7.8 Give examples to demonstrate how nursing services provide the resources, education, and support to facilitate staff involvement in quality improvement activities.

Engaging nurses in quality improvement activities is the key to successful programs and initiatives that support patient care at MGH. The infrastructure described in Force 6.1 is in place to facilitate participation and provide the resources, education and support needed for nurses to contribute to and lead organizational and unit level quality improvement initiatives.

Resource and Education: The Institute for Patient Care

The Institute for Patient Care, described in Force 2.3, provides the structures to meet patients’ needs; advance care delivery systems; and foster, study, and promote innovations in care. The educational programs of The Norman Knight Center for Clinical & Professional Development, described in Force 2.4, provides all nurses the educational support needed to engage in quality improvement activities in the organization.

As described in Force 2.5, Collaborative Governance also provides an infrastructure of resources, education and support to facilitate staff involvement in quality improvement activities, both at the departmental and unit level. Staff Nurse members of Collaborative Governance committees receive formal orientation and training and ongoing mentoring and support from coaches. Committee members are also supported by activities, such as retreats and the annual award and recognition dinner to celebrate the success of their work. This year, Collaborative Governance at MGH celebrated its 10th anniversary, which included a visit by Carol Channing (attachment 7.8.a).

The new Center for Innovations in Care Delivery is another component of The Institute for Patient Care, which offers resources and support to bring nursing and interdisciplinary teams together to identify opportunities to improve care, evaluate the impact of care and implement changes to improve the delivery of care. The goals of the Center for Innovations and an introduction to the first nurse Innovations Specialist hired to support the Center is highlighted in November 2006 issue of Caring Headlines (attachment 7.8.b). Examples of quality improvement activities supported by the Center for Innovations include:

- White 8/NICU Project

This unique pilot project was designed to empower staff nurses to control their practice at the unit level. Staff Nurses, who care for two very different and distinct patient populations,
were brought together to look at their practice and identify opportunities to engage in quality improvement activities. Nursing leaders specifically chose to work with Staff Nurses working nights, as it is more difficult to engage them in quality improvement activities when they are not available for regularly scheduled meetings.

Staff Nurses from White 8, a General Medicine unit, and the Neonatal Intensive Care unit (NICU), the two Nursing Directors and Clinical Nurse Specialists from both units were given three tools to help them evaluate practice both prospectively and retrospectively in an effort to continually improve practice at the bedside.

Attachment 7.8.c is a summary of the initial retreat held with the two groups of staff reviewing the tools used and the outcomes achieved. A follow-up retreat was held on July 25, 2007. To support ongoing education, the Innovations Specialist also stayed connected to the groups using e-mail communications. She provided incremental information about the quality improvement tools to help build the Staff Nurses’ knowledge base and to encourage them to use the tools in the time between the two retreats.

As a result of this work, Staff Nurses from these two very distinct units have come together in a very special way. They have learned that although there are innate differences in their work, they share some of the same practice challenges. They have developed an ongoing relationship where they continue to share ideas and learn from each other.

The Staff Nurses on White 8 identified communication as an opportunity for improved practice on their unit. Having struggled with this issue in the past, NICU staff shared the way they used patient care rounds to improve communication. Based on this dialogue, White 8 Staff Nurses visited the NICU to observe their practice and to see how they could incorporate some of the practices into their unit’s communication plan.

The NICU Staff Nurses identified a problem with PICC lines that occurs when manual pressure is applied when flushing the line. Having identified this problem, they took the next steps to quantify the impact on practice and care to patient. An in-depth presentation, “PICC Patency Assessment”, describing the issue was submitted to the Massachusetts Institute of Technology (MIT) Biomedical Devices Design Laboratory class for consideration as a course project. In July 2007, the Nurse Director of the NICU was notified that their project was selected as a finalist for the course (attachment 7.8.d). This is the first time a nursing project is being considered for this highly competitive process. If chosen, MIT graduate students will
engineer and build a prototype solution to address the PICC line patency issue identified by the NICU Staff Nurses.

- Expansion of Therapeutic Touch (TT) Program

  As described in Force 6.27, TT was studied and successfully implemented on Ellison 14, the Medical Oncology and Bone Marrow Transplant Unit. The research study showed that with dedicated nursing time, TT was *a vehicle for comfort, caring, and presence; that shifts to the personhood of the patient and reawakening of the essence of nursing; and illuminates the power of linking practice, theory, and research.*

  Based on the success of this nurse-driven research, other patient care units were invited to submit proposals to replicate the study for their patient population. With the support of the Center of Innovations, Staff Nurses and the Clinical Nurse Specialist for the Medical Intensive Care Unit submitted a proposal to participate in the expansion of this program. *Attachment 7.8.e* is the proposal that was approved by the Therapeutic Touch Steering Committee. In Fall 2007, the staff on the units selected will participate in two training programs to learn TT techniques prior to initiating the research and quality improvement study on the units.

**Professional Development Coordinator**

The role of Professional Development Coordinator for The Munn Center for Research was created to facilitate an environment that supports ongoing research and scholarship for staff in Patient Care Services. This nurse provides leadership, mentoring and guidance in the development of research and training projects. She supports staff in their efforts to identify resources and develop strategies to obtain funding to support initiatives across Patient Care Services such as the RN Residency Program described below.

- RN Residency: Transitioning to Geriatric and Palliative Care Grant

  MGH Patient Care Services was awarded a $600,000 grant from the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Division of Nursing to support the development and implementation of a nine-month mentored residency program for MGH employed nurses.
This quality improvement project will increase the hospital’s geriatric and palliative care nursing capacity and address the goal of Health People 2010 to increase quality and years of healthy life through secondary and tertiary prevention of adverse events of hospitalized elders by nurses with specialized knowledge of geriatrics and palliative care. The objectives of this three-year grant are to:

1) Strengthen the nursing workforce by increasing knowledge, skills and competencies in specialties of geriatric and palliative care;
2) Improve retention of the RN workforce at MGH by providing career pathways and transitioning to specialties;
3) Improve the quality of nursing care to elderly patients and families.

Staff Nurses have an opportunity to participate in the project in one of two ways, as an RN Preceptor or an RN Resident. Staff Nurses with two to five years of nursing experience, working thirty-two hours a week with interest in geriatrics and palliative care will be eligible to become a RN Resident. These nurses were targeted for the residency training because current research that suggests that 57% of new graduate registered nurses leave their first positions within two years (Bowles & Candela, 2005) and the focus is to retain nurses who have “mastered the task world.” (From Novice-to-Expert, Brenner, 1984)

Staff Nurses forty-five years old or older and who are working at least twenty-four hours a week on acute care units will be eligible to apply to become RN Preceptors. They will assist the RN Resident in caring for patients and their families while being mentored by faculty to further shape their own careers and develop senior mentorship competencies.

One RN Resident and one RN Preceptor will come together as Care Partners, to share a single nursing assignment on patient care units for the purpose of this mentored learning experience. The RN Residency Program will provide didactic classroom, on-line and web-based learning modules with precepted clinical experiences and innovative development strategies, such as Margaret Newman’s interview protocol which assesses what is meaningful to patients and families and journaling as way to reflect on practice.

The first RN Preceptor program is scheduled to begin in October 2007. The first RN Residency program is scheduled to begin in January 2008. A complete copy of the RN Residency: Transitioning to Geriatric and Palliative Care Grant proposal is available on-site for review.


**Resource: Time**

Time is another valuable resource provided that enables nurses to participate in departmental and unit-based improvement activities. Indirect time is budgeted into each nursing unit’s operating budget specifically for non-patient care activities; such as Staff Nurse orientation, education, administrative and project work. This allows Nursing Directors the flexibility to give staff time to participate in quality improvement activities, such as the White 8/ NICU project and Collaborative Governance committees, without impacting patient care. Indirect time is currently running slightly over the 5% allocated budget on the patient care units.

**Clinical Nurse Specialist Support**

Clinical Nurse Specialists are an invaluable resource to Staff Nurses as engage in quality improvement activities. As clinical experts and nursing leaders, the Clinical Nurse Specialist mentors the Staff Nurse as they participate in quality improvement activities.

As depicted in Force 7.6, the Staff Nurse Sheath Removal Team is actively involved in quality improvement. Supported by Clinical Nurse Specialists from the Heart Center, the team of Staff Nurses meets bi-monthly with the goal of optimizing patient care. They collect and review data, raise clinical questions for inquiry, review the literature for current articles to support their evidence-based practice and work with interdisciplinary team members to build alliances and foster support for this ongoing initiative. In June 2006, the group met with the Medical Director of the Vascular Medical Lab to discuss operational plans for the team. After reviewing evidence-based articles about FemoStop, a new sheath device being introduced to the unit, they discussed a potential research study on Therapeutic Touch.

The Documentation Communication (Doc Com) Project also demonstrates Clinical Nurse Specialists’ support for staff in quality improvement activities. In addition to the financial and staff resources for Doc Com described in Force 1.3, unit-based resources are also committed to this project. Each patient care area has unit-based Staff Nurse Documentation Champions who have become documentation experts providing resource support to their peers on their respective unit.

Before the project is initiated on a patient care unit, the Champions attend an educational retreat (attachment 7.8.f) to prepare for implementation. After the retreat, Clinical Nurse Specialists,
along with Nursing Directors and Doc Com program leaders are available to mentor and support the Champions, as they take the lead in providing peer support to their co-workers.

Clinical Nurse Specialist support for this project is illustrated by this example from the Same Day Surgical Unit (SDSU). Prior to the start of the Doc Com project, the SDSU had already formed a Staff Nurse Documentation Committee to support the multiple documentation requirements derived from their varied patient population. The committee reviews systems within the perioperative practice including: preoperative assessment, intra-operative and postoperative care. Supported by two unit-based Clinical Nurse Specialists, the Staff Nurses on the committee are to review documentation standards and provide their peers with updates and clarify expectations to improve the documentation process.

As a result of this ongoing work, Staff Nurses involved on the initial committee, volunteered to be the Documentation Champions for the Doc Com initiative. Since the start of Doc Com, they have conducted weekly documentation chart audits with the support of the Clinical Nurse Specialists. Through this process the Champions have gained greater knowledge of the standards of practice for documentation, thereby improving the quality of documentation and identifying areas of improvement with their peers.

Making a Difference Grant Program

Making a Difference Grants Program offers grants up to $5,000 to support employee initiatives that improve the quality of care and services for patients and their families or improve the work life of employees at MGH. Jointly funded by the hospital and the Massachusetts General Physician’s Organization (MGPO), the program has supported more than 100 projects since its inception in 2001. Grants are awarded in the summer with the intent that grant recipients use funds for the quality improvement activities during the upcoming fiscal year. Following are examples of two nurse lead quality improvement projects funded by the Making a Difference Grant Program. A full list of the 2006 and 2007 Making a Difference Grant awards is listed in attachment 7.8.g.

- Communication Boards Help Facilitate Care and Reduce Anxiety

  Staff Nurses on White 11 and Bigelow 11, two General Medical units, identified impaired communication with the nonverbal patient as a common nursing diagnosis for their patient population. This isolating and potentially life-threatening disability can lead to anxiety and stress
not only for the patient, but also for family members and staff. The proposed solution was to add augmentative communication boards to facilitate communication with nonverbal patients. The grant application proposal (attachment 7.8.h) outlined the problem, proposed solution and expected outcomes for this quality improvement project. The units requested and received $450 to implement this project.

- Comfort Carts

  The human passage of dying in an ICU is a unique experience. It is complicated by the fact that when a patient is admitted to an ICU there is an expectation that the patient will be "saved". The awareness that the patient may not live, but will die comes as a shock to both the patients and their families. It is further complicated by the fact that family members have so little time to process this information. Loss, grief, and bereavement can affect the patient, family, and nurses caring for the patient and family. (Taken from the "Making a Difference Grant proposal dated Aug. 25, 2006, submitted by Traci Durkin, RN, Staff Nurse).

  As a result of funds received from the grant, the MICU created the Comfort Cart designed to give staff the tools needed to provide comfort, relaxation, support, and sense of peace for the dying patient and their family. Items available on the carts will be available for all staff to use for patients’ families as needed to help them through the bereavement process. In addition, to the Comfort Carts, arrangements have been made with the Department of Food and Nutrition Service for food trays for the families, if requested. And, parking vouchers will be made available to family members after their loved one has died, so they will not have to pay for parking when trying to leave the hospital after saying good-bye to their loved-one.

  Comfort Cart Items include:
  - Puffs Plus Tissues
  - CDs and a CD player
  - Catholic Bible
  - Protestant Bible
  - Copies of the Koran (Arabic and English translations)
  - Spiritual books
  - End-of-life brochure with resources listed
  - A throw (colored blanket to place over the MGH linen)
  - Handmade quilts (made by the MGH quilters)
  - Colored pillowcases
Backpacks for children with coloring books, crayons, stickers, finger puppets, etc.
Collaborative governance, commitment and Carol Channing

The imitable, Carol Channing, at this year’s collaborative governance celebration
(See Jeannette Ives Eriksen’s column on page 2)
The Center for Innovations in Care Delivery: a cornerstone of The Institute for Patient Care

Over the past few months in a number of forums, I’ve spoken about the new Institute for Patient Care, its mission, and the programs it comprises (see diagram below). The philosophy of the Institute is based on the core competencies articulated by the Institute of Medicine (IOM) in 2002:

- Promote patient- and family-centered care; identify, respect and care about patients’ differences, values, preferences, and needs;
- Relieve pain and suffering; coordinate continuous care; listen to, inform, communicate with, and educate patients; share decision-making; and advocate for disease-prevention, wellness, and healthy lifestyles.
- Work interdisciplinarily teams; cooperate, collaborate, communicate, and integrate care.
- Employ evidence-based practice; integrate research into clinical expertise and patients’ values for optimum care.
- Employ quality-improvement measures; identify errors and hazards; understand and implement basic safety principles; continuously understand and measure quality of care; and design and test interventions to change systems with the objective of improving quality.
- Use information; communicate, mitigate error, manage knowledge, and support decision-making using information technology.

In this column, I’d like to focus on The Center for Innovations in Care Delivery, the newest component of The Institute for Patient Care.

Page 2

Goals for the Institute:
- Foster an environment of clinical inquiry and experiential learning.
- Promote team learning to optimize safe, effective, culturally competent patient care; create an environment that promotes safety for patients, families, and staff.
- Participate in the development and evaluation of organizational initiatives.
- Support the development of a diverse current and future workforce.

The Institute for Patient Care
advancing clinical excellence through collaboration, education and research

Goals (continued):
- Enhance the relevance of research as it relates to public health.
- Support research that advances care that is safe, effective, and evidence-based.
- Provide leadership for innovations in learning for staff, patients, and families.
- Develop, implement, and evaluate programmatic initiatives that impact staff development and organizational effectiveness.
- Make innovations visible through internal and external publications and presentations.

Programs/Initiatives
Collaborative Governance
Clinical Recognition Program
Credentialing
Ethics
Organizational Evaluation
Culturally Competent Care Curriculum
Leadership Development
Visitor Program
Simulation
Awards/Recognition
Workforce Development

The Knight Nursing Center for Clinical & Professional Development
The Maxwell & Eleanor Blum Patient & Family Learning Center
The Yvonne L. Munn Center for Nursing Research
The Center for Innovations in Care Delivery
Attachment 7.8.b continued

Jeanette Ives Erickson
continued from previous page

The mission of The Center for Innovations in Care Delivery is to match interdisciplinary education and research with opportunities to impact care delivery. The intent is to bring teams together to identify opportunities; evaluate the impact of proposed changes; and construct and implement innovations to improve the delivery of care.

We have been fortunate in nursing to have the Yvonne L. Moon Center for Nursing Research to advance our research agenda and the Knight Nursing Center to promote nursing education. My vision for The Center for Innovations in Care Delivery is to bring interdisciplinary research and professional development opportunities to all disciplines within Patient Care Services.

I’m happy to announce that Barbara Blakeney, RN, former president of the American Nurses Association, has agreed to help us in this work. She joins our team as innovations specialist for The Center for Innovations in Care Delivery.

As we launch the new Center, we will be introducing a new role to Patient Care Services: that of site miner. This is a role that has proven effective in other industries, and we hope to capitalize on its success. A site miner is an experienced clinician who networks with other clinicians to identify unexplored opportunities to solve problems, enhance professional practice, improve care, and promote patient and staff safety.

Think of a site miner the same as you’d think of any other miner — someone who ‘prospects’ through raw materials looking for hidden treasures within the ore; and support, he or she transforms that raw material into something precious and valuable.

We will be looking for site miners who:

• have a proven ability to think outside the box
• have strong communication skills
• embrace change
• are familiar with the complex environment of an academic medical center
• are skilled at developing effective interdisciplinary relationships and alliances
• are comfortable when faced with uncertainty or ambiguity

The Center for Innovations in Care Delivery has received a sizable donation (one million dollars) from a donor who wishes to remain anonymous. Thanks to this generous contribution, we will be able to bring clinicians from all disciplines together to think, explore, invent, and create better ways of doing business, better ways of caring for our patients.

The Institute for Patient Care, with all the programs and centers it encompasses, gives us the collaborative infrastructure we need to leverage our talents and resources to meet the challenges of the future. These are exciting times. I hope you’re as proud and eager as I am to be part of this ground-breaking work.

Blakeney joins PCS team as innovations specialist

Barbara Blakeney, RN, joins the Patient Care Services team as innovations specialist in The Center for Innovations in Care Delivery. Blakeney brings considerable expertise in ergonomics and staff safety and will work with staff and leadership throughout Patient Care Services to improve the application of technology, workforce safety, and the practice environment.

Blakeney is the immediate past-president of the American Nurses Association, where she served as chair of the Board of Directors, chair of the House of Delegates, chief spokesperson for the Association, and representative to the International Council of Nurses. Blakeney has served as principal public health nurse for Homeless Services and Addiction Services for Public Health Nursing, and director of Clinical Services with the Long Island Shelter System of the Boston Public Health Commission. She was a member of the Institute of Medicine’s Quarantine Stations at Ports of Entry Committee; the Centers for Education and Research in Therapeutics Steering Committee; the US delegation at the 2003 World Health Assembly; the Nursing Advisory Committee of the Joint Commission on Accreditation of Healthcare Organizations, and she has worked as an adult nurse practitioner for Boston’s Department of Health and Hospitals.

Blakeney has published and presented extensively. She is the recipient of many prestigious honors, including the Pearl Meader Public Health Award and the College of Nursing Alumni Award from the University of Massachusetts. She has also been listed among the top 100 most powerful people in American health care. A Massachusetts native, Blakeney earned her master’s degree in Nursing from the University of Massachusetts.

Blakeney will play an integral part in advancing the mission of the Institute for Patient Care and The Center for Innovations in Care Delivery. Please welcome Barbara Blakeney to Patient Care Services and this exciting new position.
Summary of the Planning and Proceedings of the White 8 and NICU project

Barbara Blakeney, RN (Innovation Specialist); Marita Prater, RN, Margaret Settle, RN, (Nursing Directors); Lauren Kattany, RN, Janet Madden, RN (Clinical Nurse Specialists)

April 20, 2007

The Goal: To empower staff nurses to control their practice at the unit level.

The Plan: To provide to a sub-set of the nursing staff (night shifts) of the NICU and White 8 medical floor 3 tools with which to evaluate practice both prospectively and retrospectively and to continually improve practice at the bedside.

The Tools: Failure Mode and Effects Analysis (FMEA), Root Cause Analysis (RCA) and Rapid Cycle Improvement (RCI)

Failure Mode and Effects Analysis is a prospective process that seeks to identify and proactively eliminate possible errors. It seeks to anticipate problems in design or process, and to take corrective action prior to implementation.

Root Cause Analysis is a retrospective process that seeks to understand why something went wrong and to take corrective action in order to prevent the error in the future. It is retrospective.

Rapid Cycle Improvement is an iteration of the Denning Cycle sometimes called the Plan-do-check-act cycle. This method supports repeated and rapid improvements in practice to optimize patient care.

The Process: Leadership (Nursing Directors and Clinical Nurse Specialists) from White 8 - Marita Prater RN and Lauren Kattany RN and the NICU-Peggy Settle RN and Janet Madden RN met several times with Barbara Blakeney RN from The Center for Innovations in Care Delivery to plan a program that would provide the staff with tools to better assess, manage and enhance their practice. Discussion began with the focus on the Toyota model, however, a literature review suggested this model needed to be a top down approach and thus was abandoned. Barbara researched the tools and brought the recommendation to the group that the FMEA and RCA models be used. Later in the discussion it was decided to add RCI.

The plan evolved to include a full day retreat during which the group would be exposed to FMEA and RCA. They would choose an issue or problem from their unit and spend 6 weeks using one of the tools to help analyze the problem in depth and develop a plan of action. At the end of the 6 weeks the group would reconvene, and present their work to each other for critique and next steps.

At this point the staff would learn about the third tool-rapid cycle improvement.

The retreat was held on April 6, 2007 and the groups from the two unit came together well. The getting to know you exercise lead to some easy banter between the units and the discovery that while one unit dealt with “little people” and one dealt with adults, there were many similarities.
The fundamentals of FMEA and RCA were presented and discussed. The group broke for lunch and returned to move into unit based groups.

White 8 Staff Nurses identified communication as their issue. They began prior to the meeting by identifying their top three concerns and bringing that list to the retreat. The list included such issues as incomplete packets of patient information, i.e., incomplete treatment records, Discrepancies in roles, lab slip issues and staff assignments. The nurses have chosen the FMEA process to address issues of communication. At the end of their session they had framed the broad outlines for their work.

The NICU Staff Nurses identified a problem with PICC lines. Because of the size of their patients, the lumen is very small. Additionally, because of the material that the PICC is made of, the lumen wall is very thin. These two factors create a risk of rupture or shredding of the line when pressure of any kind is applied, and this risk is significantly increased when manual pressure is applied when flushing the line. Different nurses will determine that the same line is patent, sluggish or blocked. The question is how to standardize the amount of pressure applied, and there is also a desire to remove the nurse’s subjective opinion from the process. The nurses wish to explore the use of Medex SMART pump to administer flushed fluids. They have chosen the FMEA process and by the end of their session had framed the broad outlines of their work.

The meeting concluded with the groups presenting their issues and the basic work that was done in the breakout session.

Next steps were discussed.

- Work in the ensuing 6 weeks to continue to define the problems and explore possible solutions by using the FMEA method
- Develop basic skills in using the FMEA method
- Possible presentation in Innovation Rounds
- Possible opportunity to share with other units
- Perhaps publish in Caring or some other communication tool

The debriefing at the end of the day was universally positive. Comments such as

- “This was great—I have some tools and a way to address problems”
- “We aren’t really as different as we thought we were.”
- “I feel like I can be part of the solution.”
-----Original Message-----
From: Osborn, Lynn R.
Sent: Friday, July 20, 2007 5:06 PM
To: Settle, Margaret D., R.N.
Cc: Brady, Thomas J., M.D.; 'Hong Ma'; 'Culpepper, Marty - MIT'; Ford-Carleton, Penny F
Subject: MIT/CIMIT Biomedical Devices Design Laboratory

MIT/CIMIT Biomedical Devices Design Laboratory

September - December 2007

Congratulations! Your clinical problem **PICC Patency Assessment** is a finalist for the MIT 2.75/2.996 Biomedical Devices Design Laboratory. The goal of the course is for graduate student teams to engineer and build a prototype solution in one semester to the problem you present. Below is an overview of your involvement in the course.

1. Preparation
   Two page description with sketches or figures by **August 31, 5 PM**.

2. First Session - Physician Presentation
   
   Audience: professors Marty Culpepper, Hong Ma and engineering graduate students. The students will choose their project based on your presentation. There are two possible times in September dedicated to physician presentations to the students.

   **Please advise your preference for presentation date and time.**
   **Monday, September 10, 11 - 12:30 PM**
   **Or**
   **Monday, September 10, 5 - 7 PM**

   **Presentation Format**
   10-minute presentation
   Very Brief background
   Problem definition:
   - Existing approaches
   - Name and contact particulars for lab
   - 10 minutes Q & A and discussion

3. Student research and analysis - 10 weeks
   
   Be available for students
   Students will be working in teams of 5
   Students will need a point of contact for questions
   And to arrange visit(s) to laboratory
   Goal is to build a prototype

4. Student Presentation at MIT - Early December - to be scheduled
   
   Team presents proposal to class
   Team responds to questions from classmates (important to let the students answer questions)
   Physician provides concluding remarks
5. CIMIT Forum Presentation - at MGH - March 3 and 10, 4 - 6 PM
Physician and student teams present at the CIMIT Forum

Please let me know if you have questions. We are looking forward to a lively semester.

Sincerely,

Lynn

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Proposal to Replicate the Ellison 14 Therapeutic Touch Program: 
Implementation and Evaluation of a Therapeutic Touch Program in the Blake 7 Medical 
Intensive Care Unit (MICU)

May 22, 2007

Background

The Medical Intensive Care Unit (MICU) is an 18-bed medical intensive care unit. The patients are primarily non-cardiac medical patients with acute respiratory failure, sepsis, and a variety of other life-threatening conditions. The clinical leadership, medicine, nursing, respiratory therapy and social work are committed to ensuring that the MICU is Family and Patient Centered. The nursing staff delivers primary care to these patients. Recently, the staff in the MICU completed a three-year project titled “Merging Palliative and Critical Care Cultures in the Medical Intensive Care Unit. This project, partially funded by the Robert Wood Johnson Foundation (RWJF) was a multifaceted quality demonstration project designed to improve the care of patients who were critically ill and nearing the end of their lives. (Billings, Keeley et. Al., 2006)

Approximately twenty percent (n=193) of patients die each year in the MICU. This mortality rate is slightly less than the national average. A variety of interventions were part of the project. They included for example, collaborating with Palliative Care Clinicians, educating nurses as Palliative Care Champions, opening visiting hours, teaching about and promoting family meetings.

Proposal:
The MICU nursing leadership would be interested in replicating the study “The Experience of Implementing and Evaluating a Therapeutic Touch Program on Ellison 14” Replicating the study would facilitate the unit nursing leadership’s goal to shift nursing practice from a disease state focus to personhood focus and to integrate the nursing practice-research-theory linkages.

Benefits to Unit
The staff involved would offer therapeutic touch to anyone who requested it but the focus of the program would be on the patients who were identified as moving from cure to care mode. It would benefit the unit by improving the care that is delivered to families and patients who are at the end of their lives. In addition, it is expected that the nurses’ experience with therapeutic touch will have beneficial outcomes for themselves also.

Personnel
The following nurses have been identified for the study: Mary Lauriat R.N., Gloria Gilson, R.N. (Staff Nurses), Lillian Ananian, R.N. (Clinical Nurse Specialist) and Edward Coakley, R.N. (Center of Innovations). Two other staff nurses will also be involved. These nurses have yet to be identified.

Attachment 7.8.f continued

Documentation of the Plan of Care

There is no reference to the plan of care by nurses.

- The priority is on individual components:
  - Assessment
  - Problem List (Interventions and Outcomes)
  - Nursing Progress Notes

Nurses state that documentation of the progress helps them to utilize critical thinking skills.

- Information is in the chart, but it is fragmented and documents do not appear to be linked.
- Documentation rarely reflects problem resolution.
- Frequently, a new Problem list is initiated as the patient is transferred from unit to unit.

Nursing Documentation

- There is a lack of documentation of the ongoing discharge plan by nursing.
- Progress Notes are written in both problem and system-oriented models.
- Even within one patient record, there is variation from nurse to nurse and shift to shift.
- Progress Notes are written with a shift focus, resulting in a lack of real-time documentation.

Communication of Clinical Information

- Hand off (shift report) methods and tools are inconsistent between units (departments) with varying degrees of staff satisfaction.
- Kardex’s used for hand offs contain valuable data that are (in) not recorded in the permanent medical record (i.e., system assessment, discharge planning).
Attachment 7.8.f continued

Communication of Clinical Information (cont)

- Nurses report satisfaction with utilization of the Kardex; for report followed by brief verbal updates; nurses not utilizing a Kardex verbalized that report is time consuming

Break Out Session: Nursing Practice

Gordon's Functional Health Patterns

- Pattern of Health Perception & Health Management
- Nutritional - Metabolic Pattern
- Pattern of Elimination
- Pattern of Activity & Exercise
- Cognitive - Perceptual Pattern
- Patterns of Sleep & Rest
- Pattern of Self Perception & Self Concept
- Role - Relationship Pattern
- Sexuality - Reproductive Pattern
- Pattern of Coping & Stress Tolerance
- Pattern of Values & Beliefs

Breakout Session: Nursing Practice

- Question to Answer:
  - Independent of physician orders, what kind of care would you as a nurse provide to your patients?
  - What patient outcomes would you impact?

Nursing Practice Break-Outs Summary

- Independent of physician orders, what kind of care would you as a nurse provide to your patients?
- Advocacy for the patient
- Understanding needs, goals of care
- Physical limitations and ADA
- Work in facilitating the patient & family
- Parent education
- INSTRUCTIONS for care
- Interpret medical information
- Coach self-care environment
- A nurse's patient-specific issues and medication (e.g., oxelabor)
- Keep patient files in areas and preserving patient privacy
- Increase patient's perception of quality care
- Decrease patient and family pain patient interactions
- Increase ability of patient to participate in care
- Personal and family issues
- Manage patient expectations

Three Focus Areas Have Been Identified For the Morning Design Session

Plan of Care: Nursing Database

Accountability for Plan of Care

Communication: Shift Report

Health Improvement
Accountability for Plan of Care

- Could "also assign" new grad RNs in a Care Team with primary preceptor for a Career Plan shared with everyone on the team including the Charge Nurse to meet learning needs.
- Will need to address culture issues and expectations about what a new orientee transitioning off should be able to do and what continued support is needed.
- Orientee’s duties: understanding the continuity of care.

Accountability for Plan of Care

- Would this change certain aspects of the Charge Nurse role? May be more effective to have nurses assign tasks.
- WHO can be a "Care Leader"?
- Agenda need to work closely with Resource Nurse role in long-range assignment planning.
- Can support a new nurse in learning the "Care Leader" role by pairing with experienced nurse and support of resource nurse.

Accountability for Plan of Care

- Nurse who admits patient has to make decision at that time if they can be the "Care Leader" based on patient's needs, estimated length of stay and discharge plan.
- At time of admission, admitting nurse works with Resource Nurse to identify "Care Leader" and team if admitting nurse is unable to be leader and/or decide who should do admission.
- Use White Boards to identify Care Leader and Care Team.

Accountability for Plan of Care

- Care Leader assignment should be a priority.
- Assignment sheet has to have a 24-hour form from the perspective of care team assignments.
- Need to do continued work to amend addressing cultural perspectives that impact unit assignments, patient care perspective of care team.
- Barriers - guidance to change - change would need to be thoughtful.
- Support around accessibility of plan of care will be needed.

Workforce Transformation: Change Management

- The source of resistance comes from resistance to change:
  - Want to maintain control over the change.
  - Fear of change.
  - Lack of communication or coordination.
  - Inability to control the change.
  - A lack of understanding about the change.
  - Fear of change.
  - Unwilling to let go of their care.

Workforce Transformation: Change Management (cont.)

- Target "stakeholders" to have staff nurses who are change leaders.
- Pertain staff nurses with change champions.
- In terms of change - a step-by-step guide to the manager to make the change.
- Assessment of change and make sure that the methodology supports the development of education and coaching tools.
- Incorporate a change Plan and make sure to track some metrics.
- Establish a timeline and document milestones.
- Answer questions from staff: "Will this be implemented?"
- Plan for resistance to change: what to expect it will be explored.
- Demonstrate face-to-face groups with other medical-arts feedback.
- Pair planned forms in more meaningful team groups.
- Guiding Coalition: a pull together and build team that are struggling.
- Nursing Grand Rounds educate about future care.
**Workforce Transformation: Change Management**

- **Vision:** "At MGH, systems and processes are designed to support the nurses' ability to provide excellent nursing care and ensure that the patient's story travels with him/her across the care continuum."
- **Leadership Focus:**
  - Culture Shift from a Unit-Based View of the Plan of Care to a Global View of Plan (across the continuum)
  - Clinicians Will Communicate the Change Messages
  - One Standard of Care

**Recommendations: Workforce Transformation**

- **Change Management**
  - Leadership Focus
  - Culture Shift from a Unit-Based View of the Plan of Care to a Global View of Plan (across the continuum)
  - Clinicians Will Communicate the Change Messages
  - One Standard of Care

**Nursing Communication & Documentation Vision:**

"At MGH, systems and processes are designed to support the nurses' ability to provide excellent nursing care and ensure that the patient's story travels with him/her across the care continuum."

**Attachment 7.8.f continued**
Making a Difference Grants

2006 Recipients

- “Pediatric Epilepsy: an Education Program on Behalf of Children and their Families,” Amy Morgan, PhD - Pediatric Epilepsy Program
- “Teen Oncology Support Group,” Heather Peach and Suzanne Rose, RN - MGH Cancer Center
- “Individualized Education for Patients with Heart Failure,” Susan Stengrevics, RN - Cardiology (Force 11.9)
- “The Sensory Room: a Therapeutic Respite,” Tina Gulliver, RN - Inpatient Psychiatry (Force 3.5)
- “The Roger H. Sweet Patient and Family Learning Center,” Claire Conlan, Peggy Carolan, Eileen McAdams RN - MGH Charlestown Health Center
- “Removing Communication Barriers for New Moms and their Nurses,” Victoria Baldasarre, RN - Vincent Obstetrics
- “Patient Survey Results: Helping to Guide Resident Physicians,” Blair Fosburgh, MD, Karen Bruynell - Internal Medicine Residency Program
- “Pagers Help Families Stay Connected,” Stella Moody - Vincent Obstetrics
- “Communication Boards Help Facilitate Care and Reduce Anxiety,” Susan Wood, RN - General Medicine Nursing (Force 7.8)
- “Creating Innovative Exercise Options for Children with Cystic Fibrosis,” Denise Montalto, PT - Physical Therapy
- “Helping Families and Providers Cope with the Loss of a Child,” Pat O’Malley, MD, and the Pediatric End of Life Task Force
- “Looking to the Future: Advancement Opportunities for Front Line Staff,” Rosemary Crowley - Practice Support Unit with the MGH Revere Health Center
- “An Unfailing Commitment to Preventing Infant Abduction,” Phil Stewart, Joe Crowley, Lori Pugsley, RN - Police, Security & Outside Services and the Vincent Obstetrics Service
- “Educational Program for Patients After Amputation of a Limb,” Cheryl Brunelle, RN - Nursing
- “Operation Save a Life,” Laurie Petrovick - Trauma Center, Surgery
- “Pediatric Orthopaedic Service Creates Videos for Patient Education,” Erin Hart, NP, Maurice Albright, MD - Pediatric Orthopaedics (Force 8.6)
- “Nurturing Nurses: The Relaxation Response,” Catherine Calder, RN - Nursing (Force 9.3)
- “Therapeutic Activity Kits,” Kate Barba, RN, Patti Fitzgerald, RN, Catherine Downing, RN - Nursing
- “An Underwater Adventure in the Same Day Surgical Unit,” Pam Wrigley, RN - Same Day Surgical Unit
- “Helping Patients Self-Manage Heart Failure” Susan Lozzi, BSN; Dottie Noyes, NP - MGH Revere Health Center
2007 Recipients

- "Sensory Room/Area in APS", Colleen Desmond – Acute Psychiatry Service/Psychiatry (Force 3.5)
- "MGH Charlestown ‘Your Health Care Folder’ for Adult Medicine Patients”, Eileen McAdams, RN - Charlestown Health Care Center
- “Coping and Distraction Resources to the Rescue”, Ashley Laliberte - Child Life, Ellison 17
- “Diabetes Blood Glucose Workstation”, Elizabeth Belcher - Diabetes Center
- “Relaxation Channel for MGH Closed Circuit TV”, Shelly Bazis, NP, Catherine Calder, RN -Decision Support Unit & Nursing (Force 8.7)
- “Be Fiscally Fit”, Leslie Strachan – Employee Assistance Program
- "Meeting Patient Education Needs through Popular Technology”, Sally Hooper, Barbara Cashavelly, RN, Karin Hobrecker, Judy Tarselli,RN, Denise Whall-Strojwas, RN, Martha Lake-McNulty,RN, Gwendolyn Mitchell, LPN, Lourdes Sanchez, Mary Ellen Heike,RN, Jennifer Duran - Interdisciplinary: Social Service, Cancer Center, Interpreter Services, Nursing
- “Improving Crisis Control in Surgical and Medical Patients in the PICU”, Josephine Lok, MD – Medicine & Pediatric Critical Care
- “The Bigelow 9 Recreational Activities Collection”, Danielle Dumas, RN, Susan Gavaghan, RN, Lauren Cosgrove, RN, Mary Findeisen, RN - Nursing, Bigelow 9
- “Ventilator Family Education Booklet”, Susan Gavaghan, RN, Lori Powers,RN, Mary Findeison, RN, Allison Miller, RN, Kristen Brescia, RN - Nursing, Bigelow 9
- “The Solitude Room”, Mary Guanci, RN, Melissa Thurston - Nursing, Blake 12
- “Family/Friend Locator Program”, John Murphy, RN, Melissa Thurston -Nursing, Blake 12
- “Remembrance Gift”, Melissa Thurston - Nursing, Blake 12
- A Model Family Bereavement Program in the MICU, Ed Coakley, RN, Nursing, Blake 7 (Force 7.8)
- “Measuring Pitchers for Heart Failure Patients”, Susan Stengrevics, RN & Caregivers on Ellison 10 - Nursing, Ellison 10 (Force 9.3 & Force 11.9)
- “Diabetic Education Bedside Model”, Marian Jeffries, RN, Jacqueline Collins, RN - Nursing, Ellison 16
- “L.A.P.T.O.P. - Laptop Accessibility Provided to Oncology Patients”, Mimi Bartholomay RN - Nursing, Infusion Unit
- “Artwork on a Medical Unit: The Effect on Patient and Staff Satisfaction”, Gerry Cronin, White 9
- “Slave Terminals for OB Ultrasounds”, Toni Hurton - Obstetrics
- “Comfortable Inpatient Waiting for Radiation Treatment”, Carey Palmquist - Radiation Oncology
- “Is Your Relationship Affecting Your Health”, Bonnie Zimmer, MSW & Domestic Violence Working Group - Social Service
2006 MGH Making a Difference Grant Application

Submitted by:
Susan Wood RN
Clinical Nurse Specialist
Nursing Department
White 11
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Managers Name: Susan Morash RN, Nurse Manager White 11

Department Head: Theresa Gallivan RN, Associate Chief Nurse

Problem Statement:
It can be extremely frustrating for patients who are unable to verbally communicate their needs due to disorders impairing communication. This isolating and potentially life-threatening disability can lead to anxiety and stress not only for the patient, but also for family members and staff. A recent study published in Heart and Lung shows that a majority of patients who need to be mechanically ventilated experience high levels of frustration with their inability to effectively communicate their needs. The undue stress and anxiety as well as potential complications caused by a communication barrier can subsequently affect the treatment and experience of the nonverbal patient and possibly lead to a prolonged hospital stay (Patak et al., 2004).

The nursing staff on White 11 has identified impaired communication with the nonverbal patient as a frustrating problem that has impacted patient care. Due to the increasing complexity of the medical population, medical nurses have increasingly been exposed to the nonverbal patient. Education and augmentative communication tools have been a focus in the ICU and neurologic settings but have not been regularly implemented on general medical units. General medical units care for a broad range of patients which would benefit from augmentative communication tools including AIDS, Amyotrophic Lateral Sclerosis, Autism, Cancer, Cerebral Palsy, diseases of the larynx, head injury, stroke, and other chronic and neurodegenerative disorders that lead to communication impairment.

Proposed Solution:
To add augmentative communication boards to facilitate communication with nonverbal patients. In-services on caring for the nonverbal patient and use of the communication board will be provided to participating units. In-services should focus on research-based strategies for communicating with nonverbal patients. • Nursing staff should be educated regarding the level of frustration that nonverbal patients experience when communicating
• Nursing staff should routinely ask patients short, “yes” and “no” questions about their feelings and state of mind
• Nursing staff should be attentive to the nonverbal patients, inform them of the plan of care, and establish a return time when they leave the bedside
• Approach patients with a kind and patient demeanor, and investigate their communication needs
• Provide writing materials and read the patient’s words as they write (Connolly et al, 1991)

In-service education surrounding the care of the nonverbal patient is required as well as the tools needed to assist the RN in communicating with the nonverbal patient. These tools include communication boards.

The proposed augmentative communication boards contain a dry erase board where the patient can express their needs. The communication board holds a body chart that allows the nonverbal patient to point and identify location. Adjacent to the chart lies a column of several words describing type and degree of pain. This feature enables the patient to clearly articulate their affected body part and degree of pain. The boards will be available in English and Spanish assisting in the care of the nonverbal, Spanish speaker. Augmentative communication boards will help nurses clearly identify nonverbal patients needs, feelings, and state of mind diminishing feelings of isolation and frustration in the nonverbal patient. These boards will also be an important tool in obtaining the nursing assessment, aid in communication with other disciplines and ultimately facilitate in discharge planning.

**Expected Outcome:**
Qualitative data will be compiled from informal staff and patient interviews. We expect easier and more accurate expression of patient needs, as well as decreased frustration of patient, family and nursing staff caring for the nonverbal patient.

**Measurement of Impact/Outcomes:**
Evaluation of the boards will be achieved through feedback from staff, patients and families. Registered nurses and families should express decreased frustration in caring for the nonverbal patient. The nonverbal patient should report decreased frustration and isolation. Registered nurses should report improved communication.

**Amount Requested:**
To purchase communication boards for two general medical floors, White 11 and Bigelow 11, as a pilot, which could potentially be expanded to other units if boards are found effective.
Attachment 7.8.h continued

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Itemized Budget:
- a) English Language Board- Qty 50 $237.50
- b) Spanish Language Board- Qty 25 $118.75
- c) Extra Wet- Erase Markers- Qty 100 $85.00
  TOTAL $441.25

Time Frame:
It is expected that this entire project will take 3-6 months to implement boards
and in-service units.

Grant Submitted by:

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Extension x43747

Susan Morash RN
Nurse Manager, White 11
Extension x63031

Department Approval:

Theresa Gallivan RN
Associate Chief Nurse, Ext: 6-2596

related to communication during mechanical ventilation. *Heart & Lung: The Journal of Acute and Critical Care*, 33(5),
306-309.

Nursing*, 19(2) 115-22.

*Topics in Geriatric Rehabilitation*, 10(2):56-70.