5.8 Describe how the continuity of the patient’s care is addressed in the professional model(s) for the delivery of patient care.

As described in Force 5.5, the patient care delivery model at the Massachusetts General Hospital (MGH) is interdisciplinary, patient and family-centered care. Although it is named the same in every care delivery location, the way the patient care delivery model is operationalized is dependent upon the needs of the specific patient population.

![MGH Patient Care Delivery Model](image)

Continuity of care speaks to the seamless delivery of health care to the patients and their families. The Patient Care Delivery Model reflects patient centeredness as the central theme of the model, placed within a dynamic internal health care environment and informed and influenced by the socio political and professional dimensions of nursing practice. The person, family/group are viewed as a unique, dynamic and complex whole, who experience health in a personal way, informed by their own history and cultural experiences. Acknowledging the uniqueness of each person/family unit, the professional nurse within the MGH system, recognizes that care across the system must be tailored to the experience of the individual and informed by the knowledge of the discipline.
The nurse interacts with the individual/family, by being fully present and in the moment, engaging in a process of reasoning and decision-making (assessment, diagnosis, planning, intervening and evaluating) to acknowledge responses to the illness experience and providing needed information to create a smooth transition between sites and settings across the health care system. As the person/family moves through the system they are known as a unique whole and that the knowledge and experiences of the individual(s) are communicated and recognized by each provider of care across the spectrum of care.

External standards of professional practice along with regulatory structures provide assurance that care across the system, delivered by the professional nurse, is used to guide role performance and acknowledge each professional’s commitment to collaboration, competency, autonomy and control over professional practice and responsibility. The assurance that each nurse provider at the MGH adheres to the same standard care, credentialing and privileging and regulatory structures, work to offer patients and families a commitment to patient care excellence, wherever care is delivered within the MGH. As the patient moves throughout this system, strategies used for communication, documentation, assignments etc., adhere to a similar model of care and promote high quality, cost effective, safe, timely and efficient care to all. This commitment to patient centered care serves as a framework for assuring continuity of care.

Illustrations of Continuity in Care

The following are examples of how continuity of care is promoted in a variety of practice settings.

Caring for Patients on the Psychiatric Inpatient Care Unit

To promote continuity of care for patients on the Psychiatric Inpatient Unit on Blake 11, the guidelines below are followed:

- All patients are assessed by an RN at the time of admission and a full psychiatric nursing assessment along with the general nursing assessment is performed.
- All patients are asked to complete a Crisis Prevention Plan (attachment 5.8.a) that identifies any potential triggering events and ways that they already know of to manage their stress. The Crisis Prevention Plan is placed in the patient’s record and the nurse creates the problem and intervention list based on the interventions that the patients help to identify for themselves. This tool is meant to provide staff with information that may help to prevent a
In the event that a patient ends up in restraints or seclusion after interventions failed, they are asked to complete a debriefing form (attachment 5.8.b) to process the event and work with staff to identify alternative strategies which can then be placed on the updated Crisis Prevention Plan in an attempt to avoid future incidents.

Caring for Surgical Patients

Thousands of patients each year come to the MGH for surgery. Below is a narrative written by the Nursing Director of the Phillips House 22 General Surgery Unit about a patient’s experience throughout the surgical care continuum. The admission and post-operative process was anticipated and went smoothly due to many factors that were operationalized prior to the patient’s admission. This speaks to the commitment of MGH nurses to provide seamless and expert care.

“Mrs. D was a patient of one of our orthopedic surgeons and was scheduled for a total hip replacement (THR). During her evaluation with the Nurse Practitioner (NP) in the surgeons' office, many concerns were expressed by the patient that may impede her successful recovery. The patient was extremely anxious about post operative pain and repeatedly referred to a previous surgery at another hospital where she felt her pain was "ignored and not treated appropriately." The NP knew that if this information was not passed on to the peri-operative and post-operative team that this patient’s outcome may not be successful. The NP contacted the Pre-Admission Testing Area (PATA) staff to provide them with vital information that would be necessary in preparing the patient for the hospital course. She informed the PATA nurse who would be caring for Mrs. D about the patient’s concern with post-operative pain and also her fear of not being "listened to." When the patient was scheduled for PATA, the nurse was able to anticipate the patient’s needs and successfully prepare the patient for the day of surgery and her expectations post-operatively. The PATA nurse reviewed with the patient and her family member, the Pain Scale used by staff and patients to assess the patient’s pain level. She was also able to provide relaxation techniques to the patient which the patient could use to complement her pain medication. The PATA nurse also informed the patient that she would be communicating with her colleagues in both the pre-op and post-op areas to make sure that they were aware of the patient's concerns and fears. The PATA nurse was in fact creating a detailed plan of care which was incorporated into the Nursing Data Set. The Nursing Data Set is a living document that follows the patient throughout her hospital course and which provides key information to the nursing staff caring for the patient. The PATA nurse not only documented the plan of care on the data set, but also communicated to her
colleagues in the Same Day Surgical Unit (SDSU) and the inpatient unit, regarding the patient's needs and concerns. On the day of surgery, the Pre-Op nurse having the Data Set present, and also having received communication from the PATA nurse about the patient's history, was able to tailor Mrs. D’s care to address her concerns and fears. The PATA nurse was able to come up to the pre-op area and provide relaxation techniques to the patient which alleviated the patient's anxiety and provided confidence that the plan of care was communicated to all staff.

Post-operatively, in the Post Acute Care Unit (PACU), the patient was familiar with the pain score and was able to successfully work with the PACU staff on getting her pain under control. The patient was then transferred to Phillips House 22 General Surgery where the Staff Nurse who admitted her to the unit was able to review the Nursing data set and continue the plan of care that was implemented pre-operatively. This process of providing communication throughout the patient's hospital course is evident of the commitment of the nursing staff in providing patient-centered care.

I spoke with the patient after her surgery and she was very happy with the outcome of this surgery. She stated that she felt as if all the staff caring for her knew her story and had her best interest at heart. She said her pain was well controlled and she felt as if staff really listened to her.”

Bessie Manley, RN, MPA/HA, Nursing Director, Phillips House 22 General Surgery

Caring for Older Adults

Barbara Roberge, RN, PhD, is the lead investigator on a Robert Wood Johnson Interdisciplinary Nursing Quality Research Initiative with Ellen Mahoney, RN, DNSSc, Sung Chuang, MD, Kenneth Minaker, MD, Kathleen Leahy, RN, BSN and Lauren Parks, RN, BSN, titled, “Targeting Older Adults at Risk of Adverse Events During Hospitalization: Development of the Pre-Hospital Risk Index Profile (Pre-RIP). The focus of this study is to develop a pre-hospital index for older adults to identify risk of adverse outcomes during hospitalization. Below is Phase 1 of a three-phase project.

Methodology for the study includes a cross sectional survey design using a retrospective chart review. To develop the risk assessment tool, ambulatory medical record reviews are being conducted on hospitalized older adults from a geriatric primary care practice. A hospitalized group (N = 200) is being compared with a random sample of non-hospitalized older adults from the same practice (N = 100) to assess discriminate validity. Index variables selected by review of the literature, expert opinion and data availability include: sociodemographic, functional, diagnostic, laboratory, cognitive, physical, nutritional and social risk factors, twelve months preceding
hospitalization. Statistical models will be developed using logistic and multinomial regression analysis, predicting hospitalization and, once hospitalized, adverse event and discharge location. Analysis will also be conducted between groups.

To date, 198 medical record reviews have been completed (age range 74-93; 50% women). Factors placing patients “at risk” are common with one-fourth having a diagnosis of dementia, close to 50% walk with an assistive device and 25% live alone. Unique to this study, a level of help-seeking behavior is seen in the month prior to hospitalization. Therefore, the number of ambulatory practice contacts, including telephone calls and office and emergency visits are analyzed as additional risk predictors.

In future studies, the investigators will test the risk index prospectively in hospitalized older adults and target interventions using the Risk Index Profile. Results from all phases of this study will help to guide communications between ambulatory care practices and other settings where these older adults receive care. In addition, the risk index profile will help facilitate the delivery of safer care for this patient population.

**Safe Patient Transport**

In today’s fast-paced health care environment, the number of “hand-offs” that occur during a patient’s stay can be many. The Safe Patient Transport Policy & Procedure (attachment 5.8.c) describes how patient safety is ensured during times of transfer from a unit or between units and that it is the responsibility of all members of the health care team. All members of the team are responsible to determine the code status, safety status and other pertinent information related to the patient prior to transferring the patient from a unit for a test, procedure or to another unit. It is also each individual staff member’s responsibility to transfer key information about the patient to the next care provider.

**Documentation**

As fully described in Force 6.5, nursing documentation is an essential component in the communication process that contributes to quality patient outcomes. Comprehensive documentation is also an invaluable tool to promote continuity of care from shift-to-shift, unit-to-unit, or facility-to-facility.
Case Management

A key nursing role that facilitates continuity of care for patients at MGH is the Case Manager. As noted in Force 1.2, Case Managers are experienced nurses who assist in providing care for patient populations that require specific consideration and planned resources for post-hospitalization and/or post-treatment care. The Case Management Department has 70 Case Manager FTEs who provide coverage for 37 inpatient units, the Emergency Department (including the Emergency Department Observation Unit), the Pre-Admission Testing Area, and the Admitting Department. They also support areas such as the Same Day Surgery Unit, the infusion unit, and over twenty primary care physician practices and health centers. Case Management planning involves coordination with pre-and post hospital settings, arrangements for specialized care during the hospital stay, and effective communication of patient information across the continuum. Attachment 5.8.d includes the reprint of a clinical narrative from the August 16, 2007 issue of Caring Headlines that illustrates the important role that MGH Case Managers play in promoting continuity of care.
Inpatient Psychiatry Safety Tool & Crisis Prevention Plan

Date/Time Initiated: ______________________

Identifying Behaviors: When you are feeling out of control, do you ever exhibit any of the following behaviors that might put you or others at risk for being injured?

- Suicidal behavior
- Withdrawal/Isolation
- Striking out
- Intrusiveness
- Self injurious behavior
- Destruction of property
- Verbal abuse towards others
- Anger
- Feeling unsafe
- Severe agitation
- Dissociation
- Severe agitation
- Feeling unsafe
- Verbal abuse towards others
- Threats of violence

Triggers: What are some things that may make you upset or angry and lead to a crisis?

- Being touched
- Not being listened to
- People in uniform
- Called names or made fun of
- Yelling
- Bedroom door open
- Loud noise
- Being stared at
- Darkness
- Not having choices
- Sudden movements
- Particular time of day
- Time of year
- Being threatened
- Being restrained
- Contact with family or person who is upsetting
- Nightmares/distressing thoughts at night. If so what?

Other: _____________________________________________________________________________

Warning Signs: What are your warning signs when you feel you may lose control?

- Sweating
- Crying
- Becoming rude
- Loud voice
- Distraction
- Clenching fists
- Wringing hands
- Singing inappropriately
- Laughing loudly/Giddy
- Dissociation
- Pacing
- Rocking
- Can't sit still

Other: _____________________________________________________________________________

Safety Plan Strategies: What interventions may help prevent you from feeling upset/agitated?

- Room in ICU area
- Listen to music
- Pacing in the halls
- Relaxation tapes
- Warm or cold drink
- Writing a letter
- Calling a friend/family member
- Voluntary time in the sensory room with staff
- Use of weighted blanket
- Using ice
- Taking a hot/cold shower
- Doing artwork/painting drawing
- Deep breathing/mindfulness exercises
- Rocking chair glider
- Exercise/stationary bike
- Sound machines
- Coloring
- Scheduled time in sensory room
- Reading
- Writing in a journal
- Dark Room (dimmed lights)
- Talking to staff
- Talking with peers on unit
- Voluntary time in the quiet room
- Wrap up tight with sheet/thin blanket
- Putting hands in cold water
- Lying down with cold face cloth
- Hugging a pillow
- Bean bag tapping/brushing
- Hot balls/sour candy
- Stress ball
- Watching TV
- Medication
- Complete chain analysis
Trauma History:
Do you have a history of abuse or other type of trauma as a child?  ☐ Yes  ☐ No
As an adult?  ☐ Yes  ☐ No
What type of abuse or trauma have you experienced?  ☐ sexual  ☐ emotional  ☐ physical  ☐ combat
☐ Other?  
Describe briefly (if able to):  

Seclusion and Restraint:
Have you ever been placed in a seclusion room?  ☐ Yes  ☐ No
Have you ever been restrained?  ☐ Yes  ☐ No
If yes, When?  Where?
What happened?

Patient informed of Mass General Hospital’s policy on restraint/seclusion?  ☐

In Extreme Emergencies:
Restraint and seclusion may be used as a last resort. Is there anything you find helpful in emergency situations that could prevent them from being used?
Alternative physical spaces such as:  ☐ Sensory room  ☐ Quiet room  ☐ Your room
☐ Medication by mouth  ☐ Emergency injection  ☐ Other:  

Medical Conditions:
Do you have any physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc. that we should be aware of when caring for you during an emergency situation?  ☐ Yes  ☐ No
If yes, explain:  

Are there any medications that are helpful?  ☐ Yes  ☐ No  If no, why were they not helpful?  

Is there anything else that would make your hospitalization better?  

☐ Patient involved in safety plan  ☐ Patient given a copy

Patient signature:  
Staff signature(s):  

<table>
<thead>
<tr>
<th>Safety Plan &amp; Goals Revisions/updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
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Massachusetts General Hospital
Patient Debriefing and Comment Form

Patient Name: ____________________________________________
Date/Time restraint or seclusion (R/S) ended: ___________/_______

We view a restraint or seclusion as a serious occurrence. We would like to work with you to avoid this occurrence in the future. We would like to understand what this incident was like for you through your answers to the following questions. If necessary, staff will help you fill out this form. Attach extra pages if necessary.

1. Were there any early warning signs you or staff might have been able to notice to alert us that things were becoming difficult for you?

2. Are there other ways you could have helped yourself stay calm and in control? Did you use the techniques in your Crisis Prevention Plan to feel calmer? For example: refocus your attention on a book, music, or activity? Is it best for you to be alone in that circumstance?

3. Could staff have done anything more to help you stay calm and in control? Was there a problem that the staff might have been able to help resolve? Did the staff use any of the interventions in your Crisis Prevention Plan, which you indicated might be helpful? Might medications have helped avoid the situation?

4. Are there staff members you feel more comfortable talking to? Would talking to a staff member help you cope with how you feel about the restraint or seclusion? Is there anyone else who might be helpful for you to talk with about this experience?

5. Are you aware of any physical complaints or injuries that occurred as a result of this experience?

6. Is there anything we can do to help you better understand or cope with this experience?

7. Is there anything else you would like to tell us?

_____________________________________/______________________/_____________
Patient’s signature      Date & Time  Staff signature           Date & Time

To Staff: This debriefing and comment form must be offered to the patient within 24 hours of the R/S. It may be re-offered later if the patient chooses not to comment initially. The patient may comment in writing or verbally. If verbally, the staff person will complete the form. Staff must sign and date form even if the patient chooses not to comment.

Follow up Actions for Staff: Please circle any that apply
Medical            Human Rights Officer                   Counseling                     Crisis Plan        Treatment Plan update
Other____________________________________________________________________________________________
1 POLICY:

1.1 All patients who are transferred from a unit will be assessed to determine their status related to transfer. All pertinent clinical information will be documented by the clinician providing care for the patient to the next clinician responsible for their care.

1.2 Please refer to the Patient Verification and Identification Band policies located in the Clinical Policy and Procedure Manual.

2 OVERVIEW:

2.1 Patient safety during times of transfer from a unit or between units is the responsibility of all members of the health care team. All members of the team are responsible to determine the code status, safety status and other pertinent information related to the patient prior to transferring the patient from a unit for a test, procedure or to another unit. It is also each individual staff member’s responsibility to transfer important information about the patient to the next care provider.

3 PROCEDURE:

3.1 If an order for a test is written and transcribed, the requisition is sent to the appropriate department via electronic Provider Order Entry (POE) or by fax. Confirmation of the test being scheduled is confirmed by the Operations Associate (OA) on the unit. Arrangements are made with the Patient Transport Department, either by the test site or the OA, to bring the patient to the site indicated. If a patient is on Precautions, this information will be communicated to the Patient Transport Department.

3.2 The nurse caring for the patient is responsible to

3.2.1 Assess that the patient is safe to transfer.

3.2.2 Complete the required documentation describing the clinical status of the patient.

3.2.3 Call the receiving unit/department and communicate any additional information about the patient (Attachment A: Patient Status Requiring Telephone Communication to the Receiving Site)
3.2.4 Determine the appropriate level of staff who should accompany the patient off the unit. *(Attachment B: Patient Status Requiring Clinician Escort to the Receiving Site)*

3.2.5 Determine any equipment that needs to accompany the patient such as cardiac/respiratory monitoring.

3.2.6 Assure that all equipment/materials accompanying the patient are adequate for the transfer, such as enough oxygen in the tank for the transfer.

3.2.7 Assure that the patient’s medical record accompanies the patient when he/she leaves the unit.

3.2.8 Utilize the appropriate patient verification method to identify the patient and that the medical record matches the patient’s information.

3.2.9 Assess the status of the patient and determine the appropriate personnel to accompany the patient during transfer.

3.3 If the patient’s nurse determines that the patient does not require clinical staff accompaniment, she/he will contact Patient Transport Dispatch at 6-2255 to coordinate the movement.

3.4 Transporters will adhere to the following procedures from the unit to the test site, in order to ensure the safe, efficient movement of the patient:

3.4.1 After receiving assignment, record it on the Patient Transportation Log Sheet and obtain stretcher/wheelchair, IV pole and oxygen cylinder, as requested.

3.4.2 Report to the location immediately.

3.4.3 Check in at the Nursing station and announce arrival.

3.4.4 Request patient’s chart (patients cannot travel without their charts) and compare the name on the Patient Transportation Log Sheet with the name on the chart.

3.4.5 Request assistance.

3.4.6 Report to patient’s room, identify yourself to the patient and inform them of where they are going (questions should be referred to the nurse).

3.4.7 Utilize the appropriate patient verification method then verify that the patient has an ID bracelet and compare it to the name and medical record number on the chart (patients cannot travel without bracelet).

3.4.8 If a patient is on any type of precautions, ensure that the chart is labeled and placed in a plastic bag.
3.4.9 Assist nursing staff with the transfer of the patient to a stretcher or wheelchair (this task is mandatory, not optional).

3.4.10 Assist in the movement of bedside equipment, under the direction of Nursing staff. Do not set oxygen levels.

3.4.11 Transport patient to the assigned location using the best route.

3.4.12 Obtain a signature from the person at the test site that you have informed of the patient’s arrival.

3.4.13 Assist in the transfer of the patient at the test site if it is requested

3.5 The receiving staff member at the test site will adhere to the following procedures upon receipt of the patient in order to ensure the safety of the patient while in the department.

3.5.1 Receive patient’s chart from transporter.

3.5.2 Sign transport sheet indicating that you have received the patient into the department.

3.5.3 Note any precautions and/or safety issues on the paperwork included with the patient’s chart.

3.5.4 Place patient in area with appropriate visual contact for nature of safety issue.

3.6 The staff member performing the test will utilize the appropriate patient verification method then verify that the patient and ensure the patient, chart and test order are confirmed before performing the test.

3.7 Patients waiting for return to their units will be held in areas with appropriate visual contact based on the nature of the safety issue.

3.8 As described in 3.1 and 3.2, the staff coordinating transfer back to the patient care unit will assess the patient’s condition to travel, determine the appropriate personal and/or equipment necessary for safe transfer and will communicate, as appropriate, the patient’s current status.

3.9 Transporter will adhere to the following procedures from test site to unit, in order to ensure the safe, efficient movement of the patient:

3.9.1 Check in at the test site and announce your arrival.

3.9.2 Ensure that you have the correct patient, utilizing the appropriate patient verification method and patient medical record.

3.9.3 Transport the patient using the best route.

3.9.4 Arrive at the unit and check-in at Nurses’ station
3.9.5 Return patient’s chart and obtain initials from the person at the station.

3.9.6 Request Nursing assistance.

3.9.7 Assist Nursing staff with the transfer of the patient from the stretcher or wheelchair (this task is mandatory, not optional).

3.9.8 Assist in the movement of bedside equipment, under the direction of Nursing staff.

3.9.9 Obtain a signature from the nurse or the person you assisted with transfer (this confirms your task is finished).

3.9.10 Call central dispatch to complete the call.

4 DOCUMENTATION:

4.1 A transfer note will be documented in the progress note each time the patient travels/transfers off of the unit with or without clinical staff. It will include the patient’s condition, i.e.; stable, unsteady on feet, and time of travel/transfer. Depending on the patient’s condition, any safety concerns, i.e.; falls or precautions will also be documented. In addition the bedside binder that includes vital sign sheets, medication administration record, Life-Sustaining Policy, etc, must accompany the patient.

Developed by: Safety in Motion Taskforce (7/05) (9/05)
Reviewed and approved by: Clinical Policy and Record Committee (9/30/05) (10/05)
Reviewed and approved by: Medical Policy Committee (4/07/04)(10/05)
Safe Patient Transport P & P Attachment A
Patient Status Requiring Telephone Communication to the Receiving Site

Patients with the following conditions require additional information to be communicated to a
receiving site. The clinician sending the patient should report these issues in a telephone call to
the receiving site:

- Precautions for infection control
- Communication issues, e.g.; aphasia, non-English speaking
- Pre-medication
- Change in mental status, e.g.; confusion, agitation
- Patient at risk for injury, i.e.; who may require physical restraint or an observer
- Other – patient that the clinicians are concerned about or that may need to be expedited,
i.e.; a bariatric patient
- Patients on high flow O2 that travels with more than one tank and
- requires monitoring of O2 volume.
Safe Patient Transport P & P Attachment B
Patient Status Requiring Clinician Escort to the Receiving Site

Professional staff must accompany any patient that is clinically unstable during transport and at the test site. This includes but is not limited to a patient with:

- Neurological instability requiring continuous monitoring
- CSF drainage system
- Respiratory or airway instability, newly inserted artificial airway,
- Mechanical ventilation, high risk for aspiration, or need for frequent suctioning
- Cardiac instability, requiring continuous cardiac monitoring
- Hemodynamic instability
- High risk for injury to self or others
- Intravenous medications requiring titrations during the period of absence from the unit
- Pre-medication for sedation prior to test/procedure and may receive additional doses of the medication
- Running transfusion or blood or blood components (plasma, platelets, cryoprecipitate, IVIG)
- Infusing chemotherapy
- Interpreter services required.
Continuity of care a treasured part of practice for oncology case manager

My name is Rosanne Karp, and I am a case manager on the Bigelow 7 Gynecology-Oncology Unit. Working as a case manager provides a wide range of opportunities and responsibilities, including the most treasured part of my practice, the ability to follow patients through the continuum of care. I meet incredibly strong, wonderful women and their families and follow them from initial diagnosis, through treatment, and for many, through their final days. It is an incredibly rewarding experience.

I first met Mrs. P in September, 2001. She was referred to MCH with new findings of stage III ovarian cancer. She had had surgery for tumor staging and experienced a complicated post-operative course that included a pulmonary embolus and wound-care issues. When Mrs. P was admitted, I introduced myself and encouraged her and her husband to use me as a resource, especially for questions about discharge planning and anything she needed once she started treatment. Mrs. P was referred to her local VNA for wound care and anticoagulation management, which included a transition from Fragmin injections to Coumadin, and on-going monitoring of her blood tests. She wanted her primary care physician to manage her anticoagulation care, so I coordinated contact between our team and her PCP.

Within a month, Mrs. P's course became more complicated. She required TPN (total parenteral nutrition), intravenous antibiotics, and drain care. They hired a home infusion service to provide these specialty therapies, and her care was coordinated with the VNA. Both Mrs. P and her husband took this in stride, willing to do whatever was necessary to be able to return home. This was the hallmark of their attitude throughout her increasingly complex care.

For the next few months, Mrs. P underwent chemotherapy. During her treatment, she required the support of specialty drugs to maintain her blood counts so she could continue treatment. Again, she accepted these challenges without question. I explained the approval process and prerequisites necessary for her to obtain these medications.

Mrs. P returned to MCH in March of 2003 with recurrent disease after several months of relatively good continued on next page
Attachment 5.8.d continued

Clinical Narrative (continued)

health. She underwent another surgery that resulted in a colostomy, and she was started on a new line of chemotherapy. When I went to see her for discharge planning, we picked up where we had left off. We had the same easy rapport we had enjoyed from the beginning.

In time, I would see Mrs. P periodically as she came in for treatments. Though she had no complex needs, we spent time talking about how she felt and her concerns for herself and her husband. I saw her intermittently, but kept abreast of her progress as she went through four more courses of chemotherapy.

In October of 2004, Mrs. P presented for placement of a gastrostomy tube as she was developing recurrent small bowel obstructions. After several months, the tube was removed, and she continued with chemotherapy.

I saw Mrs. P again at the beginning of 2007. By this time, she had undergone many lines of chemotherapy. She had no G-tube, no active services, and was managing her home activities. Mrs. P was admitted with a new bowel obstruction. Her goal was to get home as soon as possible, and indeed, she decided to leave for home late one evening before her obstruction had resolved. I discussed the situation with her attending physician, and we agreed it was more important for her to be at home in light of the likelihood of her disease progressing. I worked with the office staff to arrange for her to have home intravenous fluids and services and follow-up to monitor her condition.

Unfortunately, Mrs. P was re-admitted three weeks later with the same issues. I could see she was becoming progressively distraught as her situation worsened. I alerted Social Services that she would need supportive counseling. Mrs. P told me she wanted to try to manage oral fluids on her own and keep her life as normal as possible. She declined support services, but I assured her that supports would be in place when she felt ready. We all recognized the need for her to have some control over her situation.

In February, 2007, another G-tube was placed to manage the progression of her disease and its symptoms. She declined home nursing care, but knowing Mrs. P had experience managing G-tube, I wasn’t concerned. I was concerned, however, that her situation was becoming more complex. Again, I discussed her care with the team, and we decided to let her indicate to us when she felt ready to accept support.

Over the next month, the team started to discuss palliative care with Mrs. P, but she wasn’t emotionally ready. She requested one more course of chemotherapy. At this time, she agreed to VNA support, especially to help with pain-management and intravenous hydration. She was starting to lose weight and had a rapidly increasing pain-medication regimen. Throughout this difficult time, the lines of communication stayed open between Mrs. P, her physician’s office, home-care providers, and our team on the inpatient unit. This thread of continuity and constant communication proved invaluable.

In April, Mrs. P returned with worsening symptoms of bowel obstruction. She felt she was ready to prepare for and accept hospice care. I met with her and her husband to discuss what this transition would mean. I always clarify with patients and families before initiating a conversation about hospice care. What is their understanding of what this means? Whenever one of my patients transfers to hospice care, I stress that this is not the end of care, rather, a change in the focus and goals of care to meet their changing needs. Most patients appreciate this information. One of the most common fears I hear is that patients feel they’ll no longer have access to the team that has cared for them for so long.

Mr. and Mrs. P clearly verbalized their accurate understanding of hospice care and let us know they wished to proceed. I reviewed the options with Mr. P and Mrs. P, and they chose an agency. As soon as the referral was completed, Mrs. P was discharged home with a plan for the hospice nurse to meet her the next morning.

A round of many good-byes was shared with staff, as Mrs. P said, “I don’t expect I’ll be back to see you again. I just want to thank you for all your help.”

We knew she was right, we likely would not have an opportunity to see her again. Before she left, her husband, who had always been a quiet, gentle man, came over to me and said, “Thank you for always being there for us.” It was all I needed to hear.

Conclusions by Jacinetta Deos Kieckens, RN, senior vice president for Patient Care and chief nurse

Rosanne’s narrative describes the importance of allowing the patient to lead the way. She understands the need for Mrs. P to maintain control for as long as possible and tailor her interactions to meet that need. Their long-standing relationship informed Rosanne’s actions in arranging care and services and in maintaining a presence as a concerned and compassionate caregiver. So many patients require extended services after they leave the safety and security of MGH. Rosanne ensured that Mrs. P received high-quality, patient-centered care throughout her long illness.

Thank-you, Rosanne.