to us to make judgments; we are simply here to provide service and care."

Angela S. Castillo, B.S., RN, Unit Manager for 7 Pavilion, a med-surg step-down unit, states the same point forcefully. "When we discuss pain management with our nurses, we emphasize that it's not my perception, it is not someone else's perception, it is the patient's perception that matters. When nurses do not communicate with the patient and educate them we are not doing pain management effectively."

This is not simply a matter of dosing the patient on a regular schedule, but also communicating with them with human warmth. "What is the patient's perception?" Castillo asked. "Are you going back to them and asking how they feel? The key points here are communication and perception."

The HCAHPS survey asks whether pain is "sometimes" or "always" well controlled. This makes it particularly important to educate patients about the different kinds of pain, and what "well controlled" means. It does not mean "feeling no pain at all."

"We need to educate patients about realistic expectations," Castillo said. "If they have a chronic pain and it's never at zero, we need to make them aware that it won't be at zero just because they're in the hospital. At the same time we can work with them to find alternatives, using a heating pad or pillows to help the patient feel more comfortable."

On 7 Pavilion the team rounds at 11:00 in the morning, including the care coordinator, dietitian respiratory therapist, and physical therapist. "That is when we communicate with the patient about their level of pain," Castillo said. "If their pain is not well controlled, we can bring in a pain management consultant or communicate with their physician."

In situations where a patient feels they have not been treated appropriately, South Miami has an effective grievance process. These cases are reviewed by a group that includes the vice president of operations,

senior nursing leadership, pastoral care, and performance improvement staff.

If there appears to be a pattern in which a particular nurse or physician isn't following standard processes for pain management, they are coached and monitored. Hindin recalled a case in which one provider had fairly frequent complaints that the patient's pain had not been controlled. The medical director sat down with the provider and reviewed cases in which appropriate medication was not offered. "Nurses had been concerned about this provider, and brought a series of specific examples to my attention," Hindin said. "However, after the medical director intervened, over a period of time that problem has completely gone away."

South Miami Workflow Focuses on Pain

Over the past two decades, South Miami has evolved a culture that takes pain management very seriously and invests resources in understanding and responding to the patient's experience of pain. This means that pain management is embedded as a priority throughout workflow processes, including:

- Every patient room has a whiteboard on pain. It lists the time of the last dose of medication, and the time when the next dose is due. For confidentiality reasons, it does not include the names of specific medications, but it does let the patient know what to expect.
- Nurses and care assistants do hourly rounding on the floors, and they always address pain during their rounds.
- Nurse managers round specifically to check whether the pain board is up to date, and to ask the patient whether they have been assessed for pain.
- The hospital has implemented a "no pass zone," which means that when a call light is on, whoever sees it first responds to it. "It doesn't matter what your discipline is: you answer the call light, address patient needs, and then report back to the person who is responsible for that patient," Green-Blumstein said. "This deals with many patient requests, of course including pain."
- The interdisciplinary plan of care for pain is reviewed at every shift change, and the patient's level of pain is assessed as a specific indicator.
- Hospitals routinely use "code blue" to signal that a patient is in an emergency situation, requiring immediate help from a team of providers. In addition, many hospitals have "code rescue," which signals that the patient is going downhill, and needs extra help. At South Miami, nurses are trained to consider inadequate pain control a reason to escalate the level of care. In fact, South Miami has developed an innovative tool, called the MITE Criteria (Monitoring Intervention Tool for Escalation), which summarizes nine key indicators into a color-coded measure of the need for monitoring and intervention (see Appendix). When nurses call code rescue for pain management, an interdisciplinary team including physicians responds.
- South Miami uses its electronic health record to document workflow processes related to pain management. For example, patients should be assessed within 15 minutes after an IV medication, or within 30 minutes after an oral medication. If this does not happen, the computer screen displays a red flag alert screen. The hospital routinely uses a barcode scanner to scan the medication barcode as well as the patient's wristband to confirm the correct medication is given to the patient. When pain medication is overdue, the scanning device turns pink, alerting the nurse in a very noticeable way. Nurse managers can access these records to see whether patients are receiving medications at appropriate times.

Pharmacy Department Plays a Key Role

The pharmacy department plays a key role in educating nurses and other practitioners about the specific effects of various medications. Ali Mazinani, Pharm.D., Pharmacist Pain Specialist, serves on the Pain Council. He writes newsletters on pain management and has helped develop posters and reference tools on pain-related issues.

When needed, the pharmacy department generates medication utilization reports on specific opioids or analgesics. These reports identify the opportunities for improvement in the areas of pain management and reduction in adverse drug reactions. Once identified, the pharmacy investigates the causes of adverse reactions and takes steps to prevent them from happening again.

Clinical pharmacists may be called in to consult for individual patients, especially during daily patient rounds. "This is when we ask, 'Is the patient's pain managed?'" Mazinani said. "If not, then the pharmacist plays a useful role in recommending additional options to the nurse, so she can ask the attending physician whether the medication could be changed to one that is higher in strength and potency."

Mazinani participates in daily rounds on the intensive care unit, including weekends. Other clinical pharmacists share coverage on the weekend and during the week as needed to cover the units. Nurses from other units often call him and the other clinical pharmacists with specific questions about patients whose pain is not well controlled.

"Ali has played a crucial part in our department. We have all been much more involved in supporting nursing in any endeavor, and particularly in pain management," said Frances A. Ordieres Gonzalez, Pharm.D., Clinical Pharmacist Coordinator. "This is a multidisciplinary approach. During rounding the nurse plays an essential role in letting the team know that the patient's pain control is still not where it needs to be. We all try to encourage the use of a pain consult or an anesthesia consult, when appropriate, depending on what the particular issues are in each case."

Each Unit Faces Unique Pain Management Challenges

Each program and unit at the hospital faces specific challenges in pain management, related to the particular patients it serves. In the post-acute care unit (PACU), managing pain begins before surgery. Most patients come to the pre-planning department for an educational session that discusses reasonable expectations for pain control after surgery. "They understand that they will still have some level of pain during recovery, and after they go home," said Ami Kruger, B.S.N., RN, Nurse Manager, Pre-Op. "That's a normal expectation after surgery. We show them the pain scale, and explain that 10 means the worst possible pain and zero no pain at all." The unit makes a strong effort to include families in the educational process, particularly since the person who is having an operation may not remember everything right after the surgery.

Before surgery, patients are put on a "Bair Paw" (a forced-air warming gown) that keeps them warm and reduces infection. "This

adds to their comfort and reduces their anxiety before surgery," said Maria Elena Cepero, RN, PACU/PH II Manager. "They have individual controls so they can set the temperature based on their own preferences."

The patient's pain level is assessed before surgery, after surgery, and before discharge. The pain level needs to be at zero to three before the patient is discharged to the Phase 2 area, where patients are ready to go home. "Our Phase 2 nurses are very good at working with patients individually, educating them on what to expect, and checking to see whether they have any questions," Kruger said.

The pre-op nurses make post-op phone calls on all discharged patients, and one of the most important questions is, "How is your pain?" If pain is not well controlled, the nurse directs them where they need to go, or sometimes facilitates a phone call with their surgeon.

The emergency department faces the special challenge of patients who may or may not have a history within the system, and may be seeking narcotic medications. South Miami's new emergency department opened in January 2013. It is a 27-bed department, using a team nursing model. During high-volume hours (11:00 a.m.–11:00 p.m.) a medical provider is available at triage, so patients can be evaluated as soon as they arrive. The "door to doc" time averages 28 to 30 minutes.

Emergency department nurses are empowered to do advanced nursing interventions, using medical protocols based on symptoms. If pain medication is needed, the medical provider is on hand, so patient needs can be met in a timely manner.

When dealing with patients who appear to be drug-seeking, the hospital turns to Baptist Health's unified electronic medical record, which can identify prescriptions from every visit within the system. When medical providers believe the patient is seeking narcotics, they have a frank conversation with the patient and review their recent encounters. Patients who are dealing with chronic pain are offered a referral to the Baptist Health Pain Management Center. Pain management specialists there will conduct a comprehensive assessment and develop a plan of care that includes a number of ways to respond constructively to chronic pain, including medications, physiotherapy, surgery, and/or electrical stimulation.

When patients present who have no previous visits on record, practitioners make individual assessments of potential drug-seeking behavior. "Sometimes you have a patient who tells you, 'I'm allergic to morphine and therefore I need Dilaudid,'" said Hindin. "That sets off an alarm bell. Based on their assessment the physician may say, 'We're not going to give you Dilaudid, we're going to give you Toradol instead.' We do this very nicely—our patient satisfaction scores are in the 99th percentile—but we're very honest with our patients."

Bariatric surgery faces a special challenge due to the risk of addictive behaviors after surgery. The hospital established its weight-loss surgery program in 1998, and the program currently sees over 300 patients per year. It offers three surgery options: adjustable gastric band, sleeve gastrectomy, and gastric bypass. The program offers comprehensive services including nutritional and psychological counseling and post-surgery support.

"Many of our patients habitually use food as a coping mechanism," said Maria I. Fuego, RN, Bariatric Coordinator. "After this surgery, since they can only eat small amounts of food, they could no longer use food as a source of comfort. We find that some bariatric surgery patients transfer addictive behaviors to other habits such as drugs, alcohol, or gambling. In fact, out of 140,000 bariatric surgeries completed in the United States each year, about 20 percent of the patients develop addiction transfer."

To prevent this problem the weight-loss surgery program at South Miami offers a five-hour preoperative class for all patients. They meet in small groups together with a nutritionist, physical therapist, respiratory therapist, social worker, and a nurse who specializes in this area. Each patient receives a binder with a summary of all the issues involved in bariatric surgery. "During the class we discuss the side effects of narcotics, and encourage them to use other methods of pain control," Fuego said. "I meet with them on the day of surgery to go over any last-minute questions they may have."

Recently the unit changed post-op orders for bariatric patients to include Toradol and IV Tylenol. Narcotic pain medications are only to be given for breakthrough pain. This means patients start out with medications that are less likely to lead to addiction. The program includes supportive services after surgery, including a "Bariatric Buddy" program that pairs patients to offer each other mutual support during the weeks after surgery.

In addition, the weight-loss surgery program faces a unique challenge because it sees quite a few patients who've had their initial surgery done at other facilities and outside the United States. Many of these patients are on high doses of narcotics when they arrive at the hospital, and South Miami is developing methods to help wean them off their pain medications.

South Miami Hospital Excels in Physician Communication

The HCAHPS survey questions on physician communication are:

During this hospital stay...

A. How often did doctors treat you with courtesy and respect?
B. How often did doctors listen carefully to you?
C. How often did doctors explain things in a way you could understand?

South Miami Hospital has consistently excellent scores on physician communication—in large part due to its history. The hospital was started by physicians and a few local businesspeople; it was a small community hospital with about 100 beds. "We started out as a physician-run hospital with a commitment to quality," said James G. Stewart, M.D., Physician Liaison, who's been on staff for more than 40 years. "We try to maintain our tradition, that we're all part of a team. The nurses are peers. No one you see in the hallway is inferior to you. We're doing very important work, and it's an honor to do it. Whenever you see a patient, they're putting their life in your hands."

While South Miami does have a hospitalist group, for the most part the staff consists of community physicians. "Many of our physicians have been here for 10 or 15 years, and they have a long-standing relationship with their patients," said Selgas. "Because of this, we really have a family atmosphere, and communication with patients happens naturally."

When physicians join the staff at South Miami Hospital they receive a thorough orientation handbook, describing the hospital's structure, department locations and phone numbers, research access, dictation procedures, and plans for severe weather. It has all the basic tools and facts new physicians need to orient themselves to this particular hospital environment.

The handbook also includes Baptist Health South Florida's "Culture Tool," which describes health-related attitudes and behaviors for more than 20 different cultural groups. The information includes dietary preferences, communication styles, spiritual beliefs, attitudes towards pain, and beliefs about health and treatment of illness. No doubt this cultural orientation helps physicians communicate well with all sorts of patients. This is particularly important since Miami is an international destination, and the hospital often needs to communicate effectively with foreign visitors.

In addition to the orientation handbook and formal credentialing, the Physician Relations Team, which was formed about 10 years ago, makes presentations about the culture and peer expectations at South Miami. It works very closely with the medical staff office and administration to ensure physicians receive proper onboarding and are followed up throughout their tenure. The team works with various aspects of recruitment and retention of physicians, including orienting new members, planning social events for networking, addressing needs as they arise, assessing key service areas, and ensuring that the hospital has the specialists it needs to fulfill its strategic plan. The team works with a variety of departments to provide physician support when needed, and makes themselves available to the medical staff at all times to ensure their needs are met.

Every incoming physician has a chance to meet with Dr. Stewart and members of the Physician Relations Team over breakfast or lunch. "They review our policies and procedures, but most importantly transmit our culture," Selgas said. "This is a very patient-centered organization, and our physicians and staff are key to making this happen. Our expectation here is that it's all about the patient."

One essential aspect of South Miami's culture is listening intently, and taking enough time with each patient. "They say that when a doctor sees a new patient the average time before interrupting the patient's conversation is something like 20 or 25 seconds," Dr. Stewart said. "We believe that keeping your ears and eyes open is a critical part of medicine. Take in everything you can—don't miss a detail. Being a doctor means you listen attentively and remember what you hear." He adds that making the correct diagnosis is only the first step in helping the patient. "In order to have an effective treatment, it's essential to know the patient, listen to the patient, and work together to find a treatment that will be most effective for that particular person."

In addition, the initial orientation process conveys the expectation that everyone works together, and works respectfully. "During the orientation session we explain that we expect them to react as physicians, to carry themselves appropriately and play the true role of the doctor," Dr. Stewart said. "I am available and other members of the medical staff are available at any time if they have questions or when something needs to be resolved."

Dr. Stewart visits each of the non-intensive care units every weekday, chatting with different people, making himself available in case there are any problems. "Dr. Stewart communicates with everyone, both employees and patients," Selgas said. "He has been here forever. When there is an issue or communication problem with a physician, he is available to contact that doctor."

About 30 percent of all hospital cases are selected randomly for physician peer review. If there are any issues related to physician quality, they are addressed by the medical staff quality peer review committee. They also have over 50 interdisciplinary performance improvement teams working on various issues. "We have a long tradition of working together to improve our practice and environment," Dr. Stewart said.

The hospital has also done considerable work to clarify and improve communications among physicians. When a consult is needed, hospital policy is that the doctors need to speak with one another, live (instead of leaving voicemails and playing phone tag). In order to facilitate this process, a physician sends a text saying, "I need to speak with you within X amount of time," and the physician on call is committed to responding in a timely manner.

South Miami won the 2013 HealthStream "Excellence Through Insight Award" for overall physician satisfaction for hospitals that excel in their ability to gain insight about their patients, employees, physicians, and community.

Accessible Resources for Patients and Staff

Because pain management is a priority for South Miami Hospital, it has invested in visible, pragmatic resources for patients and staff. Education at the bedside is kept simple and clear. The nurse explains, "If you are having pain, this is what you need to do." In addition to asking patients about their pain, rated on a scale of zero to 10, nurses also monitor nonverbal signals that can show if the patient is experiencing significant pain.

The hospital uses the Micromedex Consumer Education system, a huge database of educational materials for every condition and each stage of care. A wide range of educational videos are also available on the television in the patient's hospital room. Upon admission each patient receives a special folder, and all the educational information they're given goes into this folder. Upon discharge they take the folder with them as a permanent reference.

In each room, a laminated poster shows the patient the time of their last dose of medication, and the next scheduled dose. In addition, it says, "Although medications are frequently used to treat pain, there are other pain reducing methods, such as massage, relaxation techniques, and application of heat or cold. Ask your nurse about comfort measures to continue when you leave the hospital. **Tell your nurse if your pain or discomfort does not improve."**

The hospital has also implemented a process called "code help," so patients and their families always have a resource to turn to. "This means if the family is at the bedside and feels like they're not getting what they need for their loved one, they can dial the operator and call for code help," Green-Blumstein said. "This brings people to the room to help them resolve the issue—whether it's clinical or personal, someone arrives to help that get resolved."

The pharmacy department and the Pain Council have developed an exceptional series of resources to support healthcare practitioners in dealing effectively with pain management.

Every nursing station has a loose-leaf binder of laminated pages, called "Pain Reference Tools," with both an adult version and a pediatric version. The pain reference lists various classes of pain medications, noting equivalent doses, routes of administration, and potential harmful side effects. One page describes how to do a pain assessment for a nonverbal or cognitively impaired person. The most striking section displays the pain scale in 20 different languages.

Whenever a practitioner needs a pain consult they can call the Pain Council and access an RN who has gone through specialized training in order to serve as a pain resource nurse. The Pain Council has developed a striking series of posters and email messages. A two-page handout called "Pain Pearls for the Clinical Partner" emphasizes the risk of respiratory depression for someone who's on strong pain medication, and key signs to watch out for. "The patient may eventually stop breathing unless this problem is recognized and treated immediately," it says.

This handout also lists "Common Myths about Pain," saying in part:

> *A common myth is that we make people addicted to pain medicine. Addiction is a disease and we cannot "give" it to someone.*
>
> *Another common myth is that pain is easy to manage. Pain management is complicated; people react differently to pain as well as to pain medicines. Many times we have to try different techniques and medicines until we find the best treatment.*

The Pain Council sends out a series of pain messages to alert healthcare providers to important current issues. For example, it sent out a poster saying, "Did you know that two milligrams of Dilaudid is equal to 14 milligrams of morphine?" This was displayed in all nursing units and created a stir. It definitely alerted practitioners to an important point many had not been aware of.

Before Collins retired, she developed a series of pain education modules that have now been uploaded into the Baptist Health University (online courses accessible on the hospital Web site), and they are available for nurses and care partners to study at any time. The Pain Council organizes in-service training for nurses, inviting a series of experts to discuss pain mechanisms and pain management.

Interdisciplinary Collaboration to Promote Patient-Centered Care

What is the most important factor leading to South Miami's excellent results in patient care? Selgas points to its tradition of strong interdisciplinary collaboration. "If you focus a hospital around one particular discipline, physician-centered, nurse-centered, or whatever, you will never achieve excellent results. It takes a village to get where we need to be in healthcare. It takes the coordinated efforts of every single discipline. In order to prevent problems from arising, you have to listen to every single member of the team, and of course that includes listening to your patients."

South Miami takes many steps to encourage teamwork among all employees. Most hospitals set aside a "nurses' week" and another week to celebrate the hospital as a whole, South Miami celebrates both at the same time. At many Magnet hospitals, the nurses wear a special pin showing they have achieved Magnet status. At South Miami, both nurses and non-nursing staff wear Magnet pins. "It's a team effort. When we achieve Magnet status, we all achieve Magnet status together, and we have a party together," Selgas said.

One reason South Miami has been successful in both pain management and physician communication is that it doesn't take success for granted. Throughout the hospital, there is a pervasive understanding that quality improvement is a continuous process. "When it comes to caring for people who are sick, in pain, in a difficult and unfamiliar environment, they deserve our strongest efforts to respond to their needs and help them regain health," said Selgas. "Each day, each month, is a fresh opportunity to improve the quality of our care. We can never say that we have done enough."

Nurses on the Front Line

Nurses deal directly with patients throughout their hospital stay, and that means nurses are on the front line when it comes to pain management.

South Miami Hospital empowers nurses to take an active role. Nurses are trained to say to patients, "If your medication does not relieve your pain, please talk with me, and we'll consider what other options may be available."

Many patients are dealing with multiple sources of pain. They may have chronic illness, plus a current surgery. Some are dealing with addiction. "We get a wide variety of patients. Our nurses have gotten really good at multi-tasking and identifying the various types of pain," Green-Blumstein said. "Then they reach out to various resources we have here; it may be a chronic pain specialist or a physician who specializes in addictionology, for help in supporting these patients."

Recently the hospital restructured its way of documenting pain in the electronic medical record, so it is now more specific and user-friendly for the nurses. In the past, when nurses did free-form notes, information about pain was stored in various locations and it was difficult to find key details and compare them to previous days. "Now we put all the information together in one area," said Castillo. "Nurses are prompted for key information, including pain on a scale of zero to 10, the reassessment is done in the same section of the chart, and all the pain management information is documented in one place."

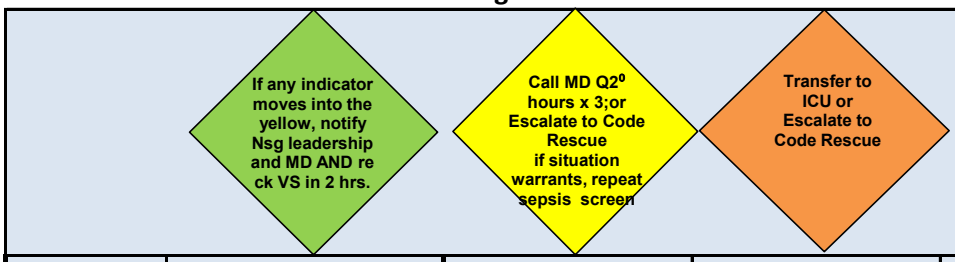
Nurses take an active role in suggesting ways to individualize medications, based on their assessment of each patient and that patient's experience of pain. Nurses who do intake are authorized to request medication orders ahead of time, based on the patient's specific history. For example, if a car accident patient has a history of migraines, the nurse could ask the physician to order migraine-specific pain medication as a preventive measure, so it will be available in a timely manner if it is needed.

Nurses have been empowered to call physicians and let them know when the patient isn't getting relief from pain. The Pain Council has done a considerable amount of training, for nurses and other care providers, on how to describe the patient's needs when talking with physicians.

"In healthcare, practitioners get a good education on background and interventions, but we don't get a whole lot of training on therapeutic communications. You don't want to just call a physician and ask them a one-sentence question," said Green-Blumstein. "Instead, we train nurses to give the physician the whole story, briefly but systematically, using SBAR [Situation, Background, Assessment, Recommendation]. You're telling the patient's full story, including their presenting condition, past medication history, current surgery, methods that have already been tried. Because you're giving the physician the full story, it is much easier for him or her to make a decision based on a comprehensive view of the situation."

Appendix 1. Monitoring Intervention Tool for Escalation

MITE - Monitoring Intervention Tool for Escalation



Key Indicators	Q4° Vital Signs	Q2° Vital Signs	Q1° Vital Signs	Code Rescue
Airway	Not on O_2 to 30% VM	Stabilized on up to 50% VM or continuous Bipap	Escalation to NRM or Bipap	Escalation to > NRM or Bipap
Temp	97°–100°	100°–101° or < 97°	100°–101° or < 97°	100°–101° or < 97°
Heart Rate	56–110	110–130 or 50–55	131–140 or 40–49	< 40 or > 140
RR	18–26	26–28 12–17	> 28 <10–12; Use of accessory muscles	< 10 or > 28; Use of accessory muscles
O_2 SAT	> 93% on O_2 or > 95% on room air	> 90% but < 93% on O_2*	< 90% on O_2	New Readings < 90%
Syst BP	90–160	161–170	171–180	< 90 or > 180
Diast BP	70–90	91–95	96–110	>110
LOC	Alert and awake X3 or remaining at baseline documented on initial assessment	Acute agitation/anxiety (check O_2 Sat to differentiate hypoxia from neurological)	Acute agitation difficulty breathing	New onset-For example but not limited to: lethargic, slurred speech, acute agitation, anxiety, confusion, or difficulty walking
Pain	N/A	Unrelieved Pain	Unrelieved pain	Chest pain, unexpected acute abdominal pain

* Unless specific parameters from Physician