5.7 Describe innovations by direct care nurses to implement the model of care and to meet the needs of specific patient populations at the unit level.

Massachusetts General Hospital (MGH) nurses are empowered to create practice guidelines, teaching materials and screening tools to facilitate their ability to meet the specific needs of their patients. The following examples illustrate an array of innovations.

Women and Children Services

Family-Centered Care is part of the philosophy of the Women and Children Services at the MGH. The nursing staff receive training about this philosophy and are expected to incorporate these ideals into practice. Examples include:

- **In-room parent sleeping accommodations:**
  - Both the newly-renovated Neonatal ICU (NICU) and Pediatric ICU (PICU) have been designed to include family sleep space. Recliners are in the rooms for parents to sleep. Ninety percent of the rooms have this capacity. This allows parents to remain with their children as much as desired or clinically indicated.
  - Rooms also have lockers for parents to store their belongings.

- **NICU:** There is no longer a restriction on the number of visitors allowed at one time.

- **Obstetrics and Same-Day Surgical Unit:** Pagers are given to the families so that staff are able to page families for any updates, issues, answering questions, etc. when the family is not on the unit. This provides families, or extended families, with peace of mind to step away from the unit for coffee or a break and still remain in touch with the care unit. This also creates a sense of belonging to the unit among family members.

- **Blake 13 and Ellison 13 Post-partum:** On these units, care is brought to the patients. Infant baths, vaccinations, hearing tests, etc. are all done in the mothers’ rooms as opposed to transporting the patients to different departments to have these tests or procedures done. This allows for the mother to observe and learn. This is called couplet care – uniting mother and baby. Of course this model doesn't neglect new fathers and a common sight on these units is to see both parents giving their new baby a bath, wrapping him or her in a towel warmed by a portable towel warmer, and father or mother cuddling an undressed baby “skin-to-skin.” (See Force 12.6, attachment 12.6.g for coverage of couplet care reported in The Vincent Memorial Hospital 2006 Annual Report.)
Neuroscience Services

Nurses and Speech Language Pathologists worked together to develop a swallow screen tool (attachment 5.7.a). In a recent national study, aspiration numbers were reported to be high, particularly in neuroscience patients. Speech Language Pathologists and the Neuroscience Clinical Nurse Specialists educated the nursing staff in all the neuroscience units how to determine which patients are at risk for aspiration. As a result, all nurses screen patients for their ability to swallow before anything is ingested by mouth.

Cardiac Services

In order to provide consistency and decision support for the nursing assessment and care planning for cardiac patients, the Cardiac Nursing Practice Committee developed the Cardiac Patient Problem List (attachment 5.7.b). This was a collaborative effort inclusive of all subspecialty groups within cardiology and cardiac surgery. The Committee is in the process of making this problem list available on the Intranet for use by nursing staff outside of cardiology.

Emergency Department

The nurses in the Emergency Department (ED) have championed the practice of family presence during resuscitation. In the event that a patient in the ED requires resuscitation, the family is able to remain in the room, witness the course of events and participate in decision-making. Support for families is available during and after the event. A specific protocol has been developed (attachment 5.7.c) to ensure that optimal outcomes are achieved.

Ellison 10 Cardiac Telemetry

The nursing staff on Ellison 10 Cardiac Telemetry and their colleagues from the other healthcare disciplines, developed a teaching guide for patients with Congestive Heart Failure. The “Notebook” (attachment 5.7.d), (only the cover is attached; full notebook available on-site) contains a wealth of information intended to help the patient understand and manage their chronic disease. Content includes: specific disease related information, diet and lifestyle recommendations, and medication guidelines.
Attachment 5.7.a

MGH Swallow Screening

Patient: ___________________ Date: __________
Time: __________

Part 1: Patient demonstrates:
- wakefulness
- unlabored breathing
- upright posture
- clean mouth

(All four must be present to move on to Part 2)

If not, **FAIL - keep NPO** due to inability to complete Part 1 and re-screen when able

Part 2: Score patient’s function on the following 5 items (check the appropriate box):

<table>
<thead>
<tr>
<th>Present</th>
<th>Absent</th>
<th>NT</th>
<th>Score</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>normal tongue movement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>volitional cough</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>good vocal quality</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>normal pharyngeal sensation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>able to swallow water without cough</td>
</tr>
</tbody>
</table>

**Final Score**

If final score is 1-4, **FAIL**
If final score is 5 or 6, **PASS**

Final Scoring:
- **FAIL** (score ≤ 4) – make patient NPO and order SLP consult
- **PASS** (score > 5) – give patient regular diet and observe for first meal
- **FAIL** (override based on clinical judgment) – make patient NPO and order SLP consult

Signature ______________________________
Circle One:  MD    PA    RN    NP
<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Problem Description</th>
<th>Problem</th>
<th>Action Plan</th>
<th>Re:rd</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Problem: Altered Tissue Perfusion Related to (check one): ischemia; sepsis; anemia; arrhythmias; ___________</td>
<td>Altered Tissue Perfusion</td>
<td>Outcome: Patient will maintain adequate tissue perfusion throughout hospitalization.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Interventions:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A.</td>
<td>Assess vital signs including heart rate, rhythm, and blood pressure and temperature.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>C.</td>
<td>Maintain IV access.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D.</td>
<td>Document and record arrhythmias in chart.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>E.</td>
<td>Monitor electrolyte levels and replace per MD/NP orders.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>F.</td>
<td>Observe for fluid volume overload or deficit. Strict I and O. Daily weights on same scale. Identify dry weight.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>G.</td>
<td>Maintain low cholesterol, low saturated fat, low sodium diet and fluid restrictions as ordered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>H.</td>
<td>Cardio-Assist Devices per protocol (ABP, VAD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.</td>
<td>consult as needed. Nutrition Services: FT: OT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>J.</td>
<td>Signature:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Problem: Pain due to: Anginal; musculoskeletal strain; incision; immobility; other: Description / Location:</td>
<td>Pain</td>
<td>Outcome: Pain is absent / controlled. Pain score &lt; 3 or acceptable to pt., HR, RR, BP well for pt.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Interventions:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A.</td>
<td>Assess Pain using a 0-10 scale per unit standards; location, intensity, quality and duration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>B.</td>
<td>Medicate for pain as needed and ordered, reassess pain as indicated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>C.</td>
<td>Control Anginal pain with pharmacological agents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D.</td>
<td>Employ alternative therapies (i.e. music, massage, repositioning, distraction, imagery).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>E.</td>
<td>Reposition frequently &amp; scrupulously to prevent pressure sores. Identify a comfortable position for patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>J.</td>
<td>Signature:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Problem: Risk for Injury; bleeding related to: ___________ anticoagulation; ___________ invasive procedures; HIT.</td>
<td>Bleeding</td>
<td>Outcome: Patient is free of symptoms of bleeding / hemorrhage, as evidenced by hemodynamic stability throughout hospitalization.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Interventions:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A.</td>
<td>Assess vital signs, mental status, and urine output for evidence of adequate perfusion every shift.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>B.</td>
<td>Assess of vascular access site for bleeding. Vena cava and peripheral perfusion: color, sensation, motor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>C.</td>
<td>Assess back, flank or abdominal pain for vascular complications.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D.</td>
<td>Maintain invasive lines ASA™ when HP/L AT in appropriate range.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>E.</td>
<td>Maintain heparin and abciximab infusions based upon access site.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>F.</td>
<td>Ambulate and increase activity levels as tolerated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>G.</td>
<td>Administer anticoagulants and monitor therapeutic measures (APTT, INR, ACT).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>J.</td>
<td>Signature:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Attachment 5.7.b continued

MASSACHUSETTS GENERAL HOSPITAL

PATIENT PROBLEM / OUTCOME / INTERVENTION SHEET:

The Cardiac Patient

No. Date D/d Problems Report

4

Problem: Impaired Gas Exchange due to: ___ Ineffective Airway Clearance; ___ Poor perfusion;
___ Infection; ___ Shunting; ___ Sedation/Anxiolism; ___ Sleep Apnea; ___ other

Outcome: Gas exchange will return to baseline.

Interventions:
- Assess drowsiness, sleep rate, oxygen saturation, lungs sounds, and acid-base balance. ABG's
- Assess Hydration status
- Administer Oxygen therapy, nebulizers and inhaled based upon oxygen saturation and MO order
- Section as needed with order in non-ventilated patients
- Assist with coughing, deep breath, incentive spirometry
- Position for optimal gas exchange, facilitate coughing and prevent aspiration
- Consult Respiratory Therapy, in setting of CRAP and BPRF device use

Signature: ________________________________

5

Problem: Glycemic Management.

Outcome: Patient will achieve glycemic control.

Interventions:
- Monitor blood sugars, Hgb A1c
- Identify goal blood sugars
- Ensure appropriate dietary intake
- Administer pharmacological agents as ordered
- Provide patient and family teaching as appropriate (diet, medications, insulin injection, wound assessment, health management)
- Consult Nutrition Services as needed

Signature: ________________________________

6

Problem: Risk for Injury due to falls during hospitalization.

Outcome: Patient will be free from injury due to falls during their hospitalization.

Interventions:
- Assess risk to fall on admission, once daily and with status change using the Morse Fall Scale
- Assess forarthritic/hypertrophic knee as indicated
- Assess level of sedation/cognitive changes from medications
- Utilize Fall signs, rest precautions, reorientation strategies (signs and notes to remind patient to get assistance before getting out of bed), and use least restrictive means to promote patient safety; roll bed in chest, head in line position, head soft frame, turn bed schedule
- Institute visual checks: Check patient every __ nighhour
- Place patient in room within visual and earshot of high traffic areas
- Clear the "path to the bathroom" before ambulation and sleep periods
- Detach unnecessary equipment from patient as soon as possible
- Institute Injury prevention for staff and patients i.e., utilize patient's assistive equipment, rolling IV pole, non-slip footwear
- Provide Family education and involvement in plan of care to manage fall risk (family brochure)
- Consult PT, OT, Case Management as indicated

Signature: ________________________________
<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>
| Problem: Infection  
Outcome: Pt.will be free of signs and symptoms of infection  
Interventions:  
- Assess temp. & rigors, WBC count  
- Hand Hygiene  
- Maintain "Tight" glycemic control, identify blood sugar goal  
- Institute Ventilator Acquired Pneumonia precautions: HOB >30 degrees, mouth care with chlorhexidine  
- Administer Pneumovax and Flu vaccination  
- Signature:          |
| 9   |     |
| Problem: Alteration in Mental Status due to ___ Stroke, ___ Dementia, ___ Alcohol withdrawal, ___ Metabolic, ___ Sedation.  
Outcome: Pt.will be assessed early and offered preventative or secondary interventions as needed.  
Interventions:  
- Assess mental status with the Mini-mental exam as soon as an alteration is suspected (baseline assessment would be portable)  
- Assess neuro vital signs every two hours until stable if local deficits are assessed  
- Consult Stroke Team in collaboration with MD/NP  
- Follow recommendations in Alcohol Withdrawal or Delirium guidelines  
- VAP precautions  
- Neurology or Psychiatry Consult as needed  
- Consult Case Management as needed  
- Signature:          |
| 10  |     |
| Problem: Knowledge/return to hospital routine, illness trajectory, diagnostic tests and treatments  
Outcome: Patient will verbalize understanding of hospital routine, illness trajectory, diagnostic tests, and treatments.  
Interventions:  
- Assess patient/family level of understanding illness trajectory, diagnostic testing, invasive and surgical procedures; treatments, readiness to learn, and preferred learning method  
- Clear patient/family to casual and routine, equipment, call light  
- Instruct and provide written or visual material on medications and follow-up care  
- Document on the Interdisciplinary Patient and Family Teaching Record or in medical record  
- Utilize Skilled Patient and Family Learning Center  
- Signature:          |
| 10  |     |
| Problem: Risk for/Impaired Skin Integrity due to ___ Sepsis, ___ Immobility, ___ Trauma, ___ Pressure, ___ Dressing, ___ Incontinence.  
Outcome: Skin is intact or wound shows signs of granulation & improvement throughout hospitalization.  
Interventions:  
- Inspect skin every 8 hours for pressure injury and document on flowsheet or in progress note  
- Turn in regulation every 2 hours, increase mobility and readiness to the extent possible  
- Avoid shearing forces by lifting with pull sheet  
- Special bed A / or chair surface per algorithm and unit-based CNS consult  
- Consult Nutrition as needed to optimize nutritional status  
- Provide wound care per order and recommendations  
- Consult Case Management as needed  
- Signature:          |
### Problem 11

**Problem:** Nutrition: less than bodily requirements due to: ___ nausea; ___ ileus; ___ increased metabolic needs; ___ required swallow; ___ increased amylase.

**Outcome:** Dietary intake will meet metabolic requirements as evidenced by stable weight, serum albumin & lymphocyte counts; wound healing.

**Interventions:**
- Assess ability to swallow
- Check bowel sounds every shift until elimination normalizes
- Provide small, frequent, high-carbohydrate meals for nauseated patients; administer antacids as needed
- Institute calorie count for patients with decreased intake
- Consult Nutrition Services
- Consult Speech and Language Pathology
- 

**Signature:**

---

### Problem 12

**Problem:** Sleep Pattern Disturbance due to ___ sensory overload; ___ environmental changes; ___ pain; ___ anxiety; ___ elimination; ___ inactivity.

**Outcome:** Patient will return to pre-hospital sleep pattern.

**Interventions:**
- Assess sleep pattern; duration and quality
- Hydrouse routine
- Organize procedures to avoid disturbance during sleep period
- Limit daytime rest periods if excessive
- Avoid evening activities if possible
- Educate on activity program
- Medicate for pain as needed
- 

**Signature:**

---

### Problem 13

**Problem:** Activity intolerance due to: ___ dysrhythmias; ___ dyspnea; ___ anemia; ___ post-op pain.

**Outcome:** Patient will progress toward pre-admission level of activity.

**Interventions:**
- Assess for dysrhythmias, hemodynamic changes, dyspnea associated with activity
- Progress activities based on pt tolerance, hemodynamic response, fatigue level
- Teach balance of activity and rest in keeping with baseline level of functioning
- Consult: ___ PT, ___ OT, ___ Case Management
- Medicate for pain as needed before activity
- 

**Signature:**

---

Page 4 of 8
## PATIENT PROBLEM / OUTCOME / INTERVENTION SHEET:

**The Cardiac Patient**

### No. Date

<table>
<thead>
<tr>
<th>Description</th>
<th>Intervention Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Problem: Ineffective Coping Related to anxiety&lt;br&gt;Note: Coping strategies will be identified and used throughout the hospitalization.&lt;br&gt;Interventions:</td>
</tr>
<tr>
<td>15</td>
<td>Problem: Ineffective Family Coping&lt;br&gt;Note: Coping strategies will be identified and used.&lt;br&gt;Interventions:</td>
</tr>
<tr>
<td>16</td>
<td>Problem: Discharge Planning&lt;br&gt;Note: Patient will be discharged to safest situation with appropriate support.&lt;br&gt;Interventions:</td>
</tr>
<tr>
<td>17</td>
<td>Problem:</td>
</tr>
</tbody>
</table>

### Signature:

<table>
<thead>
<tr>
<th>[Signature]</th>
</tr>
</thead>
</table>
### PATIENT PROBLEM / OUTCOME / INTERVENTION SHEET:

**The Cardiac Patient**

Name and Unit Number are to be written distinctly when plate is not available.

<table>
<thead>
<tr>
<th>No.</th>
<th>Date ID’d</th>
<th>Problem</th>
<th>Outcome</th>
<th>Interventions</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 4 of 8
GUIDELINES FOR FAMILY PRESENCE DURING INVASIVE PROCEDURES AND RESUSCITATION

PRACTICE STATEMENT: In selected situations, family members may be permitted in the patient care area during either invasive procedures and/or resuscitation. The healthcare team will be responsible for assessing patient and family needs and arranging for visit.

DEFINITIONS:
Family Member- a relative or person (significant other) with established relationship with patient.
Invasive Procedure- a procedure that involves penetration or manipulation of the body.
Resuscitation- life sustaining or life saving measures.
Family Support Facilitator- a staff member (nurse, clinical nurse specialist, physician) assigned to support the psychosocial needs of the family. This person should not be needed for the immediate resuscitation or direct assistance with the invasive procedure.

PROCEDURE:
1. DESIGNATE FAMILY SUPPORT FACILITATOR
2. ASSESS/SCREEN FAMILY MEMBERS
   A. Determine preference of patient, if possible. Assess families perception and understanding of the clinical situation and scope of crisis, need to be with patient, coping abilities, comfort level with medical environment, ability to ask for help/leave area. Consider cultural preferences.
   B. Exclusion criteria would include combativeness, agitation, extreme emotional instability, altered mental status and intoxication. Families who do not wish to participate should be supported.
3. CONSULT WITH HEALTH CARE TEAM- As early as possible inform healthcare team of families presence. Request permission for visit. Both team and facilitator should be in agreement and determine appropriate time for visit. Departmental situations/constraints should be considered.
4. PREPARE FAMILY MEMBER- The facilitator will present clinical situation explaining what family member may expect to observe during patient’s treatment. The facilitator will prepare family that patient care is top priority, time limitations, where they may stand, situations in which they would be escorted out of room and reassurance that they may leave at any time. Family agrees to structure of visit.
5. ESCORT FAMILY MEMBER TO BEDSIDE-Facilitator will remain with family at all times during visit and explain procedures and answer questions. The family will be allowed to see, touch and speak with patient when possible. After visit, facilitator will escort family to private room and provide clinical updates on patient’s condition. Family follow up by facilitator, primary nurse or psychiatric clinical nurse specialist.