NK 7: The structure(s) and process(es) used to translate new knowledge into nursing practice.

Massachusetts General Hospital (MGH) has long been a leader in successfully bridging innovative science with state-of-the-art clinical medicine. With an annual research budget of nearly $550 million, MGH conducts the largest hospital-based research program in the United States—a program that spans more than 20 clinical departments and centers across the hospital. This funding drives discoveries and breakthroughs in basic and clinical research, which translate into new and better treatments that transform practice and patient care. (www.massgeneral.org)

On July 17, 2012, MGH was named America's best hospital by U.S. News & World Report based on quality of care, patient safety, and its reputation in 16 different specialties (attachment OOD 1.d). This recognition, along with Magnet® designation, the highest honor for nursing excellence awarded by the American Nurses Credentialing Center, has resulted in even greater pride and commitment among staff to providing the safest, highest quality care to patients and families in our local and global communities.

At MGH, generating, identifying, and translating new and emerging knowledge are at the core of our four-pronged mission as an academic medical center—practice, education, research, and community. The exponential rate of new biomedical knowledge discovery is estimated to reach an all time high of one million articles in 2012, worldwide. Keeping up with new knowledge is an ongoing challenge that requires a higher level of sophistication than ever before.

Traditional strategies for broad knowledge translation described throughout MGH’s 2012 Magnet resubmission document include the educational activities of The Norman Knight Nursing Center for Clinical & Professional Development (SE 4 and SE 5), the translational activities of the Collaborative Governance Quality and Practice Oversight Committee (SE 1 and NK 6), the translational research activities of The Yvonne L. Munn Center for Nursing Research (NK 4), and the evidence-based, patient education activities of The Blum Patient and Family Learning Center (EP 4).

A number of new or expanding structures and processes to translate knowledge into practice have been implemented and are highlighted in this section. They are knowledge translation through:

- Strategic Plan Implementation
- Excellence Every Day Portal
- Innovation Units
- Collaborative Governance Champions
- Retooling for Evidence-Based Nursing Practice Grant
- Expanding Translational Activities
  - Save Our Skin (SOS)
  - Let’s End All Falls (LEAF)
  - Research and Evidence-Based Practice Sub-Committee
  - 65 Plus
  - Pain Management Sub-Committee

Finally, this section concludes with several exemplars of translational activities in order to highlight how the members of PCS are using the theory and processes of Implementation Science to disseminate new initiatives with the help of technology and Champions.

- **Knowledge Translation through Strategic Plan Implementation**

  The Senior Vice President for Patient Care and Chief Nurse (CNO) and the leadership across the disciplines within PCS demonstrate an unwavering commitment to knowledge translation as the foundation to high quality patient and family care. The PCS Vision Statement begins, “our every action is guided by knowledge.” This is our mandate. The annual strategic goals for 2010-2011 and 2012-2013 (attachment OOD 3.h and attachment OOD 3.i) are prime examples of this commitment. The annual strategic planning process under the current CNO has occurred since 1996, and it encompasses a sophisticated approach to knowledge inquiry and translation through interdisciplinary and multifaceted interventions (TL 3).

  The Patient Care Services Executive Committee conducts annual strategic planning during a retreat which is held under the direction of the CNO. The strategic goals are subsequently presented to the MGH community through open forums, committee meetings, staff meetings, and published in Caring Headlines, the PCS biweekly newsletter. (attachment NK 7.a, attachment TL 3.d, and attachment TL 3.g) The strategic goals are referred to often throughout the year and become the foundation for the work of the departments and centers. The goals are responsive to new knowledge that is identified by the group as being priorities for the upcoming year. Where state-of-the-science knowledge for practice, particularly patient falls for example, is insufficient to resolve the problem in a single year, the goals typically require a stepwise and ongoing approach as new knowledge becomes available.

  As just one example, the 2010-2011 strategic goal is presented to demonstrate the processes used translate knowledge into practice. One overall goal in 2010-2011 (attachment OOD 3.h and TL 3EO) was to improve the patient, family, and employee experience through the following tactics:

  1. Improving clinical and support staff communication with patients and families;
  2. Improving responsiveness;
  3. Improving the cleanliness of the hospital;
  4. Eliminating patient falls;
  5. Eliminating hospital-acquired pressure ulcers;
The processes to meet these goals always involved an interdisciplinary approach to identify best evidence and translate it into practice. Under Tactics 1 and 2, interdisciplinary teams were established to research and implement the newly-developed Hourly Rounding protocol. The PCS Office of Quality and Safety staff created and disseminated an Hourly Rounding Toolkit to each patient care unit (attachment TL 3EO.e). Local leaders and staff nurses were responsible for implementing the new practice. The CNO used her regular column in Caring Headlines (attachments NK 7.b, attachment NK 7.c, and attachment NK 7.d) to underscore the importance of Hourly Rounding, as well as public forums, such as Combined Leadership Meetings.

Under Tactic 3, research into the state-of-the-science hospital environmental cleaning was conducted. After searching the evidence, “wet cleaning” was identified as the current standard of cleaning in health care environments. It requires that a single-use, microfiber cloth be dipped into a cleaning solution. The cloth is then used to wipe surfaces which are allowed to air dry for ten minutes in order to fully disinfect the surface. In addition to using the newest method of wet cleaning, patients were encouraged to contact their Unit Service Associates (USAs) when anything in their rooms needed attention. The USAs distributed personal name cards to each patient so that every patient knew who was responsible and could ask for their USA by name. This ambitious campaign required a large employee and patient education initiative, so that all would understand why the surfaces were required to air dry. The CNO published an article in Caring Headlines that would assist the staff in understanding the new process (attachment NK 7.e). The CNO also invited the internal expert to present at the Collaborative Governance Staff Nurse Advisory Committee meeting in order to teach staff nurses the process and rationale of the new cleaning method (attachment NK 7.f). Tactics 4 through 6 also required an expansive evidence-based approach by interdisciplinary teams and ambitious campaigns for implementation (SE 1EO and EP 7EO).

These examples provide evidence of the structures and processes used at the executive level of PCS to translate new knowledge into practice. In this way, PCS executives model the way for evidence-based decision-making as well as make evidence available and transparent for the members of the department. For every decision, PCS leaders look first to the evidence and then structure a comprehensive, interdisciplinary approach to education and implementation.

- **Knowledge Translation through Excellence Every Day Portal**

At MGH, Excellence Every Day means striving to provide the best possible care to every patient and family in every moment of every day. It is our philosophy and our commitment.

In an effort to synergize communication and resources, the PCS Excellence Every Day Portal was launched on July 20, 2011 to serve as a central clearinghouse for information related to Collaborative Governance, Magnet Recognition, and regulatory readiness (www.mghpcs.org/EED) (attachment NK 7.g). The Excellence Every Day Portal, or EED Portal, as it is called, is readily accessible from several routes: directly from the hospital’s Excellence Every Day Portal; from a line on the header of every Patient Care Services web page; and through search engine optimization, via any major search engine (e.g., Google) by looking for “MGH EED” or “MGH Excellence Every Day.” The EED Portal is managed by an interdisciplinary group of leaders in PCS called the Excellence Every Day...
Communication Group with robust support by a web developer. Since announcing the launch in August, 2011, the CNO and the Excellence Every Day Communication Group encourage staff to visit the site through monthly “Scavenger Hunts,” through which five winners receive small gifts and are listed as winners on the website (attachment NK 7.h). The encouragement and recognition were successful in getting staff to accustomed to using this valuable “one-stop” resource.

The EED Portal has become the pinnacle of successful knowledge translation, an innovation containing just-in-time knowledge with a far reach. Originally marketed as, “a link to all things quality and safety,” the EED Portal continues to expand with new, updated, easy-to-find content. In its first year, the EED Portal logged 29,237 “page views.” Consistent with the NK 7 goal of translating knowledge into practice, the EED Portal has evolved into the destination for information about key topics in clinical practice. It now contains clinical knowledge for practice about central lines, disabilities, diversity, ethics, fall prevention, pain, patient education/health literacy, patient experience, pressure ulcers, and restraints, as well as an expanding “Glossary.” Each is updated by subject matter experts on an ongoing basis. Key topics (e.g., those related to nursing quality indicators) are annually revisited PCS-wide.

The graphic layout of the EED Portal Page (Figure 1) is pleasing and intuitive, making it easy to find information with the click of the mouse. Four buttons are horizontally placed across the top of the initial screen shot: Collaborative Governance, Magnet, Regulatory Readiness, and Innovation Units. Located directly under the four buttons, “Other Topics” are listed that are directly related to clinical practice. As new topics are added to the site, nurses and members of the health disciplines will have expanded access to...
the strategic priorities of Patient Care Services. The development of the EED Portal pages has followed the schedule below, with flexibility to move topics as opportunities arise:

<table>
<thead>
<tr>
<th>Staged Implementation of EED Portal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In 2011:</strong></td>
</tr>
<tr>
<td>• August--Fall Prevention</td>
</tr>
<tr>
<td>• September--Restraints</td>
</tr>
<tr>
<td>• October--Pain</td>
</tr>
<tr>
<td>• November--Pressure Ulcers/Skin</td>
</tr>
<tr>
<td>• December--Disabilities</td>
</tr>
<tr>
<td><strong>In 2012:</strong></td>
</tr>
<tr>
<td>• January--Central Line Infections</td>
</tr>
<tr>
<td>• February--Health Literacy/Patient Education</td>
</tr>
<tr>
<td>• March--Certification/Clinical Recognition</td>
</tr>
<tr>
<td>• April--The Patient Experience</td>
</tr>
<tr>
<td>• May--Diversity &amp; Cultural Competence</td>
</tr>
<tr>
<td>• June--Ethical Decision Making</td>
</tr>
<tr>
<td>• July/August--Caring for Older Patients</td>
</tr>
</tbody>
</table>

Future topics include:

• September 2012--Evidence-Based Practice, Performance Improvement & Research
• October 2012—Medication
• November 2012—Restraints (revisited)
• December 2012--Diversity/Cultural Competence (coincide with the holidays)
• January 2013—Infection Control
• February 2013—Pain (revisited)
• March 2013—The Patient Experience (revisited)
• April 2013—Safety Reporting/Just Culture

Using the EED Portal Page for Central Lines as an example (attachment NK 7.i), “Quick Links” takes the reader to New Policy Information. With a click of the mouse, nurses can access the latest information on Central Lines, made even more intuitive with graphic cues. The site also contains many resources. A few are included here as examples:

♦ New Policy Information (attachment NK 7.i)
♦ Central Line Flushing Policy and Education (attachment NK 7.i)
♦ Central Line Visual Guide (attachment NK 7.i)
♦ Central Line Patient Education Materials (attachment NK 7.k)

Feedback related to the Central Lines page located on the EED Portal has been very positive. A few comments are:
“The IV team LOVES it! We are using it daily as a teaching tool with staff.”
“Thank you all for a wonderful product!” (Central Lines)
“You showed a visual to catch the eye, said what is new, gave a link, and reinforced existing best practice ALL IN ONE PAGE.”
“We have great resources in Trove, but at 2AM when you get an admission and need information that is concise and you need it rapidly, the EED Portal is great!”
“Cannot thank you enough for your work on the new heparin flush policy and portal page. They are great resources!”

In summary, the PCS EED Portal continues to expand nurses’ access to knowledge for practice. This cutting-edge innovation has expanded beyond its initial conception due to the positive input and feedback from nurses and other health professionals.

- **Knowledge Translation through the Innovation Units**

  The “Innovation Units,” 12 patient care units involved in a pilot project, are serving as the testing ground for innovations in new models and processes of care (TL 4EO). The Innovation Units originated from the need to make care more effective, efficient, and affordable for patients and families, which is part of a larger Partners-level initiative known as the Patient Affordability Direct Care.

  Over a very short period, the CNO challenged nurses on the inpatient units, to embark on this project. Adventurous and inquisitive self-selected nursing leaders jumped on board, despite not fully knowing what was involved.

  Interested Nursing Directors, Clinical Nurse Specialists, and Staff Nurses wrote one proposal per unit early in the process, identifying at least one innovation that they would implement specific to their units. Over the course of several months, leaders in Patient Care Services examined a variety of evidence-based innovations that would assist units in meeting the pre-selected goals. They selected 12 for implementation on the units, seen in the Figure below, preceded by the colored bullets.

  Figure 2 shows a “progress report” of where the implementation was situated in the early roll-out of the project in April 2012. The interventions (colored bullets) are evidence-based interventions that are being piloted on the Innovation Units. They were derived from process improvement literature as promising evidence-based interventions specifically designed to improve clinical outcomes, enhance patient- and staff-satisfaction, and reduce costs and lengths of stay. The interventions were vetted with staff during thought-provoking discussions at retreats, break-out sessions, and conversations. Utilizing the EED Portal as the point of knowledge, all of the information for and about Innovation Units can be found there, as well. ([www.mghpcs.org/Innovation_Units/index.asp](http://www.mghpcs.org/Innovation_Units/index.asp))

  The Innovation Units are a proving ground for knowledge translation. A comprehensive evaluation is being conducted, specifically examining fidelity and barriers to adoption of the various components. External consultant, Marita Titler, PhD, RN, FAAN, a specialist in implementation science and author of the Translational Research Model.²

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advocates for piloting and evaluating new evidence-based practices in order to know whether the intervention will be successful in a particular environment. In essence, the Innovation Units are implementing “bundles” of evidence-based interventions, by using rapid-cycle change, a process that has become popular since our work on Transforming Care at the Bedside (TCAB). The sources of the evidence are listed on the EED Portal page as tabs under “In the Literature” (attachment NK 7.l). The Innovation Units are a novel way to translate evidence into practice. The interventions “that work” will be disseminated to the other units in the hospital. A comprehensive dissemination plan will follow to inform the entire Partners system and the country.

“Patient Journey” Framework: Progress-to-date

Before  

Admission Process: ED, Direct Admits, Transfers  

Patient Stay; Direct Patient Care, Tests, Treatments, Procedures, Clinical Support, Operational Support  

Discharge Process  

Post Discharge Care  

Intervention  

Preadmission Care  

Admission Process: ED, Direct Admits, Transfers  

Patient Stay; Direct Patient Care, Tests, Treatments, Procedures, Clinical Support, Operational Support  

Discharge Process  

Post Discharge Care  

Intervention  

In Progress  

Ready for Implementation  

Intervention  

Relationship Based Care  

Increased Accountability through Attending RN role  

Hand-over Rounding Checklist  

Intervention  

Enhances Clinical Data Collection Pre-Admit  

Create Innovation Unit Welcome Packet  

Revise Domains of Practice  

Interdisciplinary Team Rounds  

Electronic Whiteboards  

Voalte Communication Technology  

Portable Devices: hand-held/Tablet  

Discharge Planning Readiness Tool  

Discharge Follow-up Call Program  

Figure 2. Interventions for Innovation Units Are Next to Colored Bullets

Knowledge Translation through Collaborative Governance Champions

The re-design of Collaborative Governance was in response to evolving needs of patients and families and the changing health care environment. The re-design has been fully described in SE 1 but is highlighted here because of its role in the translation of new knowledge into practice.

An often quoted statement about knowledge translation is that it takes, on average, 17 years for new knowledge to go from bench to bedside.3 The goal, however, is to quickly put evidence into practice, where it can help patients and families. As new knowledge is translated into practice guidelines, policies, and procedures, the challenge is to make frontline nurses aware of new knowledge as quickly and effectively as possible.

The Champion model has accelerated the pace of translation. Previously associated with the MGH’s Magnet Recognition and Excellence Every Day initiatives, the Champion model became an integral part of the Collaborative Governance re-design. The Champion model provides frontline staff with the authority and accountability for conveying key information to their colleagues. The CNO states, “… the word Champion better reflects the evolution of committee members into the empowered communicators, content experts, and leaders they have become” (attachment NK 7.m). In fact, those who participate in Collaborative Governance derive a higher level of meaning and competence from their experiences, as illustrated in the CG evaluation (SE 1).

According to the Translational Research Model,² the adoption of new knowledge into practice depends on the characteristics of the innovation and how the innovation is communicated to end users within an organization (attachment NK 7.n). Champions on the Staff Nurse Advisory Committee value their monthly meetings with the CNO. Evaluation reveals that they feel privileged to have early access to information and take their roles as communicators seriously (SE 1). One Champion wrote, “It feels very empowering to explain to staff the innovations being trialed and the reasoning behind them.”

Along the same topic, Collaborative Governance Champions accelerate adoption of new knowledge because they are the ones communicating the knowledge to their peers. Similarly, through two-way communication, other members of the organization are educated by the experiences of frontline staff.

One example in 2012 relates to staff nurses’ and other clinicians’ questioning the accuracy of the temporal artery thermometers. Two internal content experts visited the Policies, Procedures, and Products Sub-Committee and the Staff Nurse Advisory Committee meetings to clarify some misunderstandings around the programmed settings and use of the temporal artery thermometers (attachment NK 7.o and attachment NK 7.p). Based upon a thorough review of the literature that was conducted by Evidence-Based Practice (EBP) Mentors, the experts confirmed the reliability of the thermometers in normothermic and hypothermic patients. The experts then informed the Champions that a research study was planned to evaluate the thermometer’s accuracy in hyperthermic patients. Thus, the Champions were able to report to their colleagues with new and accurate information about the issues relating to the thermometers and what was being done.

Collaborative Governance committee meetings are a testing ground for new ideas, often raised by frontline nurses, who seek the latest evidence to guide decision making. The Champions have an increasing responsibility to be evidence communicators to their colleagues on their units. To increase their knowledge of evidence-based decision making, two EBP educational sessions were held to introduce the Champions to the concepts of EBP as they relate to their work in Collaborative Governance (attachment NK 7.q).
• Knowledge Translation through Retooling for Evidence-Based Nursing Practice Grant

The Retooling for Evidence-Based Nursing Practice Project (REBNP) is an intensive, three-year project (2009 – 2012) designed to enhance and accelerate the translation of knowledge into practice. The project aims to educate nurses about EBP and to provide mentored assistance in EBP projects. The REBNP Project was the first formal EBP initiative, building upon the interests and work of earlier EBP initiatives.

For many years, EBP has been of interest across disciplines at MGH. Its early beginnings in nursing stem from a small group of dedicated Clinical Nurse Specialists (CNS) who were passionate about advancing an agenda of EBP at MGH. The CNSs conducted a two-year review of the published literature in order to update policies about the care and maintenance of nasogastric feeding tubes (2007-2009). The results of their study, in which they recommended radiographic confirmation of nasogastric tube placement prior to the start of feedings, navigated numerous hospital committees until it became the standard of care. Another small group of CNSs sponsored two EBP conferences for MGH nurses. The conferences were well received and generated more interest in EBP. Several oncology nurses contributed to the Oncology Nursing Society’s Putting Evidence into Practice (PEP) Cards program on a national level. Another active group was comprised of several oncology Advanced Practice Registered Nurses (APRNs) who work in the MGH Cancer Center. However, EBP was, for the most part, an informal endeavor.

In 2007, recognizing the need to intensify efforts in EBP, financial support was provided by the PCS Institute for Patient Care for two Nurse Scientists in The Yvonne L. Munn Center for Nursing Research, along with a Clinical Nurse Specialist, to attend advanced training in EBP at the Advanced Practice Institute conducted by EBP-expert Marita Titler, PhD, RN, FAAN, then at the University of Iowa Hospitals and Clinics. Upon returning to MGH, the nurse scientists created a comprehensive plan to build overall EBP capacity. One nurse sought external funding to accelerate the pace.

In 2009, Retooling for Evidence-Based Nursing Practice (REBNP) Project was funded in the amount of $899,130 (attachment NK 7.r). The overall aim was to build evidence-based nursing capacity by developing, implementing and evaluating a staged professional development program based upon the Iowa Model of Evidence-Based Practice to Promote Quality Care (Iowa Model). The Project Director aimed to create a common framework for EBP, a term that tended to be loosely used and with various meanings. The goals were to:

1) strengthen all levels of the nursing workforce by teaching knowledge, skills, competencies, and outcomes of EBP through multimodal continuing education programs;
2) to provide opportunities for nurses to participate in mentored evidence-based practice projects that would improve the quality of care and patient outcomes; and 3) to build infrastructure necessary to support and sustain EBP in our complex academic medical center.

The REBNP Project was implemented by two doctorally-prepared nurses and several master's-prepared nurses. The Project was able to fund partial salaries of two CNSs, essentially providing an eight-hour/week fellowship in EBP. The REBNP Project consisted of sequential, multimodal education, which was available to nurses in all roles at MGH. Additional information of the REBNP is found in SE 5. The initial courses were live, one-hour sessions which were held in the first two years of the grant. Thereafter, the focus was centered on creating three online HealthStream courses, which would be more accessible to nurses. Nurses could take more in-depth online courses as pre-requisites for more intensive live training sessions.

In Figure 3, the column on the left represents live, one-hour courses designed to present basic concepts of EBP to all role groups (EBP 100); to Nursing Directors and Clinical Nurse Specialists (EBP 101); to Staff Nurses, Clinical Nurse Specialists, and Nursing Directors who wished to start a journal club on their units (EBP 102); to all newly hired RNs (EBP 103); and to Doctorally-Prepared Nurses who would be mentoring Staff Nurses and others conducting EBP projects.

Courses listed in the center column are available to RNs after they complete one course in the 100 series. Multi-modal education is important in order to meet the education needs of RNs on the night shift, in particular. The courses listed on the right hand column are considered intensive courses and require that one 100-series course and one 200-series course be completed first.

The most intensive training was provided in the EBP 303 Clinical Inquiry Institute (CII), a three-day training targeted to Clinical Nurse Specialists who are recognized as the experts of clinical nursing practice. It was intended that the CNSs, called “EBP Mentors” would take the leading role in mentoring EBP projects upon completion of the funded period (EP7 EO). Clinical Nurse Specialists are unit-based, readily accessible to Staff Nurses who generate excellent clinical questions for inquiry. Having Staff Nurses with an advanced EBP skill set is critical to the success of EBP, which is extremely time-consuming and difficult, especially critiquing and leveling evidence.
A list of the classes, numbers, and attendees of EBP Courses is found in Table 1.

Table 1. Summary of Classes and Attendance in REBNP Project

<table>
<thead>
<tr>
<th>EBP Classes (2010-2012)</th>
<th>Sessions</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBP 100: Achieving Excellence in EBNP</td>
<td>15</td>
<td>114</td>
</tr>
<tr>
<td>Clinical Inquiry Institute: preparation sessions</td>
<td>4</td>
<td>37</td>
</tr>
<tr>
<td>EBP 101: Nursing Leader’s Guide to EBP</td>
<td>8</td>
<td>36</td>
</tr>
<tr>
<td>EBP 102: Starting a Journal Club to Promote EBNP</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td>EBP 103: RN Orientation</td>
<td>28</td>
<td>566</td>
</tr>
<tr>
<td>EBP 200: EBP in Nursing: Advancing the Art and the Science</td>
<td>on line</td>
<td>152</td>
</tr>
<tr>
<td>EBP 201: Finding the Best Evidence</td>
<td>on line</td>
<td>61</td>
</tr>
<tr>
<td>EBP 202: EBNP: Delirium Recognition and Screening</td>
<td>on line</td>
<td>45</td>
</tr>
<tr>
<td>EBP 303: Clinical Inquiry Institute (3-day May 2010)</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>EBP 303: Clinical Inquiry Institute (2-day Apr-May 2011)</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>EBP 304: EBP Seminar</td>
<td>20</td>
<td>208</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>1294</td>
</tr>
</tbody>
</table>

In addition to the planned classes supported by the grant, the Retooling for Evidence-Based Nursing Project staff took advantage of every opportunity to teach EBP. In Table 2, twenty-one EBP presentations were given to 545 nurses and other clinicians at MGH. In Table 3, five EBP presentations were given externally to 353 nurses. Presentations about EBP were also provided to our visiting colleagues from China, Korea, and Bermuda.
Table 2. Other MGH Presentations and Symposiums by the REBNP Project Staff

<table>
<thead>
<tr>
<th>MGH Presentations &amp; Symposiums</th>
<th>Sessions</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Nurse Specialist Forum 2009</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Nursing Grand Rounds 2009</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Quality &amp; Safety Committee Dec. 2010</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Doctoral Forum 2009</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>EBP and Delirium: Dr. Inouye Sep. 2010</td>
<td>1</td>
<td>37</td>
</tr>
<tr>
<td>1st Oncology Nursing Conference: EBP in Action: Keynote Presentation, 2010</td>
<td>1</td>
<td>98</td>
</tr>
<tr>
<td>EBP for Nursing Leaders: M. Titler, PhD, FAAN Apr. 2010</td>
<td>2</td>
<td>87</td>
</tr>
<tr>
<td>RN Residency 2010, 2011</td>
<td>2</td>
<td>73</td>
</tr>
<tr>
<td>Doctoral Symposium Sep. 2011</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Collaborative Governance Champions Symposium (x2) Sep. 2011</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Professional Practice Symposium Sep. 2011</td>
<td>2</td>
<td>70</td>
</tr>
<tr>
<td>Staff Nurse Advisory Presentation Dec. 2011</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>Journal Club Sessions</td>
<td>5</td>
<td>55</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
<td><strong>545</strong></td>
</tr>
</tbody>
</table>

Table 3. External Presentations and Symposiums by the REBNP Project Staff

<table>
<thead>
<tr>
<th>External Presentations and Symposiums</th>
<th>Sessions</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning Keynote Address, Sanford University of South Dakota Medical Center Research and Evidence-Based Practice Conference, Sioux Falls, SD, Sep. 2011</td>
<td>1</td>
<td>150</td>
</tr>
<tr>
<td>Afternoon Keynote Address, Sanford University of South Dakota Medical Center Research and Evidence-Based Practice Conference, Sioux Falls, SD, Sep. 2011</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
<td><strong>353</strong></td>
</tr>
</tbody>
</table>

Outcomes of the REBNP Project include:

- Educational programming totaling 121 classes, presentations, and/or consultations involving 2164 attendees or 1634 unique nurses locally, nationally, and internally;
- A common language of EBP within Patient Care Services at MGH;
- Enhanced clinical decision making based upon evidence;
- Dissemination of the Iowa Model as the model of choice at MGH;
- Targeted education to specific groups (Acute Care Documentation, Collaborative Governance, Doctoral Forum, CNS, and Nurse Practitioner groups).

Much has been accomplished to advance the understanding of EBP and advance best practices in the clinical setting during the past four years. A major initiative in knowledge translation and Implementation Science through the Retooling for Evidence-
Based Nursing Practice Project was described, demonstrating an increasing capacity among Staff Nurses, Clinical Nurse Specialists, Nurse Practitioners, Executive Nurse Leaders, and Nursing Doctorates to find and utilize knowledge for clinical decision making. This demonstrates an ongoing commitment to knowledge translation in our organization, from the CNO to the bedside.

- **Expanding Translational Activities**

  The REBNP Project was a comprehensive education and mentorship initiative in EBP. A secondary outcome was capacity building in the area of Implementation Science. The large number and diversity of implementation projects in an academic medical center of our size requires a more sophisticated approach to what we often refer to as “roll outs.” Traditionally, initiatives were rolled out as a discrete activity. More effort was invested in the roll out, the time line, the message, and the materials; less effort was invested in a consideration of factors that would influence the adoption of the innovation. The concepts of Implementation Science were not widely known.

  In several of the courses above, the concepts of the Translational Research Model (attachment NK 7.n) were taught to Staff Nurses, APRNs, and Doctorally-Prepared Nurses. To reiterate, according to the Translational Research Model,² the adoption of new knowledge into practice depends on the characteristics of the innovation and how the innovation is communicated to end users within an organization. The exemplars that follow demonstrate a focus on the principles of Implementation Science. A particularly poignant takeaway message for nurses responsible for roll-outs was to study the adoption of the innovation as it is being piloted whereas, traditionally, roll outs were conducted without much attention to the process or contextual variables.

  **Exemplar: Save Our Skin (SOS) Initiative**

  This is exactly what occurred in the Save Our Skin (SOS) initiative (SE 1EO). The Project Director made visits to the patient care units as the initiative was first introduced to identify any problems with misconceptions, content, or process. The SOS Project Director asked the nurses, “What is difficult about the SOS initiative?” to elicit barriers to implementation. Feedback was encouraged and received in a non-judgmental manner so that the process of implementation could be understood. When necessary, the process was “tweaked” to facilitate a smoother roll out. Elements of rapid cycle change were used so that the processes could be improved upon within hours.
The SOS Project Director also elicited specific information about implementation outcomes according to Proctor, et al. \(^4\) (attachment NK 7.s). The Proctor, et al., article was the foundation of EBP 104, in which we taught doctorally-prepared nurses the advanced concepts of Implementation Science (attachment NK 7.t). Sixteen doctorally-prepared nurses attended EBP 104. The learning associated with that course continues to be implemented. In addition to this specific example of SOS, the principles of Implementation Science were also used in AgeWISE (NK 8), the New Graduate Nurse Critical Care Residency Program (TL 7), the Innovation Units (TL 4EO), the LEAF Falls Prevention Program, and the Clinical Ethics Residency in Nursing Program (EP 23).

**Exemplar: Let’s End All Falls (LEAF) Initiative**

Similar to SOS, the Let’s End All Falls (LEAF) Initiative was a comprehensive, translational program designed to prevent patient falls, a major challenge faced by all healthcare organizations and a major focus of The Joint Commission (TJC). Patient falls are recognized as nursing sensitive indicators by TJC and the National Database of Nursing Quality Indicators (NDNQI). Hospital-acquired pressure ulcers and falls are both believed to be amenable to hourly rounding, which was formally rolled out in May 2011 (attachment TL3 EO.e).

Under the leadership of an Associate Chief Nurse, an interdisciplinary clinical team assessed our fall-prevention status and provided recommendations for improvement. One of the team’s key recommendations was to develop a comprehensive fall-prevention and education program. Titled “Let’s Eliminate All Falls,” this program draws from evidence-based research conducted at MGH and three other Boston area hospitals (attachment SE 5EO.a).

Led by a Geriatric Nurse Specialist, a wide variety of staff were involved in the development and implementation of LEAF including the CNO (attachment NK 7.u), Associate Chief Nurses, Nursing Directors, Clinical Nurse Specialists, Interdisciplinary colleagues, PCS Office of Quality & Safety, EED Champions, CNS Psychiatric/Mental Health Service, Collaborative Governance, and unit-based practice committees.

Grounded in the Patient Care Services Quality and Safety goals, LEAF is an evidence-based program that educates staff on fall risks, fall-prevention strategies, and post-fall care practices. Prior to LEAF’s roll-out, fall-prevention education was included in our new-hire nurse and patient care-associate orientation and in the

65plus program. LEAF uses a blended approach to provide education to unit staff and leadership. This is accomplished through HealthStream and a Train-the-Trainers Class that covers key elements of fall-prevention, intervention, implementation, and any special fall risks associated with individual units. Clinical colleagues from the PCS Office of Quality & Safety, the MGH Center for Quality & Safety, and physicians played a crucial role in LEAF implementation.

The 65plus program had successfully piloted the LEAF program in several areas including outpatient Radiology, a Medical Unit, and New RN & PCA Orientation classes. Following a pilot of the program on an inpatient unit, the director of PCS Office of Quality & Safety and an Associate Chief Nurse developed a comprehensive implementation plan involving the staff of 65plus, the LEAF team, the Knight Center, PCS Office of Quality & Safety, and Collaborative Governance committees.

The LEAF program provides a standardized, integrated program for PCS staff. The implementation plan consisted of three phases:

- Phase I-Pilot testing LEAF on 3 pilot units October 2011.
- Phase II-Implementing on 37 in-patient units from November 2011 through May 31, 2011.
  - Phase III- Providing ongoing unit support, finalizing fall guidelines and posting falls care, implementing on several specialty and ambulatory units from March through May 2012.

Implementation was completed in 7 months on 37 inpatient units and several outpatient units.

In order to influence the program’s success, a multifaceted approach integrating policy to address practice and education was used to guide development and implementation. To influence practice, the team developed and implemented a fall prevention bundle which includes risk assessment, multimodal interventions, and post-fall guidelines and processes. Unit-based teams consisting of Staff Nurses, Nursing Directors, Clinical Nurse Specialists, and interdisciplinary team members collaborated with the Knight Center staff in the development and of the LEAF Tool Kit which includes unit posters describing LEAF components, a post-fall management guideline (attachment NK 7.v) to facilitate open dialogue, a case study teaching tool (attachment NK 7.w), a safe patient handling hand off tool (attachment NK 7.x), and LEAF signage (attachment NK7.y) for the rooms of patients at risk for falls. Ad Hoc subcommittees concurrently worked on other core components of the fall program, including fall prevention resources and equipment.

As part of the effort to integrate this work into practice and make this initiative sustainable, the LEAF program is an integral part of the Falls Sub-Committee that is part of the new Collaborative Governance Structure. In addition, an interdisciplinary Fall Advisory Committee was formed to provide guidance, combined expertise, and consultation during implementation. The LEAF team
provided ongoing coaching and monitoring of falls and unit based support during implementation. Finally, the link and integration with hourly safety rounding is a key component to support practice integration (attachment TL3 EO.e).

A number of educational interventions were developed. A primary strategy used the “train the trainer” model to develop unit-based fall prevention teams. Inservice sessions included information on:

- Risk assessment; risk for falls/injury,
- Prevention strategies,
- Patient-centered care plans for prevention of falls,
- Restraint-free guidelines,
- Creating a safe environment of care,
- Universal fall assessment and prevention strategies,
- Communication, documentation, and policies,
- Clinical application to practice (e.g., rounding),
- Post-fall guidelines and post-fall debriefing process,
- Review of interventions, and
- Review of resources: Nursing Directors, Clinical Nurse Specialists, Geriatric Specialist, interdisciplinary professionals within Patient Care Services, Patient Care Services Office of Quality and Safety; Excellence Every Day (EED) Champions; Collaborative Governance Champions.

In addition to the unit-based education, staff were offered three on-line learning courses available through HealthStream, the MGH learning management system: MGH LEAF Fall Prevention Program; the MGH GRAF PIF Scale, Pediatric; and the LTC Preventing Patient Falls.

An important component of LEAF is educating patients and families, as well as staff. Two fall prevention videos are available via the MGH Patient Education Channel. The first video addresses the strategies used by hospitals to prevent falls, the causes of dizziness, hospital safety features, the role of clutter in patient falls and strategies to decrease clutter, and tips for home safety. The second video reviews various patient scenarios, reviews factors that create higher risks for falls, and provides recommendations for at home fall prevention. A patient and family brochure, Preventing Falls in the Hospital and at Home was disseminated (attachment NK 7.z).

Feedback has been very positive, with nurses reporting increased knowledge regarding fall risks and enhanced post-fall debriefing of staff. Nurses report increased work satisfaction arising from having relevant information, skills and ability to analyze individual patient risk factors and brainstorm about fall prevention with unit leadership. Staff at the bedside are actively participating with interdisciplinary colleagues to modify risk factors and keep our patients safe. Three staff nurses wrote and published clinical narratives in Caring Headlines (attachment NK 7.aa).
During the time period of December 2, 2010 through December 1, 2011, 98% of those assigned to take the LEAF Health Stream module completed their assignments, N=2047. Aggregate data on unit fall rates was identified as a metric for assessing LEAF program intervention efficacy.

**Exemplar: Collaborative Governance Research and Evidence-Based Practice Committee**

Another structure used to translate new knowledge into nursing practice is the **Patient Care Services Research and Evidence-based Practice Committee (REBP)** which aims to foster the spirit of inquiry around clinical practice. The committee supports nurses and other clinicians in the research utilization process and communicates the results of nursing research activities. The members are highly engaged and have even published articles as a group.\(^{5,6}\)

Some of the activities developed by this committee to promote nursing research, particularly relating to the Journal Club Sub-Committee, are described in NK 4. In this section, the focus is on those processes that the REBP Committee uses to translate new knowledge into practice.

One of the three sub-committees is named the “Did You Know…?” Poster Sub-Committee. This committee supports nurses who wish to conduct an evidence review. The committee members serve as peer reviewers of the content; many of the committee members received intensive training in EBP and there is still ongoing training at committee meetings. Once they approve the content, they work with the author(s) to lay out the content on a poster. Next, a graphic designer is called in to enhance the presentation and then send the posters out for printing. The posters are distributed to every unit of the hospital. A few examples of this eye-catching evidence are:

- **Save the Veins: Vein Sparing for Patients with Renal Dysfunction** (2011)
  Mary-Sylvia Reardon, RN, DNP (attachment NK 7.bb)
- **Transporting Patients on Isolation Precautions** (2012)
  Heidi Schleicher, RN, BSN, CIC (attachment NK 7.cc)
- **What is Evidence-Based Practice?** (2012)
  Research and Evidence-Based Practice Sub-Committee (attachment NK 7.dd)

The process of knowledge distillation requires an advanced skills set, which is being developed through this process among both the authors and EBP Champions.

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**Exemplar: MGH 65 Plus**

65 Plus, another structure and process that is used to translate new knowledge into nursing practice, is an interdisciplinary model of Nurses Improving Care to Healthsystem Elders (NICHE), a national initiative of the Hartford Institute for Geriatric Nursing, New York University. MGH is one of 400 hospitals that are affiliated with NICHE, which provides the state-of-the-science geriatrics curriculum and ready-to-use clinical assessment tools. 65 Plus is responsible for planning and implementing initiatives to enhance the care of older adult patients throughout the hospital. The program focuses on improving knowledge and practices regarding the care of older adults; enhancing age specific evidence-based practice; improving the healthcare experience for older adult patients and their families; and supporting clinicians caring for older adult patients.

65 Plus program is facilitated by the Clinical Specialist for Geriatrics who is a doctorally-prepared nurses and a former Claire M. Fagin, John A. Hartford Geriatric Nursing Fellow. The MGH 65 Plus committee is comprised on nurses who have received training as Geriatric Resource Nurses (GRNs) and as geropalliative care nurses in the RN Residency Program: Transitioning to Geriatrics and Palliative Care. Other PCS clinicians interested in geriatrics also collaborate on geriatric protocols. The group has published an article on the development and advancement of 65 Plus in Nursing Management.7

65 Plus is a process used to translate new knowledge into nursing practice. Evidence-based geriatric knowledge is disseminated at meetings as well as through the Geriatrics EED Portal Page (attachment NK 7.ce). The group has collaborated to create and implement the Guideline Document: Indwelling Urinary Catheter: Indications for Use, based upon national guidelines (attachment NK 7.ff). Around 45% of all MGH inpatients are sixty-five years old and older, making geriatrics a key priority area.

**Exemplar: Pain Management Sub-Committee**

The Pain Management Sub-Committee of the Collaborative Governance Quality and Practice Oversight Committee is also an important structure used to translate new knowledge into practice (NK 6). Using the EED Portal, clinicians can find valid and reliable pain assessment tools as seen in this screen shot:

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Thanks to this handy resource, at the click of a mouse, nurses have access to valid and reliable assessments for pain that are the standard of practice at MGH. The Pain Management Sub-Committee, in an extension of the information on the EED Portal, played a big role in getting the assessment tools printed, laminated, and distributed to the units. Therefore, the Sub-Committee is an important group that is translating new knowledge into practice—in ways that are direct and helpful to nurses at the front line of care.
Jeanette Ives Erickson

2010 strategic plan
building on a solid foundation of excellence and a commitment to patient- and family-centered care

As we embark on a new year, I’m thrilled to share Patient Care Services’ strategic plan for 2010. In articulating our goals for the future, and on the heels of one of the most successful Joint Commission visits ever, we’re building on that momentum and focusing our efforts on quality, safety, and service. Our strategic goal for 2010 is to improve the patient, family and employee experience by:

- improving clinician and support staff communication with patients and families
- improving responsiveness
- improving the cleanliness of the hospital
- eliminating patient falls
- eliminating hospital-acquired pressure ulcers
- enhancing utilization of evidence-based practice to promote safety

Our tactics in achieving these goals will be multifaceted, multi-disciplinary, and require the support and participation of every member of Patient Care Services. A significant number of initiatives are already in place to advance this work, and more will be rolled out as we fine-tune our objectives.

Improving communication with patients and families is paramount. We want to ensure that all patients and family members are treated with courtesy and respect. Hourly rounding, which has already been adopted on some units, is one way to enhance both communication and responsiveness. We’re seeing that the un-scripted, 7-P approach (rounding regularly to assess Person, Plan, Priorities, Personal hygiene, Pain-management, Position, and Presence) helps build rapport, has a reassuring effect on patients, and contributes to patient safety. We’re convening an inter-disciplinary team to look at ways to roll this approach out to the wider hospital community.

Our patient and family advisory councils are an excellent source of feedback in helping us understand how to better communicate with patients and be more responsive to their needs. Our Greeter Program is a wonderful vehicle for interacting with patients and families, making them feel welcome, and getting a first-hand sense of their experience in the hospital. Social Services is developing a program to speed access to mental-health services for patients referred to MGH; Physical and Occupational Therapy has created a call center to improve responsiveness and access to outpatient services.

Eliminating (not just reducing) patient falls and hospital-acquired pressure ulcers is an ambitious goal. We wanted to be bold. Many units are having great success in this area, and we’ll be sharing best practices to take full advantage of this evidence-based learning. In collaboration with Nursing, Occupational Therapy is exploring sensory modalities to help prevent falls among patients experiencing confusion or dementia. Physical Therapy has amended its documentation to include information on mobility so that appropriate in...
Interventions can be employed to prevent falls. Physical therapists have presented fall-prevention seminars to elders in the community and through our own Senior HealthWise lecture series. Our 65-plus program has implemented unit-based, geriatric, educational programs to help promote optimal care for older patients, including fall- and pressure ulcer-prevention.

When we talk about improving the cleanliness of the hospital, I want to be clear that this is not solely the responsibility of our unit service associates. This is a Patient Care Services goal, and we all share responsibility. We’ve already made great progress in this area. The recent re-design of the operations manager role brought more focused attention to the environment of care. We developed and implemented a new training program to augment that re-design. We’re providing better tools (mop heads, micro-fiber cleaning cloths, re-configured cleaning carts, etc.) to ensure our efforts are producing optimal results. We’re re-visiting some of the tasks once assigned to unit service associates to limit the time they spend away from the unit and make better use of time spent on the unit. And we’re piloting an electronic tool—a small, hand-held device (similar to a PDA) that will automate the process of evaluating room-clealessness.

One tactic that addresses cleanliness, communication, and responsiveness, is a practice we’re implementing where unit service associates will introduce themselves and ask whether it’s a good time to clean when they enter a patient’s room. They’ll leave signed and dated cards in bathrooms noting each time the room is cleaned, and in the patient’s absence, they’ll leave tent cards letting them know their room has been cleaned.

As Richard Bluni of the Studor Group reminded us during a recent visit, quality and safety is the patient experience. By vigilantly attending to quality and safety, we can’t help but improve clinical and operational outcomes, and by extension, the patient experience. We will continue our on-going efforts to promote safety through proven, effective methods and evidence-based practice.

All of our tactics and strategies are intrinsically linked to ensure that patients and families experience the best possible care. I look forward to working with you as we execute our 2010 strategic plan, and I welcome your feedback and suggestions as we move forward.

Updates
I am happy to announce that Meghan Fitzgibbons has assumed the role of volunteer coordinator, replacing Kathy Clair Hayes, LICSW, who left in November to work with the new MGH-Boston Red Sox Home Base Program.

Cathie Harris, RN, has accepted the position of Pediatric clinical nurse specialist in the Emergency Department.

Tom Blanchard, RN, has accepted the position of clinical nurse specialist for the Blake 9 Cardiac Catheterization Lab.

And Barbara Cashavelly, RN, has accepted the nursing director position for the Phillips 21 General Medical Unit, effective January 25, 2010.

Welcome all.

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Fielding the Issues

New and improved patient rounding
a pearl of the past, a gem of the future

Question: I’ve heard that some units have implemented regular, hourly, patient rounding. Is that so?
Jeanette: Yes. A number of units have initiated regular patient rounding. Over and above responding to patients’ call lights, nurses and patient care associates conduct hourly rounds between 6:00am and 10:00pm, then every two hours between 10:00pm and 6:00am. In some settings, clinicians from other disciplines and role groups also participate in rounding if the person rounding is unable to meet a patient’s needs, he or she knows to call someone who can.

Question: Isn’t regular patient rounding already part of basic patient care?
Jeanette: Absolutely. What’s new is the evidence-based, need-oriented nature of each visit to the patient’s room. For instance, research tells us that patient falls are reduced when patient rounding incorporates an offer to help patients move from one place to another, or when staff ask, “Is there anything I can help you with before I leave?” When patients know to expect a routine visit from staff, they’re less likely to attempt things beyond their ability. And as you know, reducing injury through falls is one of our National Patient Safety Goals.

Question: Are there other benefits to regular patient rounding?
Jeanette: In addition to reducing falls, assisting patients to change position frequently can help prevent pressure ulcers.

Question: Is there any proof that regular patient rounding increases patient satisfaction?
Jeanette: Yes, new research confirms that regular rounding increases patient satisfaction.

Question: Will more units be adopting the practice of regular rounding?
Jeanette: Preventing patient falls and pressure ulcers and increasing patient satisfaction are a major focus of our strategic plan. We will continue to explore the benefits of regular rounding as part of our commitment to Excellence Every Day.

For more information about regular patient rounding, call the PCS Office of Quality & Safety at 3-0140.
Hourly safety rounds have positive impact on patient-satisfaction

**Question:** Do all units at MGH employ hourly safety rounds?  

**Jeanette:** According to a survey of nursing directors in February, 2011, 100% of inpatient units and the Emergency Department use some form of safety rounds (compared to 49% in June of 2010).

**Question:** Why are safety rounds so important?  

**Jeanette:** Evidence shows that hourly rounds — rounds that are focused and predictable — help prevent falls and pressure ulcers, manage pain, and increase patient-satisfaction. Patients and families are less anxious knowing their needs will be met as nurses, patient care associates, and other clinicians check on them at regular intervals.

**Question:** What are the seven Ps?  

**Jeanette:** The 7 Ps stand for: Presence, that sense of being there, honoring the patient’s individual response to illness, and gaining trust; Person, introducing yourself and your role; Plan, reviewing the care plan; and Priorities, making sure you know the patient’s wishes. These are all part of the initial daily encounter. In subsequent encounters (every hour or two), staff should offer assistance with Personal hygiene (going to the bathroom), Positioning, and assessing for Pain.

**Question:** Do hourly safety rounds apply to critical care units?  

**Jeanette:** If critically ill patients are unresponsive, the 7 Ps can be used to assure family members about continuity and attentiveness of care.

**Question:** Are hourly safety rounds scripted?  

**Jeanette:** Some believe that using a scripted approach when rounding is too impersonal and sounds rehearsed. The important thing is to make sure you touch on each of the seven Ps using your own language and style of communication. Patients should know what to expect from hourly safety rounds, such as knowing they’ll be asked about their comfort and level of pain at regular intervals.

**Question:** Are we doing anything to ensure consistency around hourly rounding?  

**Jeanette:** A standardized approach to hourly rounding is essential. Consistency helps builds trust with patients and families and allows us to accurately measure the impact of safety rounds on nursing sensitive indicators such as falls, pressure ulcers, and patient-satisfaction. In the coming weeks, the PCS Office of Quality & Safety will be distributing toolkits to assist staff in achieving consistency in their hourly rounding.

As we move forward, we’ll call upon our clinical experts in falls, pressure-ulcer prevention, and pain-management to help us refine our approach in these areas of the seven Ps.

For more information on hourly safety rounds, call the PCS Office of Quality and Safety at 3-0140.
Caring

Headlines
June 16, 2011

Are the 7Ps in your tool kit?

See Jeanette Ives Erickson’s column on page 2

Staff nurse, Sheryl Ferreira, RN, during hourly rounds with patient, Patrick Rockett

Presence
Plan
Person
Personal Hygiene
Priorities
Position
Pain
Jeanette Ives Erickson

Picker Institute’s Always Events Grant speaks to success of 7Ps

Recently, MGH was named one of a handful of recipients of the 2011-2012 Picker Institute Always Events Grants for our efforts to improve patient- and family-centered care by ensuring patients always know who’s in charge of their care, that providers are always responsive to patients and families’ needs, and that our patients always get the help they need when they need it.

The Picker Institute is an independent, non-profit organization dedicated to advancing the principles of patient-centered care. In contrast to ‘never events’ with which we’re all familiar, The Picker Institute has adopted the concept of always events—to promote aspects of the patient and family experience that should always occur when patients interact with healthcare professionals. Their grant program supports the development and implementation of always-event strategies that can be replicated across healthcare settings and contribute to widespread improvement of patient- and family-centered care.

I’m very proud of this recognition. It speaks directly to the work of Patient Care Services staff and leadership to improve our responsiveness scores, and hourly rounding is a big part of that success.

You may recall that we did a comprehensive review of best practices, and the literature pointed to a three-pronged nursing approach called the 3Ps. This approach calls for a nurse to round on patients every hour inquiring about their pain, personal hygiene needs, and positioning. We tried the 3Ps approach, but it had no effect on patient-satisfaction. So we took the information from the literature and created our own approach to better meet the needs of our patients. We call our approach the 7Ps:

- Person (introduce yourself and call the patient by name)
- Plan (describe the plan of care for the day)
- Priority (integrate the patient’s goals into the plan)
- Pain (assess for pain and manage accordingly)
- Personal hygiene (assist with any personal-hygiene issues)
- Position (when appropriate, re-position patient)
- Presence (ask if there’s anything else you can do and let them know you have time for them)

I’m very proud of this recognition. It speaks directly to the work of Patient Care Services staff and leadership to improve our responsiveness, and hourly rounding is a big part of that success.

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

Picker Institute’s Always Events Grant speaks to success of 7Ps

continued on next page
When we began incorporating the 7Ps into our hourly rounding, we noticed a dramatic improvement in patient-satisfaction. ‘It takes a village’ became part of our thinking. Nurses aren’t the only clinicians who impact the patient experience. Embracing our team approach to care, we trained patient care associates, social workers, and therapists in the fine art of the 7Ps so that responsiveness and communication would be consistent from caregiver to caregiver.

As a result, we have seen:
- a decrease in patient falls
- a decrease in skin-breakdown
- improved patient-satisfaction
- improved nursing satisfaction, including a decrease in call-light usage and distance walked by nurses

A review of quarterly data on fall rates, pressure-ulcer rates, HCAPH scores, and feedback from staff tell us that in order for hourly rounds to be successful, we must have:
- the active involvement of patients, families, nurses, patient care associates, and all role groups and disciplines that comprise the patient-care team
- predictability (rounding should take place every hour between 6:00am and 10:00pm; every two hours between 10:00pm and 6:00am)
- consistent use of the 7Ps

To help achieve consistency in the use of the 7Ps and to answer some frequently asked questions about hourly rounding, the PCS Office of Quality & Safety has put together a Tool Kit, which has been distributed to all patient care units. This Tool Kit contains, among other things, a sample script of how a routine hourly-rounding encounter might unfold. Obviously, there’s some room for flexibility around what’s actually said, but it’s important to adhere to the spirit of the script ensuring that every ‘P’ is addressed, and patients understand that hourly rounding is an always event.

For more information about hourly rounding or the 7Ps, call the PCS Office of Quality and Safety at 3-0140, speak with your nursing director or clinical nurse specialist, or contact The Institute for Patient Care at 6-3111.

Update
Since January, Debbie Burke, RN, has acted as interim associate chief nurse for the MGH Cancer Center in addition to the other areas she oversees. I’m happy to announce that effective immediately, the Cancer Center will be a permanent addition to her scope of responsibility.
Maintaining a clean environment: a crucial part of patient care

Maintaining a clean environment is a crucial part of safe patient care. We’re fortunate to have a team of skilled unit service associates who understand the importance of maintaining a clean environment for patients and caregivers.

Over the past year, Clinical Support Services embarked on an ambitious campaign to improve the products, processes, and techniques involved in keeping patient care units clean. New products, training, and practices were introduced to enhance the cleaning process and increase satisfaction with the hospital environment. Success will require the support and participation of every MGH employee.

Question: What is the new practice for cleaning patients’ rooms?
Jeanette: During daily and discharge cleaning, surfaces are disinfected using a micro-fiber cloth dipped in a cleaning/disinfecting solution. Cloths are not re-dipped; they’re put in the hamper when no longer sufficiently wet or when they’re visibly soiled. The solution is applied wet and must be allowed to air dry for ten minutes.

Question: Why do surfaces have to remain wet?
Jeanette: We use the most advanced techniques and hospital-grade cleaning products to ensure optimal resistance to germs. In order to be effective, the cleaning solution must go on wet and air dry. We’ve launched an awareness campaign to highlight this aspect of the new process — we’re calling it, ‘Wet is the new clean!’ One nice side-effect of the cleaning solution is that there’s no harsh chemical smell like there is with many other cleaning products.

Question: Are we doing anything to increase patient awareness about our new cleaning practices?
Jeanette: Earlier this year we piloted a “Patient Perception of Cleaning” initiative, whereby unit service associates introduce themselves to patients, explain their role, and let patients know how to reach them if/when their room needs attention. Unit service associates now leave a signed card in each room verifying that rooms and bathrooms have been cleaned. The initiative was rolled out in inpatient areas July 7, 2010.

Question: How often are patients’ rooms cleaned?
Jeanette: Patients’ rooms are cleaned every day, and unit service associates are always available for additional cleaning. Rooms and bathrooms are checked on all unit service associates’ shifts and cleaned as needed.

Question: How long does it take to clean and disinfect a room?
Jeanette: To effectively clean and disinfect a room for discharge takes one person 45 minutes to an hour (less if the room is cleaned by a team).

Question: Why are operations managers interviewing patients?
Jeanette: We want to know what patients think about their environment and address any concerns they may have. We’re learning a lot through these interviews and at the same time reinforcing the message that we’re committed to a clean, safe hospital.

Question: What can we do to help?
Jeanette: Research suggests that satisfaction with cleanliness is influenced by the overall neatness of a patient’s room. To help, staff can:
- throw away wrappers from dressings or medications
- discard gloves in trash receptacles
- ask patients if they can throw away old newspapers or anything else that might be contributing to clutter
- keep windowsills and counters free of linen and supplies
- let a unit service associate know if a room needs attention so he/she can address it in a timely manner
- let it be known that we care about the cleanliness of every room

For more information, contact Stephanie Cooper, senior operations manager at 617-724-7841.
WET IS the New CLEAN Campaign – S. Cooper

S. Cooper presented the new awareness campaign designed to improve cleanliness of the hospital while also communicating these new improvements to patients. Some patients may notice a lack of chemical scent and that the cleaning agent is left to air dry, and be worried that their rooms are not being sanitized correctly. The campaign will explain how the newer cleaners work.

Cleaning methods have been standardized, and are being monitored. Additional training is offered where needed.

More of the USAs will now be working during the busier discharge times of 11:30 a.m. through 7:00 p.m. It can take 45 minutes to one hour to clean a patient’s room after discharge.

A staff nurse inquired about how to wash down a chair. Small items such as pumps, stethoscopes, patient charts, etc., can be wiped with a Super Sani Cloth, which is pre-treated with a cleaning solution that has a two-minute set time. Larger items such as chairs, beds, and tables should be wiped clean with a cloth that has been thoroughly soaked in Virex and left wet to air dry for up to 10 minutes. This ten-minute set time allows the chemical to fully disinfect surfaces, killing a larger spectrum of germs than if the surface is not sufficiently saturated.

A staff nurse pointed out that on the cleaning card on the back of patient room doors, there may be a date listed that the room was completely cleaned after a discharge; however, the room might not be occupied again until a future date. When a new patient enters the room and sees the older date, the patient may think that the room has not been cleaned in days. S. Cooper will develop a system to address this issue.

Clutter in the form of used newspapers or other items left on tables can appear to patients or visitors that the room or public areas are not clean. Everyone is asked to help out in this regard to create a neat appearance in their area.
2. Learning Needs Assessment – G. Chisari, RN
- The Norman Knight Nursing Center appointed a CE Redesign Task Force back in January, 2010, and is in the development process of creating more courses for nurses to keep up with their education goals.
- The CE Redesign Task Force reviewed the current CE programs. It was determined that many courses would have relevance to nurses with three or less years of service. There were less offerings geared toward experienced nurses.
- G. Chisari, RN, shared that they are working on “learning bundles” of courses similar to the Institute for Healthcare Improvement’s model.
- Another initiative underway is to develop a palate of conferences, and eventually invite clinicians from outside the MGH to attend.
- A staff nurse shared that some of the nurses are unaware of the various courses offered, and suggested that better marketing of The Norman Knight Nursing Center might be helpful.
- G. Chisari, RN, distributed a handout of an assessment tool draft, “Evaluation of Professional Learning Environment for Nurses,” (attached), and informed the nurses that the draft will be reformatted into Qualtrics. When the Qualtrics survey is finalized in October, 2010, it will be emailed out to the nurses for their responses. The survey will take approximately 10 – 15 minutes to complete, and is confidential. Only aggregate data will be used to report findings. In November, 2010, the results will be analyzed and shared.
- A staff nurse suggested that the survey include the level a nurse is on the clinical ladder, not just the number of years served at the MGH. G. Chisari, RN, agreed that was an excellent suggestion and will update the survey.
- G. Chisari, RN, asked the SNA members to contact him directly by September 14, 2010, with any suggestions for edits to the learning assessment tool. The email address is: RChisari@Partners.org or he may be reached at 617-643-6530.

3. Updates – All
- A staff nurse asked if a breast pumping room could be created for nursing mothers who are working in Yawkey. S. Taranto shared that this is presently under consideration.
- A staff nurse inquired about the validity of a rumor that the Lomasney Garage may be turned into a housing development. J. Ives Erickson, RN, mentioned reading about this recently, and if the proposed project moves forward, this would take place about three years from now. In that case, the MGH would have to locate other sources for parking.
- A staff nurse from the Cystic Fibrosis Outpatient Program shared that the pancreatic enzymes need to be crushed into formula; otherwise, they will not be activated. Also, the metal pill crushers do not work and a different model
needs to be purchased. J. Daniel, RN, will bring this issue to the Pharmacy and Nursing Practice Committees.

- A staff nurse expressed frustration with the Outpatient Pharmacy on the weekends, and think they need a nurse liaison. Often, the telephones are not answered.

- J. Ives Erickson, RN, shared that at a future meeting, information will be shared about Health Care Reform and its implications

- Everyone should be taking a closer look at systems that no longer add value and may be taking time away from clinicians. If any SNA members can suggest cost-saving measures, they are invited to share them at the next Staff Nurse Advisory meeting on October 5, 2010.
Jeanette Ives Erickson

New Excellence Every Day Portal

A link to all things quality and safety

One-stop-shopping is a popular concept in business and industry. And for good reason—it makes sense. It saves time and energy and gives consumers the opportunity to easily compare, contrast, and retrieve the products they’re looking for. That was precisely the thinking behind the new Excellence Every Day portal: one-stop-shopping for all things quality and safety.

On July 20, 2011, Patient Care Services launched the new portal, www.mghpcs.org/eed, to serve as a central clearinghouse for information related to collaborative governance, Magnet recognition, and regulatory readiness. Because these three areas are the mainstays of our Excellence Every Day philosophy, and because so much of this information is inter-connected, it made sense to create a single, unified site where staff can easily access essential materials and resources.

The Excellence Every Day portal is easy to navigate, updated monthly, and offers ‘one-stop-shopping’ for access to internal and external information related to collaborative governance, Magnet recognition, and regulatory readiness.

The home page of the Excellence Every Day portal features a new topic each month reflecting current issues and work within Patient Care Services, and these pages will be archived for future reference. The current topic is fall-prevention, and you’ll find benchmarking data, emerging trends, improvement initiatives, patient-education materials, a clinical narrative related to fall-prevention, and access to numerous links including policies and procedures, Magnet and Joint Commission standards, HealthStream offerings, and many other internal and external resources related to fall-prevention.

Fall-prevention will be the featured topic throughout the month of August, followed by restraints, pain management, hospital-acquired pressure ulcers, disabilities awareness, and much more.

From the home page of the portal, you can link to three key websites: collaborative governance, Magnet, and regulatory readiness. When you select collaborative governance, you’ll be brought to a screen containing:

continued on next page
At a time when regulatory agencies are looking for staff to be able to articulate quality and safety efforts and speak knowledgeably about patient outcomes, this site could not be more relevant. It is a resource every employee should know about and visit often. At a time when regulatory agencies are looking for staff to be able to articulate quality and safety efforts and speak knowledgeably about patient outcomes, this site could not be more relevant. It is a resource every employee should know about and visit often. And if you have stories or information you think should be included, contact Georgia Peirce at 4-9865.

I want to acknowledge the work of the Excellence Every Day Communications Group who really brought this idea to life exceeding all expectations. That group includes: Marianne Ditomassi, RN, executive director for PCS Operations; Gaurdia Banister, RN, executive director for The Institute for Patient Care; Keith Perleberg, RN, director of the PCS Office of Quality & Safety; Georgia Peirce, RN, project manager; Michael Sullivan, PT, director of Physical Therapy; Marie Elena Gioiella, LICSW, director of Social Services; Robyn Stroud, staff assistant; and Jess Beaham, web developer.

If you haven’t already visited the site (www.mghpcs.org/eed), I urge you to do so; it’s home to a wealth of information and will be an invaluable resource as we strive to fulfill our promise to achieve Excellence Every Day.
Excellence Every Day Portal - Scavenger Hunt

Excellence Every Day represents an MGH commitment to providing the highest quality, safest care that meets or exceeds all standards set by the hospital and external organizations.

To enter the June Scavenger Hunt...
simply fill out and submit the form linked here.

2012 WINNERS

May
- Kathleen Walsh, Case Management
- Fred Haigis, Marketing
- Rachel Hyler, RACU
- Theresa Vachon, Lunder 6
- Angelika Zollfrank, Chaplaincy

April
- Emily Doerr, Social Service
- Christina Franey, Medical ICU
- Kerry Grennan, Diabetes Research Center
- Dolores Merlino, Case Management
- Paige Nalipinski, Speech, Language & Swallowing Disorders

March
- Kathya Gavazzi, Labor & Delivery
- Michael Murphy, Cardiac Surgical ICU
- Marlon Rideout, The Yvonne L. Munn Center for Nursing Research
- Sandy Vance, MGH North OB/GYN
- Tracy Waterhouse, Charlestown HealthCare Center

February
- Christina Franey, Endoscopy
- Jean Gardner, Neonatal ICU
- Tessa Goldsmith, Speech, Language & Swallowing Disorders
- Martha Southworth, Social Service
- Mark Wilson, PCS Clinical Support Services

A focus on central lines — preventing hospital-acquired infections

The Centers for Disease Control estimate that 248,000 bloodstream infections occur in U.S. hospitals each year, with a large proportion associated with a central vascular catheter. Bloodstream infections typically result in a prolonged hospital stay, increased costs, and an increased risk of mortality. Central Line-Associated Bloodstream Infections (CLABSI’s) can be prevented through proper management of the central line.

NEW POLICY

Central Line Flushing Policy
(Effective Jan. 4, 2012)

- Direct link to new policy: Routine Heparin Flush of Central Venous Catheters (internal access only)
- Central Line-Related Policies & Procedures [first in a group of policies regarding central line care.]
- Policy, Procedure & Products Committee
  Meets: 2nd Tuesday monthly, 1:30pm
  Sweet Conference Room Gray/Bigelow 432
  Link to Champions and Chairs

MGH NARRATIVES

“I was not comfortable using the line without clarification of the ultrasound report. Throughout the years, I have seen many situations in which ports look OK to use, but upon further investigation have had problems. I did not want to use the port until I was confident it was placed correctly and patent.”
[read more...]

Read other MGH narratives about managing central lines:
Amanda J. DiMatteo, BSN, RN | Heather D. Kuberski RN, BSN, OCN

CENTRAL LINE TOOL KIT

Central Lines: A Visual Guide
PICC Line Flushing Tips
Videos:
Pulsatile (Push/Pause) Flushing Technique Video
Dressing Change

http://www.mghpcs.org/eed_portal/EED_centrallines.asp
Nursing Management of Venous Access Devices (VADs): View Module List

KEY CONTACTS

Ambulatory
- Mimi Bartholomay, RN, CNS (#22199)
- Cyndi Bowes, RN, CNS (#31790)
- Susan Jaster, RN, CNS (#18022)

Hemodialysis
- Mary Sylvia-Reardon, RN, ND (#13837)
- Carol Tyskienski, RN, CNS, NP (#33196)

Pediatrics
- Kate Stokes, RN, CNS (#13973)

Radiology
- Joanne Martino, RN, ND (#34014)
- Alexandra Penzias, RN, CNS (#21686)

Inpatient Clinical Areas
- Judy Curran, RN, CNS (#15477)
- Liz Johnson, RN, CNS (#32606)
- Hannah Lyons, RN, CNS (#15484)

INFECTION CONTROL

In 2009, a multidisciplinary team rolled out a central line-associated bloodstream infection prevention initiative. The goal was to develop a standard approach throughout MGH that adheres to evidence based practices. Their work led to several significant changes, including:

- Developing a standardized central line insertion kit
- Creating a central line insertion checklist and monitor to ensure all steps for safe line placement were being taken
- Introducing chlorhexidine for skin prep
- Using maximal sterile barriers
- Establishing a formalized feedback mechanism for all central line-associated bloodstream infections (CLABSI) diagnosed in ICU patients: upon diagnosis of a CLABSI on the unit, Infection Control informs unit leadership, who then perform an investigation to identify root causes and opportunities for learning
- Using color coded stickers to identify a line that was placed in strict adherence to infection control policies, versus those placed in less than ideal conditions (e.g., emergent situations)

CLABSI QUALITY IMPROVEMENT RESOURCES

- Resident Training Packet
- Central Line Checklist
- Prevention of Central Line-Associated Bloodstream Infections - Nursing Education
- Use of Chlorhexidine as site prep

Biopatch
- What is a Biopatch? click here
- How to use a Biopatch click here

PICC Line Initiatives
- Peripherally Inserted Central Catheter (PICC) Care & Maintenance click here
- “Go With the Flow” PICC Flushing Education click here
- PICC Line Flushing Tips click here

THE DATA

- Infection Control
  MGH tracks Central Line-Associated Bloodstream Infection (CLABSI) rates in most of the ICU areas, and since April 2011, in the general care areas. MGH rates are compared to national benchmarks that are published by the Centers for Disease Control’s National Healthcare Safety Network (NHSN). Below are the quarterly MGH ICU rates for the first

Did You Know?

- At MGH, an estimated $48,000 is spent monthly on 2mg/2ml tissue plasminogen activator (tPA),

http://www.mghpcs.org/eed_portal/EED_centrallines.asp
three quarters of calendar year 2011.
otherwise known as "alteplase."

PATIENT EDUCATION
Implanted Ports: What You Need to Know click here
Preventing Central Line Bloodstream Infections click here
Managing Your Non-Tunneled (Percutaneous) Catheter click here

SPOTLIGHT ON PRACTICE
Cancer Care Unit
The RNs on the Lunder 10 Cancer Care Unit are piloting a yearly "Central Line Competency." The competency was developed with the input of staff. Staff RNs from the Lunder 10 Quality Committee are taking a role in the implementation of the competency. The competency delineates the steps needed to change a central line dressing and caps. A Quality Committee member, or the CNS, will then objectively observe and evaluate another RN as she performs a central line dressing change, using the criteria in the competency. This provides a great opportunity for RNs to coach one another. This also serves as a way for the unit as a whole to maintain a uniformly sound practice. click here to view skills checklist
(Pictured left) Judith V. Curran RN, MS, AOCNS Oncology Clinical Nurse Specialist

Cardiac ICU
THE MGH Cardiac ICU has instituted several changes in an effort to address concerns commonly related to central line-associated bloodstream infections, including:

• Inservicing staff members on a 20-second scrub of access ports of all central lines
• Requiring the use of a Central Line Infection Prevention Checklist for the insertion of all central lines
• Instituting the practice of changing the cap on the stopcock after every blood draw
• Coordinating with the Cardiac Cath Lab for proper central line dressing techniques and attaching all PA cath tubing set ups to line following placement.

Central Line-Associated Bloodstream Infections in the ICU click here to view data

Patients with End Stage Renal Disease
Vein Sparing for Patients with Renal Dysfunction:
A Did You Know? poster by Mary Sylvia-Reardon, RN, DNP, nursing director, MGH Hemodialysis Unit click here to view poster
Nursing Knowledge Survey - related to PICC Placement in Patients with Renal Dysfunction click here to view
Guidelines for Venous Access in Patients with Chronic Kidney Disease or Renal Insufficiency click here to view

IN THE NEWS
CMS no longer reimbursing certain hospital-acquired conditions - cms.gov

EXTERNAL REVIEWERS
According to the Centers for Disease Control (CDC), each year, millions of people acquire an infection while receiving care, treatment, and services in a health care organization. Following are The Joint Commission's elements of performance for prevention of central line-associated bloodstream infections (National Patient Safety Goal 7).

More information
Link to the PCS Regulatory Readiness site and National Patient Safety Goal 7 resources

GLOSSARY OF TERMS
There are numerous terms and acronyms in healthcare that may be unfamiliar. Please click here to visit a Glossary of Terms that may be helpful. And please email any suggested additions.

This month's featured term: Central Line
A central Line is an intravascular catheter that terminates at or close to the heart in a large blood vessel. A central line can be used to give fluids, antibiotics, medical treatments such as chemotherapy, and liquid food if a patient is unable to eat or digest food normally. Central lines are also sometimes called central venous lines or central venous catheters. Examples of central lines are PICCs (peripherally-inserted central catheter), Hickman catheters (tunneled catheter), and Port-A Caths (implanted port).

http://www.mghpcs.org/eed_portal/EED_centrallines.asp
Excellence Every Day Portal - A focus on central lines: preventing hospital-acquired infec...

Excellence Every Day represents an MGH commitment to providing the highest quality, safest care that meets or exceeds all standards set by the hospital and external organizations.

If you have questions or suggestions related to the EED portal, please contact Georgia Peirce at (617) 724-9865 or via email at gwpeirce@partners.org.

updated 3/1/12
EXCELLENCE EVERY DAY
“offering patients, families and one another our best in every moment”

Excellence Every Day represents an MGH commitment to providing the highest quality, safest care that meets or exceeds all standards set by the hospital and external organizations.

Central Lines—a visual guide

Implant Ports | Hickmans | Non-Tunneled Catheters | PICC Lines | Hemodialysis Catheters

Implanted Ports

Bard Double Lumen Power Port

Double Lumen Bard MRI Non-Power Port

Double Lumen Bard Slim Port

Single Lumen Bard Power Port 2

Portal Pages: Disabilities | Central Lines | Fall Prevention | Pain | Pressure Ulcers | Restraints | EED Home

http://www.mghpcs.org/eed_portal/Documents/Central_Lines/Central_Lines_chart.asp
Implanted Ports:
What You Need to Know

You may need an implanted port as part of your treatment. This guide will explain what to expect.
When to Call Your Doctor or Nurse

Call your doctor or nurse right away if you have:

• Leaking from tubing or from port needle site
• Redness or swelling at port site
• Drainage from the incision
• Temperature greater than 100.5 degrees
• Increasing pain or tenderness in your neck, chest/arm area or around your incision
• Shortness of breath
• Swelling of the neck, arm, wrist, or fingers

Ask for a Port Information Card when you have your port put in.
What Is an Implanted Port?

A port is a special type of intravenous (IV) device. It is a small, hollow disk with a catheter attached to it. The catheter is inserted in a large vein just under your collarbone.

The port is small, firm, and a little larger than a quarter. It is placed in a pocket of tissue just beneath your skin. Ports are usually placed in the upper part of the chest, over your ribs and just below your collarbone. You will feel a firm round bump just below your skin.

Why Do I Need a Port?

You need a port because your treatment requires it or your veins are difficult to use. It will save you from being “stuck” for IVs.
How Does a Port Work?
Your nurse will place a special needle through your skin into the center of the port. This is called “accessing” the port. This allows your nurse to give you IV fluids, medications, or chemotherapy. You may also have blood drawn through your port.

How Is the Port Put In?
Your port will be put in by a radiologist in Interventional Radiology.

You need to bring someone with you who can drive you home after the procedure. The medications you get for the procedure will make you too drowsy to drive.

The procedure will be done under local anesthesia, which means you will be awake during the procedure. You may receive medication through an IV to help you relax.

You will have one small incision in your neck and one incision in your chest.

The port is placed in a pocket of fatty tissue just beneath your skin, and the catheter is put in a large blood vessel under your collarbone.

The incisions will be closed with strips of paper tape and covered with a dressing. An X-ray is taken to make sure the port is in the correct place.

The incisions and the muscles around the port will be tender to touch. There may be some bruising around the incisions. Tylenol should relieve your discomfort from the procedure. Your doctor may order a pain medication, as well.
After Having Your Port Placed

For 1 day after the procedure, do not:

- Drive a car
- Use any heavy machinery
- Drink alcohol
- Make any important decisions

Keep your incisions dry for 48 hours after your procedure. On the 3rd day, you can take the dressing off and shower. Leave the incisions open to air. Let the strips of paper tape fall off on their own.

Do not lift heavy objects (5 pounds or more) for 7 days.

Do not do repetitive shoulder movements such as swimming, playing sports, or yard or house work for 7 days.

Call Your Doctor Right Away if You Have:

- Pain or tenderness in your neck, chest, arm, or around your incisions
- Redness or swelling at the port site
- Temperature greater than 100 degrees
- Shortness of breath
- Drainage from the incision
- Leaking from tubing or from port needle site
- Swelling of neck, arm, wrists, or fingers
How Do I Care for My Port?

Call your doctor or nurse if you have redness, swelling, or tenderness around your incisions.

Make an appointment with your doctor or nurse to have your port flushed every 4 to 6 weeks. Flushing your port will prevent the catheter from getting blocked.

Place a soft cloth or other covering over your port site when using a seat belt or shoulder bag to prevent rubbing.
How Do I Care for My Accessed Port?

An accessed port means that a needle has been put into the middle of your port. The needle connects the IV tubing to your port so you can get the fluids and medications you need. If you go home with the access needle in your port, there will be a clear dressing over it to keep it dry and in place for up to 7 days. After 7 days, the dressing must be removed or changed.

Ask your nurse if you may shower. If you can shower, your nurse will show you how to protect the needle and dressing with plastic wrap.

While your port is accessed, do not:

- Change the dressing over the needle
- Pull or tug on the needle or IV tubing
- Catch the tubing on your clothing
- Swim or do any activities where your body is under water — for example, using a hot tub or taking a bath
When Do I Need to Call the Doctor or Nurse?

Call us if:

- The needle comes out
- The IV tubing or dressing leaks fluid or blood
- The dressing becomes moist or damp
- The cap falls off — if this happens, immediately clamp the tubing
- Your infusion pump alarms
- You have swelling, redness or pain around the port site
- Tubing breaks, leaks or tears. If this occurs, clamp the tubing with your fingers or use the tubing clamp. Use the clamp closest to your body.
Common Questions

How long will I have my port?
The port will stay in as long as your doctor determines you will need it. However, if it is not used for 4 to 6 weeks, you will need to arrange to have it flushed to prevent blockage.

Can I still have MRIs, CT scans, or radiation therapy with a port?
Yes, you can have most MRIs, CT scans, and radiation therapy. It is always good to check with your doctor or nurse. The information should be on the Port Information Card. However, not all ports are able to have CT dye infused through it. Show your Port Information Card to the radiology technician before any test is done.

Can the port be removed if I no longer need it?
Yes, when it is no longer needed, the port can be removed in a procedure similar to the one used to put it in. This procedure will be done with a local anesthetic and you will be able to drive home.

Will my port activate the security alarm in airports?
Sometimes. If it does, simply show your Port Information Card to the security guard. Always carry your card in your wallet.
“Discovery consists of seeing what everybody has seen and thinking what nobody has thought.”
— Albert von Szent-Gyorgyi, biochemist, recipient of the Nobel Prize

Overview: The MGH Innovation Unit

Massachusetts General Hospital (MGH) is dedicated to providing every patient and family with the safest and highest-quality care possible. As part of this ongoing commitment, the hospital has established 12 Innovation Units to identify and study innovations that will help the hospital raise an already high standard even higher. We’re looking at ways to ensure that the experience of every patient and family at MGH goes smoothly from start to finish. That they know who is taking care of them and how they can be reached. And, when they’re ready to go home, everyone feels prepared.

Each Innovation Unit is testing twelve care interventions. For example the new role of “Attending Nurse” is designed to coordinate the delivery of patient care with the entire healthcare team. The Attending Nurse will check in and review each patient’s health plan with them every day. Patients and families will also receive a newly-developed “Patient & Family Notebook,” with pages for them to note questions they want to review with the care team. And we’re designing new ways to help prepare patients to make a smooth return home.

TOOLBOX

- 12 Interventions at a glance
- Cbeds Electronic Whiteboard
- Conceptual Schema
- Domains of Practice
- In the Literature
- Innovation Unit Leadership
- Patient Journey Framework

(In internal access only)

- Admitting Face Sheet
- Attending RN Guidelines
- Discharge Envelope
- Domains of Practice
- Logo Download
- MGH SBAR Guide
- Patient & Family Notebook

Click here to view a larger image of the Patient Journey Framework

“Innovation in service delivery and organization is a novel set of behaviors, routines and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness of users’ experience and are implemented by planned and coordinated actions.” (Greenholgh, 2005)
MGH INNOVATION UNITS

Complete list of Innovation Unit Leadership

- Bigelow 14 Vascular Surgery
- Blake 10 Neonatal ICU
- Blake 11 Psychiatry
- Blake 12 ICU
- Blake 13 Newborn Family
- Ellison 9 Cardiac ICU (CICU)
- Ellison 16 General Medicine
- Ellison 17 & 18 Pediatrics
- Lunder 9 Oncology
- White 6 Orthopaedics & Oral-Maxillofacial
- White 7 Surgery/Trauma

Clinical Support Service Presentation

INTERVENTIONS

The 12 Interventions at a glance

Throughout the Patient Experience

- Relationship Based Care
- Increased Accountability through Attending RN (ARN) role
- Handovers

Pre-Admission

- Pre-Admission Data Collection
- Innovation Unit Patient & Family Notebook

During Hospitalization

- Revised Domains of Practice
- Interdisciplinary Team Rounds
- Whiteboards: Electronic, In-Room
- Portable Devices
- Electronic Communication
- Discharge Readiness Toolkit

Post-Discharge

- Discharge Follow-up Phone Calls

RELATED TOPICS

- Education
- Evaluation
- Innovation Resources
- CMS Innovation Advisors Program

IN THE NEWS

Nursing Experts Release Guiding Principles for Patient Engagement
Robert Wood Johnson Foundation

Noisy hospitals need Rx for quiet as patients rest, Associated Press

Nurses leading through innovation, The American Nurse

‘Innovation advisers’ appointed to improve care, costs, Bend Bulletin

Massachusetts General Implements Volaltés Communication System, Consumer Electronics Net

‘Innovation advisers’ chosen for ideas to improve health care, cut costs, The Washington Post

Innovation Is A State of Mind, Forbes
Collaborative Governance

A look at the newly re-designed collaborative governance

On May 15, 1997, Jeanette Ives Erickson, RN, senior vice president for Patient Care, informed the original members of collaborative governance that their work was about to change. She described how their participation in collaborative governance would give them an opportunity to interact with diverse teams of clinicians and support staff, with colleagues from different disciplines, and with professionals who want to create a better place for patients, families and employees.

Almost 14 years later, Ives Erickson’s prediction is a reality — collaborative governance has become an integral part of Patient Care Services and the MGH culture. Thanks to those original committee members and leaders and all those who followed, we have compiled an impressive list of accomplishments:

- The Diversity Committee
  - Created and organized annual HAVEN (Helping Abuse and Violence End Now) gift-giving program
  - Coordinated annual Black History Month Pinning Ceremony
  - Sponsored educational programs on healthcare disparities and culturally competent care

- The Ethics in Clinical Practice Committee
  - Raised awareness around advance care planning among staff, patients, families, and the community
  - Educated MGH community about ethics through case studies, journal articles, and local and national presentations
  - Collaborated with other collaborative governance committees on educational programs for the MGH community

- The Nursing Practice Committee
  - Updated and revised many policies and procedures
  - Collaborated with the Electronic Medication Administration Record (EMAR) and Acute Care Documentation (ACD) workgroups
  - Collaborated with Materials Management on product reviews

- The Nursing Research Committee
  - Developed the Did You Know evidence-based poster series
  - Developed the Nursing Research Journal Club, which brings journal authors together to share and discuss their research with clinicians
  - Coordinated annual Nursing Research Day and Expo

- The Patient Education Committee
  - Collaborated with the Quality Committee to implement “Ask Me 3” and “Teach Back” patient-empowerment programs
  - Surveyed PCS clinicians to evaluate their patient-education practice and implemented interventions to address relevant issues
  - Educated MGH clinicians, staff, and the public on issues of health literacy through educational conferences and resources written in plain language

- The Quality Committee
  - Reviewed cases for reportability to the Board of Registration in Medicine
  - Provided leadership preparing for Joint Commission visits and responding to CMS (Centers for Medicare and Medicaid Services) visit

Almost 14 years later; Ives Erickson’s prediction is a reality — collaborative governance has become an integral part of Patient Care Services and the MGH culture.

continued on page 17
Champions embrace new collaborative governance model

One exciting aspect of re-designing collaborative governance has been the integration of the champion model into the committee structure. What this means is that if you participate in collaborative governance, you’re now considered a champion. While it might seem like semantics, the word champion better reflects the evolution of committee members into the empowered communicators, content experts, and leaders they have become.

Over the years, the champion role has been closely associated with Excellence Every Day and Magnet recognition (and re-designation). Effective immediately, those champions and the work associated with Excellence Every Day and Magnet are now part of collaborative governance. This new approach ensures an environment of quality, safety, and regulatory compliance in an organization that supports professional nursing practice, autonomy, and superior patient outcomes.

Claire Paras, RN, staff nurse on Phillips House 22 served as an Excellence Every Day champion. When asked what being a champion meant to her, Paras spoke of being a liaison between her peers and the Excellence Every Day program. “Communication was critical to the success of the program. It’s what allows all our quality efforts to succeed.”

Identifying the best way to communicate also ensures success. Along with unit leadership, Paras offered weekly quizzes and Jeopardy games with prizes and group discussion of important topics.

Joanne Parhiala, RN, staff nurse on the Blake 11 Psychiatric Unit, served as a Magnet champion. Parhiala agrees that communication is critical to the success of Magnet recognition. “Being able to frame the forces of magnetism in the context of our unit allowed us all to communicate in the same language.”

Parhiala personalized posters with pictures of staff engaged in activities related to quality and safety; she held a variety of informational forums. “You have to know what works on your unit,” she says. “One communication style doesn’t fit all.”

Paras is now a champion on the Skin Care Subcommittee, and Parhiala is a champion on the Restraint Usage Subcommittee, both offshoots of the new Practice & Quality Committee.

Says Paras, “The new collaborative governance structure makes sense. It promotes a more cohesive, inclusive, and complete foundation by which to communicate quality and safety issues.”

Parhiala cautions us not to forget the lessons learned from the Magnet experience. “Communication, information, and clearly identified outcomes are key.”

With the experience, talent, and enthusiasm all the collaborative governance champions bring to the table, the new committee structure promises to be a powerhouse of communication, commitment, and teamwork.

For more information on the re-designed collaborative governance, call Mary Ellin Smith, RN, at 4-5801.
Collaborative Governance (continued)

The Diversity Committee supports the PCS goal of creating an inclusive and welcoming environment for patients, families, and staff through professional development, student outreach, community outreach, and culturally-competent-care programs. Champions will increase their knowledge of cultures, ethnicity, traditions, and life experience and how they impact patients’ responses to illness, health, work, and social situations. Meets on the first and third Tuesdays of the month, 12:00–1:00pm, Founders House 311.

The Ethics in Clinical Practice Committee develops and implements programs to further clinicians’ understanding of ethical aspects of patient care and identifies strategies to integrate ethical judgment into professional practice. Champions will gain better understanding, recognition, and articulation of ethical issues. Meets on the first Wednesday of the month, 1:00–3:00pm, Founders 1, ED conference room.
Collaborative Governance (continued)

The Informatics Committee

The Informatics Committee evaluates and makes recommendations related to new technology and its application to clinical practice. Champions should have an interest in learning about and sharing information related to technology and its impact on clinical practice and care-delivery. Meets the second and fourth Thursday of the month, 1:00–2:30pm, Yawkey 7-980.

The Patient Education Committee

The Patient Education Committee supports staff in developing their role in culturally appropriate, patient-education activities. Champions facilitate and generate knowledge of patient-education materials to improve care and enhance the environment in which clinicians shape their practice. Champions should have an interest in learning how verbal and written materials enhance patients’ participation in decision-making. Meets on the second and fourth Wednesdays of the month, 1:30–3:00pm, Sweet Conference Room, GRB 432.
The Research & Evidence-Based Practice Committee

The Research & Evidence-Based Practice Committee fosters a spirit of inquiry around clinical practice through the dissemination of evidence-based knowledge and research findings. Champions should have an interest in learning how to find, appraise, and share current research as the basis for clinical decision-making. Meets on the first Monday of the month, 1:00–2:30pm, Blake 8 Conference Room.

The Policies, Products & Procedures Sub-Committee

The Policies, Products & Procedures Sub-Committee reviews and approves all policies and procedures to ensure they are appropriately vetted and evidence-based; reviews and approves products and plans for product roll-out. Champions should have an interest in influencing how policies and procedures are reviewed and implemented and in decisions to purchase and trial products in the clinical area. Meets on the second Tuesday of the month, 1:00–3:00pm, Yawkey 2-210.
Collaborative Governance (continued)

The Skin Care Sub-Committee

The Skin Care Sub-Committee ensures that clinicians have the knowledge, resources, and skill to maintain skin integrity and prevent and treat hospital-acquired pressure ulcers. Champions will collaborate to develop and update guidelines and resources; serve as a consultant to colleagues; and collaborate with unit/department leadership to track, analyze, and try to prevent skin breakdown. Meets on the fourth Tuesday of the month, 1:00–3:00pm, Yawkey 2-210.

The Restraint Usage Sub-Committee

The Restraint Usage Sub-Committee identifies evidenced-based interventions to reduce the use of restraints. Champions will gain knowledge in identifying and intervening effectively to minimize the likelihood of restraints being used. Champions should have an interest in minimizing the use of restraints through early identification of patients at risk, collaboration with the patient’s family, and use of alternative therapies and interventions. Meets on the third Tuesday of the month, 1:00–3:00pm, Yawkey 2-210.
Collaborative Governance (continued)

The Pain-Management Sub-Committee

The Pain-Management Sub-Committee assists in developing and disseminating materials that give clinicians the knowledge, resources, and skills to address and treat pain. Champions serve as resources to colleagues, and should have a desire to influence and learn more about pain-management, both pharmacologically and holistically. Meets on the first Tuesday of the month, 1:00–3:00pm, Yawkey 2-210.

The Fall-Prevention Sub-Committee

The Fall-Prevention Sub-Committee strives to provide a safe environment for all patients and develop individualized plans of care for those at risk for falling. Champions empower staff with evidence-based knowledge to assess risk and implement fall-prevention care plans; provide staff with guidelines for fall-prevention, intervention, and post-fall care. Champions should be interested in creating a safe environment by recognizing warning signs of patients at risk for falling and have an interest in sharing that knowledge with colleagues. Meets on the third Thursday of the month, 1:00–3:00pm, Yawkey 7-980.

(Left): Michael Murphy, RN, co-chair; Paul Arnsten, RN, coach/advisor; Jennifer Carr, RN, co-chair; and Wendy Adams, recorder

(Thanks to the MGH Photo Lab for many of the collaborative governance photos in this issue of Caring Headlines)
Collaborative Governance (continued from page 10)

- Worked with colleagues and unit-based leadership to create an environment of quality and safety
  
  **Staff Nurse Advisory Committee**
  - Provided input on recruitment and retention efforts
  - Served as a liaison between senior nursing leadership and clinicians regarding day-to-day clinical issues, quality of work-life, and helped plan for regulatory and Magnet site visits

  The work of these committees has been transformative. So why redesign collaborative governance? The answer lies in the changing healthcare environment and its focus on informatics, healthcare reform, and meeting the needs of our patients. If we are to continue to provide the best possible care to patients and families, the work of our collaborative governance committees must be aligned with our current reality and with Patient Care Services’ strategic goals.

  The re-designed collaborative governance structure merges the Nursing Practice and Quality committees to form the Quality and Practice Oversight Committee, comprised of five sub-committees:
  - Fall-Prevention
  - Pain-Management
  - Policies, Products & Procedures
  - Restraint Usage
  - Skin Care

  A new Informatics Committee has been created, and the Nursing Research Committee is now interdisciplinary and has been re-named the Research & Evidence-Based Practice Committee.

  The philosophy and work of the Excellence Every Day and Magnet champions will be incorporated into the work of every collaborative governance committee. Every collaborative governance member is now a collaborative governance champion.

  Other than the shift to the champion model, the Diversity, Ethics in Clinical Practice, Patient Education, and Staff Advisory committees were not affected by the re-design.

  While much has changed, much remains the same. Collaborative governance continues to place the authority, responsibility, and accountability for patient care with clinicians, integrating clinical staff into the formal decision-making of Patient Care Services.

  And with the new structure comes a new look. The logo for the re-designed collaborative governance was unveiled recently (see below). Look for it on future communications related to collaborative governance.

  For more information about any of the collaborative governance committees, call Mary Ellin Smith, RN, at 4-5801.

---

**Re-Designed Collaborative Governance Structure**

- **Patient Care Services Executive Committee**
  - Collaborative Governance Committee Leaders
    - Diversity
    - Ethics in Clinical Practice
    - Informatics
    - Practice & Quality
    - Patient Education
    - Research & Evidence-Based Practice
    - Staff Advisory Committees
    - Tiger Teams

    - Fall-Prevention
    - Pain-Management
    - Restraint Usage
    - Policies, Products & Procedures
    - Skin Care
Translational Research Model

Characteristics of the Innovation
Type of Evidence-Based Practice

Communication Process

Social System
Hospital; Patient Care Unit

Adoption of Innovation
Adherence to the Evidence-Based Practice Guideline

Feedback on Use of the Evidence-Based Practice

Users
Nurses, Physicians and Other Healthcare Providers

Communication

Feedback on Use of the Evidence-Based Practice

Titler, M.G. & Everett, L.Q. (2001)
**Date:** February 14, 2012  
**Time:** 1:00 PM  
**Location:** Sweet Conference Room, Gary/Bigelow 4  
**Call to Order:** 1:10 PM  
**Present:** Neila Altobelli, RRT; Mimi Bartholomay, RN (Yawkey 8); Kathryn Beauchamp, RN (PICU); Maureen Beaulieu, RN (ED); Cynthia Bowes, RN (Yawkey 8); James Bradley, RN (Ellison 7); Barbara Cashavelly, RN (Lunder 9); Michelle Connolly, RN (Bigelow 7); Amanda Connors, RN; Judith Curran, RN (Lunder 10); Patricia Fitzgerald, RN (Bigelow 11); Susan Gavaghan, RN (Bigelow 9); Deborah Jameson, RN (Treadwell); Stephen Joyce, RN (PCSIS); Michelle Lander, RN (SICU); Hilary Levinson, RN (ED); Joyce McIntyre, RN; Kathleen Myers, RN; Kate Roche, RN; Erin Sinclair, RN (CICU); Richard Soria, RN (MICU); Susan Stengrevics, RN (CICU/Ellison 10); Jean Stewart, RN (White 6); Anne Marie Thompson, RN (Ellison 10); Karen Waak, PT (Physical Therapy); Ellen Walsh, RN (PACU); Heidi Schleicher, RN (Infection Control).  
**Excused:** Sheila Burke, RN (KNC); Thomas Lynch, RN (Bigelow 11); Tammy Carnevale, RN (White 13).  
**Guest:** Diane Carroll, RN  
**Recorder:** Mary Ellin Smith, RN

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion</th>
<th>Action/Outcomes</th>
<th>Follow-Up</th>
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<tbody>
<tr>
<td>Minutes</td>
<td>Regarding Biopatch- Joyce McIntyre, RN suggested that MD’s might not be aware of Biopatch and may have questions. Regarding rejected lab specimens- Kathryn Beauchamp, RN has been following up with RN’s listed on the report and has found that the nurse listed is the nurse who took the call and not the RN</td>
<td>Minutes reviewed and approved.</td>
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<tr>
<td>Topic</td>
<td>Discussion</td>
<td>Action/Outcomes</td>
<td>Follow-Up</td>
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<tr>
<td>Rejected specimen update</td>
<td>Laura Listro associate manager of lab quality control is looking for nurses who are interested in working on the issue of the high number of lab express slips that are generated. This was an issue that champions identified as a contributing factor to the rejection of lab specimens.</td>
<td>If you are interested, please contact Linda at 6-0690 or at <a href="mailto:LListro@Partners.org">LListro@Partners.org</a></td>
<td></td>
</tr>
</tbody>
</table>
| Vacuum Assisted Closure (VAC) Device Policy | Joanne reviewed the updated VAC policy. The champions recommended the following changes:  
- Add mmHg  
- Note that MGH VAC pumps are never sent home  
- Note special skin care to prevent tubing from harming the skin  
- Add a picture of the pump to enhance understanding  
- Update references | Joanne will make the changes and finalize the policy. | |
| Glide Scope Video Laryngoscope Equipment-Cleaning and Disinfectant Policy | In the PICU, RN’s are accountable for the cleaning of the Glide Scope, which has both reusable and non-reusable equipment, this policy was created to address those issues. | Champions approved the policy with the following changes:  
- Practice Area should include ED and other ICU’s.  
- Policy should be shared | |
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<tr>
<th>Topic</th>
<th>Discussion</th>
<th>Action/Outcomes</th>
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<tbody>
<tr>
<td>Champions noted that this equipment is used in other areas and that the concerns Kathryn identified- proper cleaning might be concerns in other areas.</td>
<td>with support associate staff in those areas to ensure quality control.</td>
<td></td>
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</table>
| Treatment sheets Joanne Empoliti, RN | Champions have raise the concerns they have for the treatment sheets:  
- Not updated  
- Questions about what goes on them and what doesn’t.  
- The issues with writing lab orders on the treatment sheets.  
- Treatment sheets will not be part of ACD.  
Joanne acknowledge those issues but noted the following:  
- OA’s cannot make the decision what to transcribe and where- that is the RN’s role.  
- The RN needs to review and update or have D/C the orders.  
- The concern with the lab is that we must be able to track who drew the lab. | | |
## Massachusetts General Hospital
### Patient Care Services Collaborative Governance
#### Policy Procedure and Products
##### Meeting Minutes

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion</th>
<th>Action/Outcomes</th>
<th>Follow-Up</th>
</tr>
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</table>
| | There are several options we can explore:  
- Option 1- eliminate the treatment sheet and write everything done to/for the patient in the medical record.  
- Option 2- keep the treatment sheet but look at guidelines for its use-including use of forms similar to the one used in the ED. [ED Lab Sheet.pdf](https://example.com)  
- Option 3- Adding columns on the flow sheet that address common treatments, e.g. labs.  
Champions recognized the risks associated with eliminating the treatment sheet – example free water boluses- would they get lost.  
Champions recommended trialing the lab sheet from the ED in several settings to evaluate adherence to standard and ease of communication. | | PICU, Lunder 10, Bigelow 11 and White 6 will pilot the ED form and report back to the committee. |
### Temporal Artery Thermometer

**Diane Carroll, RN**

Champions will explore changes to the flow sheet.

- Diane reviewed the use and issues associated with Temporal Artery Thermometers (TAT) at MGH.
- TAT were introduced at MGH since 2000 and used throughout MGH since 2004.
- Questions of accuracy have been raised by clinicians, especially house staff since then.
- The concerns led the Evidence Based Practice group to determine if the TAT readings were consistently accurate.
- Evidence supports the accuracy and precision of the TAT; there is insufficient evidence regarding the precision and accuracy of TAT for identification of hypothermia and hyperthermia in the adult inpatient population.

A study will be conducted on Blake 8 on patients who have a PA line, with a fever or are hypothermic. The TAT readings will be the secondary temperature source. To clean use alcohol swab and q tip. Clean between patients and every two weeks.
<table>
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<tr>
<th>Topic</th>
<th>Discussion</th>
<th>Action/Outcomes</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reasons for inaccurate readings - over 99% for an inaccurate reading are due to not cleaning the device and/or technique.</td>
<td>To scan- place probe flush on the center of the forehead and depress button. <em>Keeping button depressed</em> slide across forehead to the hairline with the button <em>still depressed</em>.</td>
<td></td>
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<td></td>
<td>Normal range temperatures using TAT is 97.4-100.2</td>
<td>A teaching module will soon be on HealthStream.</td>
<td></td>
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<td>Refrigerator labels Joanne Empoliti, RN</td>
<td>Joanne presented a new label for medication refrigerators doors. Champions reviewed and approved.</td>
<td>Joanne will communicate champions’ endorsement; labels will be placed on the refrigerators in the coming weeks.</td>
<td></td>
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<tr>
<td>IV Pump Update Joanne Empoliti, RN</td>
<td>At the last meeting Ed Raeke discussed that Partners was reviewing our contract with Baxter on large volume pumps. Every pump- Baxter, Hospira, Alaris - has had issues and the Partners hospitals currently use different pumps.</td>
<td>No decision has been made but we will communicate any updates or decision to you as soon as we hear.</td>
<td></td>
</tr>
</tbody>
</table>
Identify three takeaway messages from the meeting that you will share with your colleagues:

1. Over 99% of the errors in Temporal Artery Thermometer readings come from the lens not being clean or inaccurate use. Cleanse lens with alcohol swab and a q tip between patients and bi-weekly. To scan keep probe flush on the center of the forehead, depress button and keep it depressed as you slide it across the forehead to the hairline. Normal temperature using TAT is 97.4-100.2.

2. Four units- PICU, Lunder 10, Bigelow 11, and White 6- are piloting a lab documentation form to determine if it is easier to track lab draws.

3. For units who use the Glide Scope there is a new policy outlining the cleaning of the equipment. Contact Kathryn Beauchamp, RN at KBeauchamp@Partners.org with questions.

4. Collaborative Governance celebration will be on September 19th at 4:30 pm in the Russell Museum.

Adjourned: 3:00 pm
Next Meeting: March 13th at 1:00 pm in the Sweet conference room
Temporal Artery Thermometer Update – T. Gallivan, RN, Diane Carroll, RN, PhD, Lynda Brandt, RN, Joanne Empoliti, RN

- L. Brandt, RN, and D. Carroll, RN, PhD, shared evidence-based information about the temporal artery thermometer, (TAT). L. Brandt, RN, referenced the “Iowa Model” which guided the evidence-based evaluation. The project presentation is attached.

- A “Best Evidence Statement” Summary draft page, adapted from the Cincinnati Children’s Hospital Medical Center, was distributed.

- J. Empoliti, RN, explained some of the history behind changes in thermometers over the years. Back in the 1990s, the Nursing Practice Committee was asked to review thermometry.
- Mercury thermometers were eliminated.
- The single patient oral digital thermometers were expensive, and there were also infection control issues.
- Other thermometers were trialed. Tympanics were not reliable and were fraught with infection control issues.
- Starting in 2000, a four-year trial of the TAT was conducted in several ICUs. In 2004, the Nursing Practice Committee recommended the TAT over all other thermometers. The key point to remember is that the TAT is calibrated to core temperature readings.
J. Empoliti, RN, and L. Brandt, RN, demonstrated the proper usage of the TAT, pressing the button and holding it, starting at mid-forehead and dragging over to the hairline, lifting the TAT and placing for a moment behind the ear.

J. Empoliti, RN, also shared that you should wait 30 seconds in between readings for the TAT to reset properly.

L. Brandt, RN, and D. Carroll, RN, PhD, demonstrated how easy it is to clean the TAT quickly and effectively with an alcohol moistened Q-tip. If the lens sparkles, the device is clean and ready to use. The TAT should be cleaned every two weeks. If this is not done, it can affect the accuracy of temperature readings.

If the AA batteries in the TAT need to be replaced, there is a special screwdriver that will open up the bottom. Ample screwdrivers have been ordered and will be sent to all the units.

A staff nurse inquired about how to properly use the TAT with patients who may be heavily bandaged, such as those in the ICU. J. Empoliti, RN, said that in those cases, you may start the TAT at the midaxillary line, and work in a “Z” fashion down to the waist.

L. Brandt, RN, and D. Carroll, RN, PhD, shared that there is an initial hesitancy to trust the new device, and a number of physicians prefer oral temperature readings.

The TAT will be only used for adults at this point. Pediatric usage will be explored at a later date.

There may also be some discrepancies between adult inpatient and adult outpatient units regarding which thermometer is used.

G. Chisari, RN, shared that the USAs will be receiving retraining for cleaning the thermometers.

Norman Knight Nursing Center for Clinical & Professional Development Updates — Gino Chisari, RN, DNP

- The Center currently offers 200 MGH-developed courses via HealthStream, and most offer CE credits.
- The link to access HealthStream on your home computer is: [www.partners.org/healthstream](http://www.partners.org/healthstream)
- The electronic link will also be posted on the Norman Knight Nursing Center web site.
- You do not have to use an encrypted laptop or pc at home to access HealthStream, because there is no private patient information.
- In addition to HealthStream, there are 30-minute, unit-based sessions that take place four times a month: one Saturday, one Sunday, and two during the month at 5:00 p.m. on timely topics.
- In 2012, based upon feedback from nurses, classes in the Norman Knight Nursing Center will be shortened into 4-hour blocks, to be more convenient to take the same day as an 8-hour shift. The new model will be: 7:00 – 11:00 a.m.; 3:00 – 7:00 p.m.; and, 7:00 – 11:00 p.m. The same course will be offered at all three times in one week.
- There is continuing discussion surrounding ongoing clinical competencies, and how they can be ensured for all.
- The 2012 learning needs survey will to out in February. Your input is important and drives educational planning and programming.
- What are the skills stations that the members of the Staff Nurse Advisory Committee want to see offered? Suggestions may be discussed with your clinical nurse specialist who can forward your ideas to us, or email your ideas directly to either Jeanette Ives Erickson, RN, or Gino Chisari, RN, DNP.
- Gino Chisari, RN, DNP, will continue this discussion at the next SNA meeting, on January 3, 2012.
Updates – ALL

- A staff nurse commented about the slowness of many computers, holding up orders and looking up reference materials. J. Ives Erickson, RN, DNP, shared that some of the slowness is server-related, and there is also a push for people to delete extra files on their computers that are no longer needed, as this will free up some additional space. Some of the work stations are old, and Partners has an ongoing program to replace some of the out-of-date computers.
- A staff nurse shared her concern about the revolving doors in the Lunder Building left unlocked in the evenings. People can just walk in off the street without even checking in at a security desk. K. Whitney, RN, indicated that there are plans underway to lock the doors from 7:00 p.m. until 7:30 a.m., and to install alarms on the back doors if they are opened.
- A staff nurse asked for some guidance with regard to sometimes experiencing difficulty getting a Catholic priest to come in a timely manner to administer the Sacrament of the Sick, to an end-of-life patient. J. Ives Erickson, RN, DNP, shared that there is a global shortage of Catholic priests, and the priests who work in the hospital also have to work in churches as well. One thing to note is that the Sacrament of the Sick may be administered at any time with end-of-life patients, and does not need to always be during the final hours. Some patients receive the sacrament within the days ahead of their final hours, and some are discharged home and receive it at home. A staff nurse suggested that perhaps families could be educated to also think about asking for their own parish priest if they know ahead of time that they will be hospitalized. M. Ditomassi, RN, DNP, has been working closely with the Chaplaincy and is in the process of developing a plan to maximize the ability to address faith-specific requests. As a reminder, there is an interfaith staff chaplain available 24/7 to assess and meet patient and family spiritual needs. An update on the Chaplaincy will be given at an SNA meeting early next year.
EVIDENCE-BASED PRACTICE SYMPOSIUM
FOR COLLABORATIVE GOVERNANCE
LEADERSHIP AND CHAMPIONS

EVIDENCE-BASED PRACTICE
FOR DOCTORALLY-PREPARED NURSES

The EBP Team welcomes you to the first EBP Symposium designed specifically for Collaborative Governance members. Due to the scheduled closing of the Yawkey Conference Center we will convene in the Navy Yard, Building 149, conference room A on the first floor. For those of you who park at the Navy Yard, Bldg 149 is where the bus stop is located. If you are taking the shuttle from MGH, board the ‘Navy Yard’ shuttle on Blossom street outside the Gray lobby. Please allow 30 minutes transit time. Bldg 149 is the last stop in the Navy Yard.

Thursday - September 22, 2011
Morning session  8:00am – 12:00pm
Afternoon session  12:30pm – 4:30pm
Charlestown Navy Yard, Bldg 149, Conference Room A

For additional information, please contact Lynda Brandt, RN at lbrandt@partners.org

Massachusetts General Hospital (OH-239/10-1-11) is an approved provider of continuing education by the Ohio Nurses Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center’s Commission on accreditation. Criteria for successful completion includes attendance at the entire event and submission of a complete evaluation form.

This project is supported by funds from the Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services under D11HP14632
1. DATE ISSUED: 08/25/2009
2. PROGRAM CFDA: 93.359

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

NOTICE OF GRANT AWARD
AUTHORIZATION (Legislation/Regulation)
Public Health Service Act, Title VIII, Section 831

3. SUPERCEDES AWARD NOTICE dated:
except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.

4a. AWARD NO.: 1 D11HP14632-01-00
4b. GRANT NO.: D11HP14632
5. FORMER GRANT NO.: 

6. PROJECT PERIOD:
FROM: 07/01/2009 THROUGH: 06/30/2012

7. BUDGET PERIOD:
FROM: 07/01/2009 THROUGH: 06/30/2010

8. TITLE OF PROJECT (OR PROGRAM): Nurse Education Practice and Retention

9. GRANTEE NAME AND ADDRESS:
The General Hospital Corporation
50 Stanford Street FL 10th
Boston, MA 02114-2506

10. DIRECTOR: (PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR)
Susan Marie Lee
The General Hospital Corporation
Nursing
275 Cambridge Street 4th floor
Boston , MA 02114-3108

11. APPROVED BUDGET: (Excludes Direct Assistance)
[X] Grant Funds Only

<table>
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<tr>
<th>Item</th>
<th>Amount</th>
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<tbody>
<tr>
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<td>b. Fringe Benefits</td>
<td>$60,567.00</td>
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<td>c. Total Personnel Costs</td>
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<td>d. Consultant Costs</td>
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<td>e. Equipment</td>
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<td>f. Supplies</td>
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<td>h. Construction/Alteration and Renovation</td>
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<td>i. Other</td>
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<td>k. Trainee Related Expenses</td>
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<td>l. Trainee Stipends</td>
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<tr>
<td>m. Trainee Tuition and Fees</td>
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<td>o. TOTAL DIRECT COSTS</td>
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<td>p. INDIRECT COSTS: (Rate: % of S&amp;W/TADC)</td>
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<td>q. TOTAL APPROVED BUDGET</td>
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12. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE
a. Authorized Financial Assistance This Period $309,853.00
b. Less Unobligated Balance from Prior Budget Periods
   i. Additional Authority $0.00
   ii. Offset $0.00
c. Unawarded Balance of Current Year's Funds $0.00
d. Less Cumulative Prior Award(s) This Budget Period $0.00
e. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION $309,853.00

13. RECOMMENDED FUTURE SUPPORT: (Subject to the availability of funds and satisfactory progress of project)

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<th>TOTAL COSTS</th>
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14. APPROVED DIRECT ASSISTANCE BUDGET: (In lieu of cash)

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<tr>
<td>b. Less Unawarded Balance of Current Year's Funds</td>
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</tr>
<tr>
<td>c. Less Cumulative Prior Awards(s) This Budget Period</td>
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</tr>
<tr>
<td>d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION</td>
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</table>

15. PROGRAM INCOME SUBJECT TO 45 CFR Part 74.24 OR 45 CFR 92.25 SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:
A=Addition B=Deduction C=Cost Sharing or Matching D=Other

<table>
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<th>Alternative</th>
<th>Amount</th>
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<tbody>
<tr>
<td>A</td>
<td>$309,853.00</td>
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</table>

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY HRSA, IS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
17. OBJ. CLASS: 41.21
18. CRS-EIN: 1042697983A1
19. FUTURE RECOMMENDED FUNDING:

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<th>CFDA</th>
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S.O.S. Campaign
Virginia Capasso, PhD, ANP-BC, CNS, FAAN, FAANWS
CNS, Institute for Patient Care
Co-Director, Wound Care Center
Nurse Scientist, Munn Center for Nursing Research
Massachusetts General Hospital
Instructor in Surgery
Harvard Medical School
Boston, MA
vcapasso@partners.org

Education
Pre-implementation
- CNS Group
- Nursing Director Group
- Combined Leadership
- Nursing Grand Rounds

Post-implementation:
- Unit-based presentations
- Healthstream program: “Save our Skin”
  - Initially, all staff, then part of orientation.
- NDNQI pressure ulcer staging online education
  - Nursing orientation
  - Annual mandatory training
- Patient Care Associate (PCA) educational session
- Pressure ulcer classes: Orientation and
  Phase I / II Wound Care Education Programs
- Mini-courses:
  Skin Care Committee Meeting

Evaluation
S.O.S. Campaign Implementation Evaluation
Outcomes Evaluation
- Safety reports: Stage II (new), III, IV
- Unit-based SKIN “Huddle”:
  - New pressure ulcer; weekly follow-up
    - Initially, ND, CNS, Staff nurses, PCA
    - Later, hospitalists, house staff
- Quarterly forum (e.g. CG Skin Care Committee) for
  review of trends in data from unit-based SKIN “Huddles”
- Documentation audits
  - Random unit-based audits (weekly)
  - PCS Quality & Safety (quarterly)

S.O.S. Implementation Evaluation
Evaluation of Implementation of Components of S.O.S. Campaign

<table>
<thead>
<tr>
<th>Component</th>
<th>Acceptability</th>
<th>Adoption</th>
<th>Appropriateness</th>
<th>Feasibility</th>
<th>Fidelity</th>
<th>Implementation cost</th>
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<td>SKIN Bundle</td>
<td>Pins</td>
<td>Posters</td>
<td>Magnets</td>
<td>“Huddle” Forms</td>
<td>Safety Reports for Stage II PU (new)</td>
<td>Change in skin care and treatment adherence every 3 days</td>
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</table>

One of the goals of the Retooling for Evidence-based Practice grant is to create a common language around EBP for all practice levels. Although the skills are similar to those in research, there are a few twists. Come join Susan and David for a look at EBP through the eyes of a nurse and a pharmacist. The session is specifically designed for doctorally-prepared nurses.

Wednesday - September 21, 2011
8:00am – 12:00PM
Yawkey 10-660 Conference Room

SPACE IS LIMITED

Pre-Registration required through email: KPCS@partners.org
or Call The Norman Knight Nursing Center for Clinics

For additional information, please contact: lbrandt@partners.org

This project is supported by funding from the Massachusetts General Hospital Foundation.
Fielding the Issues

Fall reduction: it’s everyone’s responsibility

**Question:** The Joint Commission made fall-reduction a National Patient Safety Goal for 2009. What are we doing at MGH to reduce patient falls?

**Jeanette:** At MGH, we have a comprehensive Fall Reduction Plan that includes assessing each patient’s risk for falling and immediately implementing interventions to minimize that risk. The plan focuses on each patient and the environmental factors that need to be in place to prevent falls. The Fall Reduction Plan includes staff- and patient-education. We must monitor falls closely and learn from every incident in order to prevent falls from occurring in the future.

**Question:** We use the Morse Falls Scale (MFS) in our risk assessment. Why did we choose this tool?

**Jeanette:** Janice Morse’s assessment tool has been in use longer than any other falls scale. The MFS has proven reliable and valid in identifying patients at risk for falling. It was created to guide nurses in rating a patient’s fall risk using measurable subscales. The tool enables nurses to consistently agree on a fall-risk assessment and develop an appropriate plan for each patient.

**Question:** Is keeping the patient safe from falls solely the nurse’s responsibility?

**Jeanette:** Absolutely not. A team approach is essential in reducing patient falls. Consideration must be given to the patient’s medication regimen, cognitive and physical abilities, cleanliness of the environment, and the patient’s ability to travel safely off the unit for tests. So, physicians, pharmacists, therapists, transporters, support staff, and clinicians from all disciplines play a part in keeping patients safe.

**Question:** I completed my patient’s Morse Fall Scale assessment and found she had no identified fall risks. Is that all I have to do?

**Jeanette:** No. All patients are at some degree of risk for falling even if they have no identified fall risks on the MFS. You should implement Universal Interventions for Fall Prevention for these patients, which includes orienting them to the room, inspecting each room for hazards that could lead to falling, explaining how to call for assistance, and educating the patient and family to the risk of patients falling while hospitalized. (See The Patient at Risk to Fall Problem List at http://intranet.massgeneral.org/pcs/Outcome.asp.)

**Question:** I had a patient who felt weak while ambulating with assistance. He needed to be assisted to the floor. Is that considered a fall?

**Jeanette:** Yes. We would ask that you report that using our on-line Safety Reporting system. A fall is defined (by the National Database of Nursing Quality indicators) as any un-planned descent to the floor, with or without injury, during the course of hospitalization.

**Question:** What’s next in our efforts to reduce patient falls?

**Jeanette:** We are increasing our focus on patient- and staff-education, as well as creating a communication strategy to heighten awareness for patients at risk for falling. For more information, call the PCS Office of Quality & Safety at 3-0140.
LEAF Tool Kit

LEAF Post Fall Management Guideline

This post falls guideline is to assist the nurse in the care/management of a patient after a fall.

- If a fall occurs, immediately:
  - Provide the patient with immediate care and support
  - Examine the patient for any injuries, especially head and extremity trauma
  - Assess mental and physical status for changes from pre-fall status
  - Assess whether or not patient can be moved to bed for further evaluation
  - Assess vital signs and neuro assessment
  - Eliminate further immediate hazards
- Reassess patient’s fall risk factors, identify and initiate appropriate interventions.
- Notify the physician, CNS, and ND. During off shifts and weekends, notify the resource nurse.
- From the physician, clarify the needs for:
  - Ongoing neurological assessment, diagnostic tests, consults, treatments, and monitoring.
  - If appropriate, ensure that the patient’s family or Proxy has been notified
- Document event in Progress notes using facts, do not document incident report in notes
- Include patient’s level of injury and condition after the fall in the progress notes,
- Complete your Nursing Assessment and utilize the Fall Intervention Sheet
- Document the interventions in place to prevent further falls on Fall Intervention Sheet, utilize the transportation sticker prn, fall risk signage
- Update the Morse Fall Scale
- Report via Web Based Safety Reporting System
- Utilize the Patient at Risk to Fall Intervention Sheet

*With your Nursing Director and/or Clinical Specialist, participate in a post fall discussion and review the updated plan of care, during off shift review plan with the Resource Nurse
- Incorporate fall risk assessment and interventions into your written/oral report
- Communicate fall to members of team, including MD, Staff, Resource Nurse, ND, CNS

*CNS Reminder: after the first 24 hours, the CNS reviews the Safety Report and completes NDNQI severity score, see below.

(For further info, see Adverse Event Policy)

The NDNQI severity score definitions are as follows:

<table>
<thead>
<tr>
<th>Score</th>
<th>Definition</th>
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<tbody>
<tr>
<td>0</td>
<td>No injury as the result of the fall</td>
</tr>
<tr>
<td>1</td>
<td>Injury requires cleaning the wound, simple dressing, ice, limb elevation and or topical medications</td>
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<tr>
<td>2</td>
<td>Injury requires steri strips/skin glue, sutures and or splinting</td>
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<tr>
<td>3</td>
<td>Injury requires cast/ traction, surgery, causes internal injury and or requires consultation for a neurological or internal injury</td>
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<tr>
<td>4</td>
<td>Injury sustained from the fall is directly attributed to the patient’s death</td>
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LEAF Program Fall Prevention Case Study

Mrs. S is an 82 y.o. female admitted to the unit one week ago for community-acquired pneumonia. Prior to hospitalization she was functioning independently at home until her son and daughter found her on the floor mildly confused and disoriented, and complaining of dizziness. Mrs. S. typically uses a cane when walking in the community but not around the house.

Mrs. S. is receiving IV antibiotics and fluids to manage the infiltration and associated dehydration. The hospital course has been complicated by the development of acute confusion following the use of IV theophylline and Atrovent and proventil nebulizers. Mrs. S. also developed a DVT of the leg which was treated with IV heparin, and has since been switched to coumadin. Mrs. S. has also been experiencing urinary incontinence that is new as of this hospital admission. Two days ago she was found to be seated on the floor next to her bed with no injuries, but did not know how she got there.

PMH also includes cataract, lower extremity weakness due to osteoarthritis, COPD, osteoporosis, insomnia, HTN, dyslipidemia, anxiety, and mild cognitive impairment with short-term memory loss.

Meds include Coumadin, Lisinopril, Fosamax, Zocor, Spiriva and Flovent inhalers, Tylenol, Remeron, Ativan, Ultram, Ambien.

- What are the intrinsic risk factors for falls?
- What extrinsic risk factors can be modified to prevent falls.
- What is her risk and other than her fall-risk screen score, what contributes to her risk of injury?
- What other interventions can be considered?
Resource RN Safe Patient Handoff Communication Tool for High Risk Patients

DATE: ______________________

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<tr>
<th>Shift</th>
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Key: Care Issues = family issues, care coordination issues /High Risk for falls = bed alarm, alcohol withdrawal patients, cognitively impaired patients Version 1 8/16/2010
Let’s Eliminate All Falls (LEAF)

Patient’s Last Name: ___________________________

I use:

☐ Walker      ☐ Cane      ☐ Crutches

I need:

☐ 1 person assist  ☐ 2 person assist

☐ Bed Alarm      ☐ Chair Alarm

☐ Other ________________

*MGH PCS Fall Intervention Program*
Fall Precautions

Let’s Eliminate All Falls (LEAF)

MGH PCS Fall Intervention Program
When you are admitted to Massachusetts General Hospital, you may be identified by your nurse as someone who is at risk for falling. Falls can cause serious injuries, and our goal is to keep you as safe as possible while you are here. This material will review roles for falling, steps you, and our staff, can take to reduce your risk, and things you can do at home to make it safe for you.

Your risk for falling may include:

- **History of Recent Falls**: People who have fallen once are likely to fall again. Let your nurse know if you have had a recent fall.

- **Age over 65 years**: Falls are a leading cause of injury and death among older people. Your age is an important risk factor to consider.

- **Medical Problems**: Some medical conditions may cause you to feel weak, dizzy, lightheaded or unsteady on your feet. Diabetes, heart disease, circulation problems and lack of exercise can affect your balance. Women with osteoporosis can easily break their hips in a fall. Let your nurse know if it is hard for you to walk or rise from a chair. You will be given assistance.

- **Vision or Hearing Problems**: Poor vision and hearing can lead to a person feeling disoriented. Let the nurse know if you will need assistance.

- **Confusion, delirium, or dementia**: Altered thinking and confusion can lead to poor judgment and decisions. Your safety is our top priority.

- **Unfamiliar Environment**: Some people may get confused when they awaken at night and find themselves in an unfamiliar environment. Please ask for assistance.

- **Walking Aids**: Canes, crutches, walkers and other walking aids should be used if needed. However, while in the hospital, please ask for assistance when using these aids.

- **Increased need to urinate**: An Intravenous “IV” is commonly used to give you fluids. This extra fluid, as well as some medications, may cause you to have to use the bathroom more frequently. Please ask for assistance to use the bathroom.

- **Anesthesia/Medications**: Medication used during surgery to make you sleep (anesthetize), and relieve pain (analgesia), may cause you to feel lightheaded or dizzy. If you receive a “nerve block” to numb an area of your body such as an arm or leg, it may be difficult to walk and move normally. Please ask for assistance to get up.

- **Pain**: Pain in your surgical incision may make it hard for you to move around. This is particularly true if the surgery was done in your arm or leg. Please ask for assistance to get up.
Preventing Falls in the Hospital and at Home

Things you can do to decrease your risk for falling while in the hospital:

- Wear non-skid slippers or shoes so you can walk with good traction.
- Clear the floor of obstacles when walking around the room.
- Wear your glasses and hearing aids when you are awake.
- Keep a light on near your bed.
- Give yourself some time to get oriented to your environment when you first wake up.
- Use the "call bell" to request assistance from the nurse or patient care assistant.
- Use any walking aid you may have such as canes, crutches, a cane or walker every time you get up.
- Do not lean on your bedside table or IV pole to support you (they have wheels and will roll away from you).
- Get up slowly from a lying or sitting position.
- Sit on the side of the bed for a moment before getting up.
- Keep your pain under control so it will be easier for you to move around.

Things we pledge to do to keep you safe from falling:

- Identify your risk level for falling and communicate it to the health care team.
- Educate you and your family about preventing falls in the hospital.
- Provide assistance to help you get out of bed and walk.
- Create a safe room environment: orient you to your room and how to call for help.
- Keep equipment and supplies stored in safe places.
- Ensure your "call light" is always within reach.
- Respond to all of your calls in a timely manner.
- Monitor medications that may make you sleepy or dizzy.
- Elevate the side rails on your bed if needed to keep you safe.
- Use a bed alarm pad so we will know if someone at risk is trying to get out of bed.
- Monitor your fluid intake to anticipate your bathroom needs.
- Check on you frequently to see if you need to use the bathroom, need pain medication, or need to get out of bed.
Things you can do to decrease your risk for falling while at home:

Many falls in the home can be prevented. A key to fall prevention is to stay healthy and fit. Staying active is one of the best things you can do to prevent falls. These tips can help:

- Stay Healthy: Have a physical exam each year to identify any new medical problems
- Stay active: balance, flexibility, strength and endurance all come from exercise
- Check with your doctor if you take any medications that make you feel weak, sleepy or dizzy. They may be able to adjust your medications.
- Eat a balanced diet.

Remove Hazards:

- Keep your home free of clutter
- Remove things that can cause you to trip (rugs, boxes, cords)
- Arrange furniture to provide a clear pathway between rooms
- Store and work with items at counter level to avoid too much bending or reaching
- Do not stand on chairs or unsteady stools
- Do not store items on the stairs
- Keep all walkways clear
- Clean up spills right away
- Avoid scatter rugs and keep a non-skid mat in the bathroom

Add Safety Devices:

- Use properly installed rails in the bathtub for support
- Place a slip proof mat in the tub
- Add handrails to both sides of stairs
- Buy a raised toilet seat
- Do not use towel rods or sliding doors for support as they are not designed to hold your weight
- Get a portable phone. Keep a phone and emergency numbers within easy reach

Improve Lighting:

- As you get older, you need brighter lights to see well
- Add nightlights to halls, bedrooms and bathroom
- Put light switches at the top and bottom of stairs
- Be sure each room has proper lighting
- Keep a flashlight available

What to do if you fall:

- Stay calm
- If you start to fall, relax your body to reduce the impact of the fall
- Call out for help
- Dial 911 if it is an emergency from home
Fall Narrative (Shaw)

High-risk patient falls while transferring with family member

My name is Lily Shaw. I graduated last May from Simmons College and started working at MGH in November. The story I’m sharing occurred at 6:30am on a 7:00pm-7:00am shift. It was my first time caring for Mrs. M. She had been on our unit for a few days, so I had seen her in passing and witnessed some nurses’ frustration when caring for her. Mrs. M had been admitted with a diagnosis of altered mental status secondary to opioid overdose, which caused her to be non-compliant and reluctant to participate in her plan of care.

On receiving report from the day-shift nurse, what stood out most was the fact that Mrs. M’s mental status had cleared somewhat, and according to her family who was very involved with her care, she was pretty much back to her baseline. Even before completing the Morse Fall Scale on Mrs. M, I noted that she would be considered a high fall-risk due to the fact that she had fallen at home prior to being admitted. She had a cast on her left ankle that impaired her mobility, and she was supposed to be non-weight-bearing. For a woman like Mrs. M who was used to being able to walk around by herself, this new handicap would be a substantial and frustrating change. She also had the potential to overestimate her abilities and be forgetful due to her recent alteration in mental status. She wasn’t connected to telemetry, but she did have an intravenous hepar lock, and she was taking medication for her blood pressure and the pain in her ankle. This had the ability to make her light-headed, another factor that increased her risk for falling. On top of all of this, there was a language barrier. Mrs. M spoke only Spanish.

Through report, I learned that Mrs. M was able to use her walker to pivot and transfer to the commode at her bedside with assistance while maintaining non-weight-bearing status on her ankle. Physical Therapy had determined she would need the cast for another two weeks. She didn’t always use the call bell for assistance, though she had been instructed and encouraged to do so. But her family was always with her, and they knew to call the nurse or patient care associate for assistance if Mrs. M needed anything. Most importantly, they were to let us know if they left her alone because then we would initiate more precautions such as turning on the bed alarm, conducting more frequent visual checks, and hourly rounds.

I felt confident in my knowledge of Mrs. M’s history and plan of care, so I signed off with her day nurse and proceeded into her room to introduce myself to her and her five family members. Mrs. M was sitting up comfortably in a chair, and I could tell she was at ease with me as I told her my name, informed her that I’d be her nurse throughout the night, took her vitals, and assessed her. Her vitals signs were all stable, and she was alert and oriented. As far as fall risk, I knew Mrs. M would have to be monitored more closely than my other patients. I could see how the cast on her ankle was a huge factor in terms of her safety and mobility. Before I left, I made sure all the proper fall precautions were in place, including non-skid socks, good lighting, no clutter. She wasn’t receiving continuous oxygen or telemetry-monitoring, she wasn’t hooked up to any intravenous medications, her walker and commode were easily accessible, and her call bell was within reach. I made sure she and her family knew how to use it and encouraged them to call if they needed anything. They demonstrated proper use of the call light and agreed to call when they needed me.

Our interactions throughout the evening and night were easy-going. Mrs. M and her children had a very close relationship, and it put Mrs. M at ease to have them there. The fact that they were there all the time reinforced how involved they were with her care. I could tell they were comfortable helping her, and I felt more at ease having them at her bedside, knowing I had an extra pair of eyes to watch her. For patients at risk for falling, I assess their risk factors every time I see them. I try to make sure they
Fall Narrative (Delgado)

Patient falls while afforded brief moment of privacy

My name is Jenna Delgado, and I have been working as a nurse on Ellison 16 since I graduated with a BSN more than five years ago. Ellison 16 is known as one of the busiest general medical units with the most challenging, medically complex patient population outside of an ICU. Perhaps that’s why our unit has one of the highest fall rates in the hospital. I’ve had two patients fall while assigned to my care, and I have assisted my colleagues with patients who have fallen numerous times.

We have successfully reduced the number of falls per patient on our unit and have taken many steps to accomplish this. Last year, we received customized, interactive fall-prevention training. This training made us more aware of the problem of hospital falls and led us to implement numerous fall-prevention tactics. Among them: new fall scales; greater utilization of chair and bed alarms; recognition of early signs of fall risk; and improved communication among healthcare providers related to fall risk and prevention.

Unfortunately, a patient I recently cared for suffered a fall. It was a frustrating and disheartening event for me and a frightening and painful experience for the patient, to say the least. I hope this experience will help me prevent falls in the future.

I first met Mr. V and his wife about two and a half weeks prior to a fall on a previous admission. Mr. V was a 58-year-old Spanish-speaking Puerto Rican man, a life-long fisherman who had been diagnosed only seven months earlier with Stage IV cancer of the larynx. He had undergone a total laryngectomy and chemotherapy, but was no longer receiving treatment when I first cared for him. His disease was resistant to treatment.

Mr. V’s first admission was essentially for failure to thrive. He had been constantly in pain, frustrated, anxious, and depressed from his diagnosis. His wife revealed that prior to admission, Mr. V had spent most of his time secluded in his room, which was a vast change from his usual way of life. He had been seen and examined by many teams, therapists, and services, only to learn that he would be discharged home with hospice care.

Because I speak Spanish, I was very involved with his care during this stay. I bonded with him and his wife as is often the case when you care for someone during their most difficult days. One Sunday morning, when his pain seemed well controlled and his mood light, I spent some time with him and his wife as he watched a fishing show on television. It was then I learned that he, like the majority of men in his family, was a fisherman. He made every effort to share his fishing tales and adventures with me.

That week, he was discharged home for only two days before going into acute respiratory distress. He completely failed at home and required a ventilator and an ICU when he was re-admitted. When he returned to Ellison 16, he was weak, somnolent, but able to be aroused. Mr. V’s mother and sister were at his bedside because Mrs. V had to return to Puerto Rico to be with her ailing mother. These two women were kind, caring, and loving, and I quickly formed a trusting relationship with them as I had with Mrs. V. They knew I would support Mr. V however I could—I stayed with him during procedures and sat with him after his family had gone home for the night. I would comfort him by speaking in Spanish, usually about anything except his condition. He would drift off to sleep while holding my hand.

When discussions took place between his physicians or social workers, I wanted to be present. Mr. V spoke very few words, but he made it clear that more than anything, he wanted to return to “mi casa.” Puerto Rico. His family echoed this sentiment. On several occasions they said their goal was to take him back to his homeland, as they put it, “dead or alive, but God willing, alive.”

Unfortunately, he made slow progress, and the plan was for him to be discharged locally. When I arrived one night, he seemed depressed but mustered a smile for me. He had not been out of bed and hadn’t bathed or changed his hospital gown. His family told me he had refused help, especially help washing. I seized the mo-

(continued on page 23)
Fall Narrative (Lessard)

May 27, 2010 — Caring Headlines — Page 21

My name is Stephanie Lessard. As I reflect on this past year, my first year as a nurse, I recall countless challenging experiences. I’ve felt excited, thrilled, stressed, and above all, a real sense of connection to the nursing profession. This feeling has only deepened as I’ve come to feel more confident in my practice, something I thought was out of my reach when I first began my career as a nurse.

One experience that stands out happened on a Saturday morning when one of my patients fell. I remember specifically the chain of events and how the impact of that one fall grew into something terrifying and challenging for me.

Mr. B was an 82-year-old man with a history of coronary artery disease and coronary artery by-pass surgery in 1993, who had transferred to MGH from an outside hospital complaining of chest pains. His primary symptoms were shortness of breath and associated chest pain. In our Cardiac Cath Lab, Mr. B was found to have further progression of his coronary disease and a further depressed ejection fraction indicating increased heart failure.

On this Saturday, as I was standing at the telemetry monitors performing my 10:00am ‘tele-checks,’ I heard the call bell for Mr. B’s room and Mr. B’s voice saying he’d just fallen. I hurried to his room and found him on his feet, flustered, and heading for the bathroom. I called for help and took hold of his arm as we moved together toward the bathroom, all the while trying to assess if he’d been injured. I stayed with him in the bathroom. I asked what had happened, how he had fallen, what he’s been doing when he fell, why he had wanted to get up, and if he felt any pain.

Mr. B seemed scared and shaken. He said he had urgently felt the need to go to the bathroom. He described how he had gotten up from his chair and fallen, striking his left shoulder and elbow; he knew he hadn’t hit his head. Fortunately, there were no bruises, scrapes, or open wounds visible as I checked him over. He said he remembered falling, but didn’t know why he fell.

As another nurse and I walked Mr. B from the bathroom to his bed, he shuffled his feet — something that wasn’t normal for him — and therefore I was concerned. As soon as I settled him in bed, I checked his neurological and vital signs, which were all normal. I thought perhaps it had been a mechanical fall, maybe he had tripped over himself while getting up from the chair and rushing to the bathroom. I paged the fellow, explained what had happened, and asked him to come assess the patient.

The fellow arrived, completed his exam, and had no new orders. He suggested I continue to watch Mr. B.

Within 30 minutes, Mr. B began to complain that his left side felt weak, and he slouched toward the left side of the bed. He said, “I’m in a euphoric state.” He couldn’t form his left index finger and thumb into a circle, but he could with his right. I paged the fellow again and he came up immediately, this time he looked worried and asked me to page the Neuro Stroke Team, stat.

I started to second-guess myself. Was there something I could have done differently to prevent this? I became overwhelmed as I thought about what had happened. But I realized it wasn’t the time to doubt myself, so I put those thoughts out of my head. Mr. B needed me to get him to CT Scan and MRI right now, so that’s what I focused on.

After reviewing Mr. B’s scans with the radiologist, the stroke fellow determined that Mr. B. was not a candidate for thrombolytic therapy. Because the radiology study showed multiple embolic strokes, possibly due to the current changes in his cardiac status, Mr. B would need to receive more con-
Fall Narrative (Berger) continued...

were intact, but her hip was asymmetrical. Only her nasal cannula had been disconnected during the event.

I called the responding physician, and the nurse practitioner responded. Neurosurgery had seen the patient at 6:30 that morning and was confident, despite Mrs. A’s long surgical procedure the previous day (more than 11 hours), that she was ready to transfer to a unit. Now the Neurosurgery Team was adding orders for Radiology and Laboratory tests. The pace of my day was picking up. One of my colleagues offered to cover my other patient for the remainder of my shift. I was becoming increasingly busy.

Mrs. A’s son and daughter-in-law arrived to visit her. I hadn’t had time to call them or let anyone know that I needed to see them before they saw Mrs. A. Before I got to her room, Mrs. A told her son that she had fallen and hurt her hip while trying to get tea. The son was upset, repeating to me what his mother had said. I tried to explain that, yes, she had fallen, but the physicians had seen her, and I was trying to get her to Radiology for an X-ray of her hip.

The day continued to get worse.

I was shocked and upset that this had happened to my patient. She had fractured her hip, which by itself would make for a complicated situation. But because she had just had brain surgery, the decision-making would be all the more complex. For the next week, Mrs. A remained in the ICU while decisions concerning anti-coagulation, orthopaedic surgery, and management of her ICU psychosis became the new priorities. The expectation that her recuperation would take weeks was turning into planning for months of rehabilitation.

I still wonder what I could have done differently to prevent Mrs. A from falling.

Fall Narrative (Shaw) continued...

have everything they need, they’ve been toileted, and they have the means to call if they need something else.

Because of Mrs. M’s limited mobility, there was a commode at her bedside for her convenience. Whenever she needed to use the commode, we made sure the room was well lit, the commode was locked in place, and the floor was clutter free.

Mrs. M’s son was present at her bedside the entire night. He was very involved in his mother’s care and was used to assisting her at home. He was, however, aware that he was supposed to call the nurse for assistance when transferring his mother.

At about 6:30 in the morning, as I was going into Mrs. M’s room to check on her, I found the lights on and saw Mrs. M sitting on the floor next to her son who was standing over her with her walker nearby. The patient care associate, who had come in to draw labs, informed me that Mrs. M’s son had told her she’d just fallen while transferring back to bed from the commode. Neither I nor the patient care associate had been alerted that she needed to use the commode.

Neither of us had witnessed the fall.

We helped Mrs. M safely back into bed, and I asked her son what had happened. He said she had needed to go to the bathroom, and he was used to helping her so he’d helped her to the edge of the bed and transferred her to the commode. When she finished, he helped her back to bed, but, “all of a sudden,” she felt weak and fell back on her butt. She reported no pain, and said she hadn’t hit her head. After Mrs. M’s fall, she was able to get up and transfer back to bed safely with assistance. The night resource nurse and night medical intern were both made aware of her fall and came in to assess and examine her.

I documented the fall in my daily shift report as well as in a formal safety report, where I described the specific details of the fall and the precautions that were in place to prevent it from occurring.

Mrs. M was discharged later that day despite the fall; however, I had been unaware of this plan while caring for her. If I know a patient is going to be discharged, I want to feel confident they’ve achieved their prior level of independence and will be able to return to their everyday lives and be safe. I might change my goals for the day, for example, to ensure they’re as independent as possible with their activities of daily living, or as close to their baseline abilities as possible.

I know that keeping the patient safe is the most important thing I can do. It’s essential to partner with the family in providing the patient the care that they require—especially when the patient is so close to discharge. Despite Mrs. M’s well-meaning family, I worry that families don’t have the understanding or skills needed to manage patients in this time of transition. I realize that within the hospital setting families can be a huge help, but instructing them also means following-up and continually educating them rather than hoping they’ll make the right choices when partnering with clinicians to keep their loved ones safe.

Despite Mrs. M’s well-meaning family, I worry that families don’t have the understanding or skills needed to manage patients in this time of transition.
Fall Narrative (Delgado) continued...

They had trusted me, I had gone the ‘extra mile’ for him, and then he fell on my watch while I was just a few feet away. The sound of him falling, but my gut told me to check. I opened the door and found him on the hard floor of the shower looking forlorn and in pain. I couldn’t believe my eyes. I didn’t want to believe it. How could this patient whom I cared so much about, I was so protective of, fall with me? And why had he gotten up when everything was right there at his fingertips. My heart raced. I felt my face turn red.

Mr. V was alert and responsive. There was no evident trauma. He said he was okay and wanted to get up. After further assessment, I helped him back to the chair. He told me he had wanted to use the toilet and that’s why he stood up without me. He said he hit his shoulder and injured a finger. I examined him. There were signs of adequate circulation, motion, and sensitivity.

I explained that I’d need to inform his family and the covering physician about the fall and that it could inhibit the plan to be discharged the following day. He begged me to conceal the information. I hesitated for a split second not wanting to jeopardize our trust, but I knew what had to be done. I walked him back to his bed, measured his vital signs, which were all within normal range for him, and left to inform the physician.

No physical injury was discovered as a result of the fall, but the event led his family and the team to realize that the plan to be discharged the next day was not in his best interest. So he remained with us and became a patient of the Hospice Service.

It’s always an unpleasant and worrisome experience when a patient falls, but this particular fall was troublesome to me because of the bond I had developed with Mr. V and his family. They had trusted me, I had gone the ‘extra mile’ for him, and then he fell on my watch while I was just a few feet away. I was extremely frustrated because my intention was to facilitate something positive, and in the end, more harm than good had come of it.
“Save the Veins”
Vein Sparing for patients with renal dysfunction

A Did You Know? poster by
Mary Sylvia-Reardon, RN, DNP Nursing Director of Hemodialysis Unit

GUIDELINES FOR VENOUS ACCESS
IN PATIENTS WITH CHRONIC KIDNEY DISEASE OR RENAL INSUFFICIENCY

TOPIC OF INTEREST
• The use of venous access devices requiring placement in both central and peripheral veins has become prevalent in modern medicine.
• Peripherally inserted central catheters (PICCs) are vascular access devices that can be inserted through a peripheral vein with the tip terminating in the central vascular system.
• Such catheters are inserted through an antecubital vein by needle puncture (Hertzog & Waybill, 2008).

INTRODUCTION
In many institutions, PICCs replace neck or chest wall central venous catheters as the access of choice for intermediate and long term intravenous therapy (Gonsalves et al., 2003). Larger populations of patients receive these lines, not only for in-hospital use, but home therapy as well (Allen et al., 2000).

A survey tool was developed to identify the nursing knowledge and current clinical practice of the PICC-certified members of the MGH IV Therapy Team related to the patient with renal insufficiency. The information gained from the responses identified a need for education. This is a beginning step in the reduction of the number of PICCs placed in this patient population. IRB Protocol #2009PP000665, SRH

In discussions with the Nephrologists at MGH, there was evidence of hemodialysis patients having PICC placement that oftentimes could have been avoided.

REVIEW OF LITERATURE
The literature revealed factors that contribute significantly to damage of upper extremity vessels:
• diameter, location and composition of the catheters
• presence of disease processes
• infusion solutions
• vein choice
• greater incidence of thrombosis in the presence of chemotherapeutic agents
• Lack of radiological visualization

IMPORTANCE OF AVOIDING PICC LINES IN PATIENTS WITH RENAL FAILURE
• Peripherally inserted central catheters (PICC) have become an essential component in the management of increasing numbers of patients, including patients who require hemodialysis or may, in the future require hemodialysis as a result of renal insufficiency (Allen, 2000).
• Complications from central venous catheters (i.e. septicemia, stenosis, thrombosis) often prevent an optimal vascular access that is critical in this population.

GUIDELINES FOR UPPER EXTREMITY VEIN SPARING
• According to the National Kidney Foundation, veins in both arms could potentially be needed for creation of vascular access at some point in time and must be preserved (National Kidney Foundation [NKF], 2006).
• Due to the large number of End Stage Renal Disease patients receiving hemodialysis, as well as peritoneal dialysis and transplant patients who may require hemodialysis at some point, the need for preservation of upper limb vessels is imperative.
• Arm veins suitable for vascular access placement should be preserved regardless of arm dominance. The cephalic veins of the dominant arm should not be used for either venipuncture or intravenous catheters (NKF, 2006).

The MGH Hemodialysis unit adheres to the NKF-Kidney Disease Outcome Quality Initiative (KDOQI) Clinical Practice Guidelines.

GUIDELINES FOR VENOUS ACCESS IN PATIENTS WITH CHRONIC KIDNEY DISEASE OR RENAL INSUFFICIENCY

Identify -
HD patients, present or future
• CKD stages 3, 4 or 5, including current stage 5 patients receiving hemodialysis, peritoneal dialysis or transplant patients

Plan -
venous access for stages 3-5

Choose -
• dorsal hand veins for phlebotomy
• proximal peripheral venous access if necessary
• internal jugular veins are preferred for central venous access
• external jugular veins are acceptable alternative

Avoid -
• the subclavian veins

National Kidney Foundation, 2006
WHY IS VEIN SPARING IMPORTANT IN PATIENTS WITH RENAL FAILURE?

- Every patient starts with only four superficial upper extremity veins and two subclavian veins.
- Avoiding unnecessary iatrogenic trauma to the upper extremity veins is critical for arterio-venous fistula (AVF) creation.
- Not only are the upper extremity veins critical for the creation of the vascular access, but a healthy venous circuit back to the heart is of equal importance.

A “SAVE THE VEINS” INITIATIVE IS BEING INSTITUTED BY THE HEMODIALYSIS UNIT AND RENAL DIVISION AT THE MGH.

If you are caring for a patient who is wearing a “Save Your Veins” band or you know your patient has renal dysfunction.

Please:
- Contact the patient’s Nephrologist or the Access Coordinator prior to PICC placement
- Avoid antecubital punctures whenever possible
- Perform venipuncture below the wrist for blood draws.
- Contact the MGH Hemodialysis Unit 617-726-3700 if you have any questions

REFERENCES


Transporting Patients on Isolation Precautions
What do you mean I shouldn’t wear gloves around the hospital?

A Did You Know? poster by Heidi Schleicher, RN, BSN, CIC

WHAT ARE ISOLATION PRECAUTIONS AND WHY DO WE USE THEM?

ISOLATION OF PATIENTS in U.S. hospitals goes back as far as 1877 when patients with infectious diseases were placed in separate facilities known as infectious disease hospitals. In the century to follow many different practices were used to prevent transmission of infection from person to person. In 1985 “Universal Precautions” were introduced in response to the HIV virus with the focus to protect healthcare workers (HCW). Gowns and gloves or “personal protective equipment” (PPE) to prevent exposure to blood-borne pathogens became the norm.

As a result, many began to routinely wear PPE. However, hand hygiene practice suffered as HCWs mistakenly thought gloves were a substitute for hand hygiene. In response, in 1996 the Centers for Disease Control (CDC) dropped “Universal Precautions” and published new guidelines for all patient care known as Standard Precautions. Transmission-based Precautions were added to provide disease or organism-specific isolation guidance.

Standard Precautions protect HCWs from blood-borne pathogens and prevent transmission of infection between patients. They require HCWs to use PPE when contact with blood, body fluids, secretions, excretions, broken skin or mucous membranes is anticipated. PPE is removed when the task is complete. Standard Precautions requires hand hygiene before and after every patient contact or contact with contaminated or potentially contaminated surfaces, regardless of glove use. Disinfection of equipment between patient uses is required. Standard Precautions are required for all patients regardless of whether they have been identified as having an infection. It is the primary strategy today to prevent healthcare-associated infections.

Transmission-based Precautions prevent the transmission of highly transmissible or epidemiologically important pathogens. They are based on the way the organism is spread or the “mode of transmission.” The process by which a pathogen “infects” a patient is shown in this “Chain of Infection” diagram.

“Transmission-based” Precaution practices interrupt this chain. For example, the flu virus is spread via droplets from a cough or sneeze of an infected person. HCWs wear a mask on entry to the room of a patient on Droplet Precautions and the patient wears a surgical mask during transport.

Airborne pathogens are very small and may remain suspended in air for long periods. Tuberculosis (TB) is an example of this where TB microorganisms spread from the infected person during talking, sneezing, or coughing. HCWs wear an N-95 respirator in the patient room and the patient on Airborne Precautions wears a surgical mask for transport.

Pathogens that are spread by direct or indirect contact can be carried from patient to patient via HCWs hands or clothing, or by contaminated equipment (e.g. stethoscopes). Enhanced cleaning of the hospital environment, meticulous hand hygiene, and consistent, correct use of PPE are critical to prevent the spread of these pathogens. Examples are: Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-resistant enterococcus (VRE), and Clostridium difficile (C. difficile). Studies found that MRSA, VRE, and C. difficile can survive days to weeks on surfaces. A study from Brigham and Women’s Hospital found a 40 percent increased odds of transmission of MRSA or VRE when the prior room occupants were infected with these pathogens despite room cleaning methods that exceeded national standards. Contaminated surfaces can contribute to the spread of these pathogens from HCW hands and/or gloves to patients.

Following Contact Precautions correctly while caring for and transporting these patients is critical to limiting contamination. Gowns and gloves are worn while providing care to prevent contamination of hands and clothing, so it is important not to wear PPE in public hallways or spaces during transport. Instead, pushing surfaces should be disinfected. PPE should be removed and hand hygiene should be used to allow for safe transport with clean hands.
### SUMMARY CONCLUSION

Published guidelines and research tell us that following Standard Precautions and Transmission-based Precautions prevents the spread of infection and protects patients and HCWs. By using appropriate barriers, when indicated, hand hygiene, and ensuring environmental surfaces and equipment are adequately disinfected, HCWs can effectively limit the spread of communicable diseases and prevent healthcare-associated infections.

### REFERENCES


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**SUMMARY OF PPE AND CLEANING DISINFECTION STEPS**

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>AIRBORNE</th>
<th>DROPLET</th>
<th>CONTACT</th>
<th>CONTACT PLUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entering Room</td>
<td>Fit-tested N-95 respirator</td>
<td>Surgical mask</td>
<td>Gloves to enter</td>
<td>In patient’s environment</td>
</tr>
<tr>
<td>Equipment and Charts</td>
<td>Wheelchairs and stretchers wiped down with disinfectant after every use</td>
<td>Equipment from room disinfected before transport</td>
<td>Wheelchairs and stretchers wiped down with bleach-based product after every use and equipment cleaned before travel</td>
<td></td>
</tr>
<tr>
<td>Patient Preparation</td>
<td>Patient wears surgical mask to contain secretions</td>
<td>Clean patient and sheet, clean patient's hands if possible and clean dressings with drainage contained</td>
<td>Team member wipes shoes of bed and equipment that travels with patient using disinfectant (use gloves for cleaning)</td>
<td></td>
</tr>
<tr>
<td>Traveling in Bed</td>
<td>Remove N-95 respirator</td>
<td>Remove surgical mask</td>
<td>Remove gloves and gown</td>
<td></td>
</tr>
<tr>
<td>Exiting Room</td>
<td>Wash hands, then Cal Stat</td>
<td>Designated “clean” person pushes buttons and opens doors</td>
<td>HCWs do not wear gowns or gloves during transport unless direct contact during travel (i.e. many ICU patients) is anticipated</td>
<td></td>
</tr>
</tbody>
</table>

At MGH the “Sticker to Ride” form tells precaution status and pertinent clinical information when transporting a patient.
What is Evidence-Based Practice?
An Interprofessional Approach to Clinical Decision-making

A Did You Know? poster by the PSC Research and Evidence-based Practice Sub-Committee

DEFINITION
“Evidence based practice (EBP) is the judicious and conscientious use of current best evidence in conjunction with clinical expertise and patient values to guide health care decisions.” (Titler, Chapter 7, in Hughes, 2008).

Simply stated... EBP is a method of clinical decision-making.

1) ASK A CLINICAL QUESTION:

PICO is a mnemonic that helps to develop a well-focused question.

P: Patient/Problem/Population: the subject of the clinical question.

I: Intervention/Issues: the treatment that might be applied to the subject (P).

C: Comparison: an alternative treatment to compare (there may not always be a comparative intervention).

O: Outcome: the expected result of the intervention (may also be the outcome of interest).

Example: Do adult abdominal surgery patients (Population) who have music therapy in PACU (Intervention) require less narcotic analgesia for postoperative pain (Outcome) than those who do not use music therapy in PACU (Comparison)?

2) FIND THE BEST EVIDENCE


Clinical guidelines are often utilized as resources in clinical practice and are from reputable organizations. The following link brings you to a national clearinghouse for clinical guidelines: http://www.guideline.gov/

To learn more, go to: HealthStream, MGH EBP: Finding the Best Evidence (2011). The Treadwell librarians are here to help

3) WEIGH THE EVIDENCE

Your clinical leadership or member of the Research and EBP Committee (REBP) can guide you to the right person(s) to help you learn the process of critiquing and weighing the evidence.

4) PUT IT INTO PRACTICE

Work with your clinical leadership to plan a change in practice. They will assist with planning a trial, or pilot of the practice change before finalizing and disseminating the new practice. Work as a team to develop your new/revised policy. This is where changes to clinical practice occur.

For an example of changing practice related to delirium, go to: HealthStream: MGH Evidence-based Nursing Practice Delirium Recognition and Screening (2011)

EBP IS THE FOUNDATION FOR EXCELLENCE IN CLINICAL PRACTICE. EBP:

• Improves clinical outcomes and quality
• Increases satisfaction for patients/families, staff, and faculty
• Improves efficiency.
• Decreases disparities.
• Decreases costs.
AT MGH WE FOLLOW

The Iowa Model of Evidence-based Practice to Promote Quality Care.

REFERENCES

American Association of Critical Care Nurses. AACN Researching the Evidence Pocket Reference, Product #400759, revised April 2011.


www.mghpcs.org/IPC/Programs/Committees/Research.asp • July 2012
A focus on geriatric care

AN MGH NARRATIVE
Ms. J. was come to the hospital following a stroke and had an long stay due to an independent living situation that was no longer safe for her. Early in her course she was quite confused and agitated, often refusing care or combative with staff attempting to provide her care. more...

Susan Gage, MSN, RN
Ellison 16, General Medical

Geriatric Certification
The E. Louise Berke Fund for Gerontological Nursing reimburses registered nurses working in Patient Care Services for the cost of the gerontology specialty certification and re-certification exams.

The Importance of Gerontology Certification for Quality Patient Care

• PCS Professional Certification Information
• ANCC Geriatric Certification
• Consult Geri Certification Review Course (Free)
• Geriatric Certification Tool Kit

Geriatric Clinical Assessment Tools
The Hartford Institute for Geriatric Nursing has created evidence-based tools to support geriatric assessment.

• Try This: Mini-Cog
• Try This: Spices
• Try This Assessment Tools
• AJN Nursing Center Try This Videos

MGH CONTACT
Deborah D'Avolio, PhD, APRN-BC,
Geriatric Specialist, Nurse Scientist and MGH 65 Plus, NICHE Leader
Ellison 6, Office 635
Phone: 617-643-4873
Fax: 617-726-1025

RESOURCE READING

http://www.mghpcs.org/eed_portal/EED_geriatric.asp
Excellence Every Day Portal - A focus on fall prevention

Articles:
Numerous articles and websites are available to support clinicians care of older adults.
- Institute of Medicine: Retool for an Aging America
- How to Try This: Fuller SPICES Article

Books:
- Evidence Based Geriatric Nursing Protocols for Best Practice. Fourth edition Springer series, Capezuti, E. Editor, (2011)
- Hazzard's Geriatric Medicine And Gerontology: Sixth Edition (Principles of Geriatric Medicine & Gerontology) (2009), by Jeffrey Haller (Author), William Hazzard (Author), Joseph Ouslander (Author), Mary Tinetti (Author), Stephanie Studenski (Author), Kevin High (Author), Sanjay Asthana (Author)
- Nursing for Wellness in Older Adults Miller, Carol A., (2008). Case Western Reserve University, Cleve Frances Payne Bolton School of Nursing (Author)

WEB-BASED RESOURCES
- American Nurses Association (ANA) - Geriatric Nursing
  The official geriatric nursing Web site for the American Nurses Association (ANA).
- The John A. Hartford Foundation Institute for Geriatric Nursing - the gateway to NICHE
  The evidence-based geriatric clinical nursing website of The Hartford Institute for Geriatric Nursing, at New York University’s College of Nursing and NICHE providing an online resource for nurses in clinical and educational settings.
- The Gerontological Society of America
  a not-for-profit multidisciplinary organization dedicated to the scientific study of aging and to the translation of research for practice and policy.
- National Gerontological Nurses Association (NGNA)
  The National Gerontological Nurses Association (NGNA) is dedicated to the clinical care of older adults. Members include clinicians, educators, and researchers with different educational preparation, clinical roles, and interests in practice issues.

Click here to view a list of more sites...

EXTERNAL REVIEWERS

The Joint Commission

Click here...

Magnet Recognition

The American Nurses Credentialing Center (ANCC) requires Magnet-designated organizations to track nationally-benchmarked nursing sensitive indicators (NSIs) to continually inform improvement efforts related to enhance patient outcomes. Examples of NSIs include, but are not limited to: patient falls, hospital-acquired pressure ulcers, blood stream infections, ventilator-associated pneumonia, and restraint use.

GLOSSARY OF TERMS

click here...

There are numerous terms and acronyms in healthcare that may be unfamiliar. Please click here to visit a Glossary of Terms that may be helpful. And please email any suggested additions.

This month’s featured term:

Excellence Every Day represents an MGH commitment to providing the highest quality, safest care that meets or exceeds all standards set by the hospital and external organizations.

If you have questions or suggestions related to the EED portal, please contact Georgia Peirce at (617) 724-9885 or via email at gepelmo@partners.org.
updated 7/9/12
1. CLINICAL GUIDELINE
   1.1. The purpose of this guideline is to prevent and reduce indwelling urinary catheter use and to limit indwelling urinary catheter use to clinically appropriate and adequately justified clinical situations.

2. SCOPE
   2.1. This clinical guideline supports the practice of all clinicians caring for patients of any age across all settings and services at Massachusetts General Hospital. Procedures established under this guideline provide the flexibility to permit the development of population specific standards, practices, and procedures that further facilitate the decreased use of indwelling urinary catheters in those settings.

3. GUIDING PRINCIPLES
   3.1. Catheter-associated urinary tract infections (CAUTIs) are the most common nosocomial infections.
   3.2. Older adults are at increased risk for experiencing subsequent adverse complications, and prolonged length of stay from urinary catheter associated infections.
   3.3. Catheter-associated urinary tract infections are preventable. To reduce the risk for infection, use urinary catheters only when clinically indicated, as determined by the evidence based guidelines.
   3.4. Indwelling urinary catheters are associated with increased morbidity, including polymicrobial bacteriuria, gram negative bacteremia, febrile episodes, nephrolithiasis, bladders stones, epididymitis, chronic renal inflammation and pylonephritis, and meatal damage.
   3.5. The use of indwelling urinary catheters should be avoided whenever possible to prevent urinary tract infections which commonly occur after urinary catheterization.

4. INDICATIONS FOR USE
   4.1. Indications for a indwelling urinary catheter:
       4.1.1. Acute urinary retention;
       4.1.2. Chronic urinary retention, if alternative treatments have failed;
       4.1.3. Monitoring urinary output of critically ill patients;
       4.1.4. Management of patients with stage III to IV pressure sacral, perineal or trunk ulcers;
       4.1.5. May be indicated as a comfort measure/palliative care for a terminally ill patient;
       4.1.6. Gross hematuria, if at risk for clotting;
       4.1.7. Following some urological/gynecological surgeries.

5. ALGORITHM TO SUPPORT INDICATIONS FOR USE
   5.1. The Urinary Catheter algorithm is a guide to support the appropriate use of indwelling urinary catheters.
Urinary Catheter Algorithm for indwelling Urinary Catheter Guideline

1. **Patient has urinary catheter**
   - RN assesses need DAILY
     - Is criteria for urinary catheter met?
       - YES
       - Obtain MD order and remove urinary catheter
       - Monitor for voiding & apply appropriate interventions to support patient
     - NO
       - Bladder Scan to assess bladder volume (See Bladder Scan Procedure)
         - Greater than 300 ml?
           - YES
           - Contact MD
           - NO
           - Encourage more PO fluids and continue to assess
         - NO
         - Return to Patient voided within 1 to 2 hours?
     - Monitor Pt as needed
       - YES
       - Bladder Scan to assess bladder volume (See Bladder Scan Procedure)
       - NO
       - Encourage PO intake, as allowed by diet
         - Provide privacy & unhurried time to void to limit stress
         - Offer intermittent assistance to bathroom/commode
         - Promote relief of physical discomfort
         - Provide sensory stimuli to promote relaxation (pouring warm water over perineum, running water, provide reading material)

Indications for a indwelling urinary catheter:
- Acute urinary retention
- Chronic urinary retention, if alternative treatments have failed
- Monitoring urinary output of critically ill patients
- Management of patients with stage III to IV pressure sacral, perineal or trunk ulcers
- May be indicated as a comfort measure/palliative care for a terminally ill patient
- Gross hematuria, if at risk for clotting
- Following some urological/gynecological surgeries

NOTE: If at anytime the Pt complains of bladder fullness, proceed to Bladder Scan.
6. REFERENCES


Cancio, Leopoldo C. Managing the Foley Catheter, American Family Physician: Managing the Foley Catheter. October 1993


Thomsen, Todd W., Setnik, Cary S. Male Urethral Catheterization, New England Journal of Medicine, 2006;354:e22.


7. RELATED POLICIES, PROCEDURES & GUIDELINES

Bladder Scanning Policy
Urinary Catheterization: Insertion
Urinary Catheterization: Removal
Urinary Catheterization: Straight Catheterization

Developed by: 65Plus Taskforce, chaired by Deborah D’Avolio PhD, APRN

Reviewed and approved by:
Nursing Practice Committee (1/09)