

2.6 Provide examples of how the organizational structure has been modified to accommodate change from an internal or external force.

“... in a period of upheaval, such as the one we are living in, change is the norm.”

Peter Drucker

Each year Massachusetts General Hospital and Patient Care Services respond to both external forces, such as major and minor regulatory mandates, and internal forces such as capacity management issues that impact the practice environment. Nursing leaders and staff are integral to the organization’s response to both internal and external drivers of change. These changes would not become part of practice without knowledge, evaluation, planning and, ultimately, implementation by nurse leaders and clinicians.

External Forces

Maternal/Newborn Licensing Regulations – Lactation Consultant

In 2006, the Commonwealth of Massachusetts refined existing Maternal/Newborn licensing regulations to reflect progress in clinical practice in the decade since these regulations first took effect and to promote higher quality care. In this case, the revisions included a requirement for every mother and infant requiring advanced lactation support to receive that support from Certified Lactation Consultants or individuals with equivalent training and experience ([attachment 2.6.a](#)). The Associate Chief Nurse and Nursing Directors for Maternal Child Health, working with the Director of Corporate Compliance, held key roles in communicating these changes, establishing a team to plan a response and ultimately preparing the application for relicensure with necessary documentation to affirm compliance.

Massachusetts General Hospital’s lactation support for the post-partum patient predates the licensing requirements. However, the implementation of the regulations did engender expansion in hours of availability of the program and the training and certification of additional lactation consultants. Nursing staff were identified, trained, and certified. With the support of the Department of Nursing, eight obstetrics nurse received International Board Certified Lactation Consultant (IBCLC) certification and another seven nurses have attended a 5-day Certified Lactation Counselor program. These nurses provide advanced lactation support 365 days/year. A program of culturally and linguistically appropriate care and services was developed through written breastfeeding information available in 12 different languages, a breast feeding log was developed in

both Spanish, English and in picture format to make it user friendly for those who do not speak either language and in-hospital and telephone-based interpreter services are available to aide in the provision of instruction.

The regulations also require that *“all licensed nursing staff caring for maternal-newborn patients shall receive orientation and periodic in-service education that provides training or documents skill in ... initiation and support of lactation.”* This education is to include information on the nutritional and physiological aspects of lactation, nutritional needs of mother and infant, positioning to promote effective breast feeding, avoidance, recognition and treatment of common complications, techniques for milk expression and storage, information about community support after discharge and cultural values related to breastfeeding. In response to these requirements, existing educational programs were enhanced to address all of the required topics. Educational opportunities have been provided to the staff in the form of classes, FYI boards, and informational emails. Each nurse has completed a 4-hour educational program taught by a Lactation Consultant which is repeated for all newly-hired nurses who also attend an inpatient breastfeeding class as part of their orientation. For 2007, each post-partum nurse participates in a competency day of which one hour is dedicated to breastfeeding (attachment 2.6.b). While this is only one part in a larger process impacting several provider disciplines, relicensure would not have been possible without it.

Regulations for Restraint and Seclusion

2006 brought changes from the Massachusetts Department of Mental Health in the use of restraint and seclusion in the inpatient psychiatric population.

(http://www.mass.gov/Eeohhs2/docs/dmh/regs/reg_104cmr27.pdf)

These changes required the development and use of *“sensory interventions and therapies designed to calm and comfort patients that utilize sight, touch, sound, taste, smell, pressure weight or physical activity”* in order to prevent or minimize the use of restraint and seclusion. To address that need, a program was developed to educate the mental health staff on the use of Sensory Modulation for the Mental Health Population (attachment 2.6.c). The regulations also stipulate that an individualized crisis prevention plan be developed on admission for each patient in collaboration with the patient and/or his/her representative, including triggers that signal or lead to distress or agitation, approaches that reduce agitation or distress, patient preferences in the event that restraint or seclusion must be used. Staff on the mental health unit worked to develop a standardized tool that aids the clinician in

assessing the patient's needs and preferences and in forming an Individual Crisis Prevention Plan (attachment 2.6 d).

These changes were anticipated by the Nursing Director for Inpatient Psychiatry and Psychiatric Clinical Nurse Specialist and with their full support and leadership implemented successfully in MGH's inpatient psychiatric service. Their continued oversight sustains this program, which was evaluated as part of the biennial licensure renewal for this unit.

Pandemic Flu Planning and Development of the MGH Influenza Specialty Care Unit

In 2006, the Massachusetts Department of Public Health held a number of Regional Pandemic Planning Conferences to plan for an anticipated influenza pandemic (attachment 2.6.e). Based on epidemiological models, it is expected that when the flu pandemic occurs in Massachusetts, approximately 30% of the population or 2 million people would fall ill resulting in over 80,000 hospitalizations and requiring as many as 11,000 ICU beds of which 3,400 will require mechanical ventilation. To respond to this surge in demand, the concept of Alternative Care Influenza Specialty Care Units (ISCU) was adopted by the Department of Public Health to care for the approximately 70,000 hospitalized patients requiring primarily supportive care in the form of oxygen therapy, intravenous infusions, and antibiotics. The Commonwealth of Massachusetts requested that hospitals develop a plan for development and implementation of ISCUs. At Massachusetts General Hospital, the Administrative Director for Emergency Services, working with a multidisciplinary team which included an Associate Chief Nurse, Staff Specialists from the Department of Nursing, the Nursing Director and nurse representatives from the Emergency Department, and nursing representatives from the Department of Infection Control, formed an ISCU Planning Work Group which initiated a plan for the development of the MGH Influenza Specialty Care Unit. Utilizing space in the Yawkey Outpatient Center, the MGH ISCU could have an 80-100 bed capacity (attachment 2.6.f).

Internal Forces

Medical Team 5

The General Medical Service at MGH has faced capacity constraints over the past several years. One of the largest drivers of capacity issues has been the concentration of patients with long length of stay (LOS). While patients with extended LOS represented only 4% of Medicine discharges, they constituted 27% of total patient days. And while half of long LOS patients had

complex medical issues requiring continuing acute levels of intervention, the remaining half remained hospitalized because of complicated psychosocial and socioeconomic issues. It was felt that a multidisciplinary team with expertise in the care and management of patients that are medically stable but face complex social issues would provide a more comprehensive approach to their care. To that end, “Medical Team 5” was created as a Department of Medicine initiative in partnership with Nursing, Case Management, and Social Services. The team works in close collaboration with Patient Financial Services, Legal Services, Physical Therapy, Occupational Therapy, Psychiatry and post-acute care placement facilities. The goals include providing comprehensive, coordinated, holistic care to patients with a focus on continuity, multidisciplinary collaboration and early intervention, facilitating the discharge of patients facing delays associated with guardianship, homelessness, substance abuse or other psychosocial factors, and reducing the impact of long LOS patients on capacity across both the General Medical Service and throughout MGH.

Team 5: Mission Statement/Philosophy



Team 5 will approach each patient with respect and dignity. We believe that providing a consistent physician, case manager, nurse practitioner, and social worker for the socially complex patient will benefit the patient and his/her family by providing intensive, comprehensive psychosocial and medical care.

To achieve its goals, Team 5 will rely on frequent communication with direct care providers. This will enable the team to intervene on subtle clinical and behavioral changes in a timely manner, advancing patient care and limiting complications.

The multidisciplinary Team 5 will likewise increase positive outcomes and reduce LOS through continuity, early intervention, and enhanced discharge planning.

Team 5 will be guided by transparency and a data driven approach to care. The team will work to support both the research and teaching missions of the hospital.

While this is a hospitalist-based team, it has a strong multidisciplinary focus and the work of the Team 5 Nurse Practitioner is integral to its success through assessment of potential patients, communication within and among medical teams, and in management and coordination of the care of the patient.

Emergency Department Observation Unit

Capacity management and patient flow were also areas of concern for the Emergency Department (ED). Lack of rapidly available inpatient beds created a bottleneck within the ED and resulted in long LOS for patients awaiting inpatient placement, which decreased ED bed availability. The ED was forced to divert patients to other area hospitals until Emergency and inpatient beds

could be made available. One mechanism to address the issues of flow and capacity was the creation, in July 2006, of the ED Observation Unit to provide care for an estimated 3200 Emergency Department patients per year who have an anticipated LOS of less than 24 hours. Under the direction of the Nursing Director of the Emergency Department, this 14-bed unit, located on Bigelow 12, provides continuous care for patients expected to require less than 24 hours of nursing care and observation. Care is provided by Emergency Department Staff Nurses with 24-hour medical coverage by Nurse Practitioners. The goals of the ED Observation Unit are to increase access to care in the ED, increase availability of inpatient beds by providing short term monitoring and care to patients who would have been admitted from the ED for testing or monitoring, and improve overall efficiency in the ED.

**Sections Relevant to Breastfeeding in the Revised Massachusetts Hospital
Licensure Regulations 105 CMR:130 Licensure of Hospitals**

http://www.mass.gov/portal/gog_cache.jsp?q=cache:WsloeR5FN9sJ:www.mass.gov/Eeohhs2/docs/dph/regs/105cmr130.pdf+Department+of+Housing+and+Community+Development&access=p&output=xml_no_dtd&ie=UTF-8&client=mgov&site=default_collection&proxystylesheet=mgov&oe=UTF-8

130.615 Patient/Family Services

- B. Each hospital with a maternal newborn service shall provide prenatal, postnatal and family-planning services either directly or through referral to an outside agency, including the following:
 - 3. Infant feeding instruction and support during hospitalization and provision of information on resources to assist the mother and family after discharge, including, for breastfeeding mothers, community-based lactation consultant resources and availability of breast pumps
- J. Each service shall have a written policy that provides for discharge planning and referrals to community agencies and healthcare providers, including lactation consultants as needed

130.616 Administration and Staffing

- D. Patient care policies. Each maternal and newborn service shall develop and implement written patient care policies and procedures, supported by evidence based resources, which shall include provisions for the following:
 - 11.* Support of lactation initiation and maintenance for mothers who choose breastfeeding. Such policies shall provide for the following:
 - a. No standing orders for antilactation drugs
 - b. Unless medically contraindicated, encouragement of breastfeeding as soon after birth as the baby is interested. A mother separated from her infant shall be assisted to initiate and maintain her milk production.
 - c. Frequent nursing periods, based on the infant's needs.
 - d. Supplemental bottle feeding for medical reasons or on request of the mother only.
 - e. Sample formula and/or formula equipment distributed to breast-feeding mothers only when an individual physician order is written or on the request of the mother.
 - 18. Policies for safe and secure storage and handling of infant feedings, formula and breast milk, including policies to ensure the correct labeling and identification of all infant feeding
- F. Nurse staffing
 - All licensed nursing staff caring for maternal-newborn patients shall receive orientation and periodic inservice education that provides training or documents skill in at least the following areas:
 - Initiation and support of lactation
- G. Lactation Care and Services

Attachment 2.6.a continued

- Each hospital shall deliver culturally and linguistically appropriate lactation care and services by staff members with knowledge and experience in lactation management. At a minimum, each hospital shall provide every mother and infant requiring advanced lactation support with ongoing consultation during the hospital stay from an International Board Certified Lactation Consultant (IBCLC) or an individual with equivalent training and experience
- Each maternal and newborn service shall develop written, evidence-based breastfeeding policies and procedures and include these in staff education and competency reviews
- An educational program of lactation support for maternal-newborn staff shall be offered by qualified staff and shall address the following areas:
 - The nutritional and physiological aspects of human lactation
 - Positioning of mother and infant to promote effective sucking, milk release and production
 - Practices to avoid, recognize, and treat common breastfeeding complications
 - Nutritional needs of the mother during lactation and monitoring the nutritional needs of the infant
 - Safe techniques for milk expression and storage of milk
 - Information about community support services available to the family after discharge
 - Cultural values related to breastfeeding

STAFF COMPETENCY OVERVIEW FOR LACTATION 2007

Anticipatory Guidance for Class

- Mother, baby and female support person
- Please medicate mothers before class
- Pillow
- Not all infants nurse in this class, some just sleep
- Please be on time, usually 1pm every day in Ellison 13 family room
- This class is for the Normal full term infant
- Infants with feeding issues need a referral and need to be seen on a on-to-one basis

Class Topics

- Where to get support in community
- Educational materials
- Breast and nipple care
- Milk production
- Feeding cues
- Latching
- Positioning
- Nutrition

Community Support

- MGH mother support group
- Nursing Mother's Council
- La Leche League list
- Family members, father of baby
- Local groups for mothers

Educational Materials

- "Your New Family" covers basic breastfeeding concerns, pumping, storing breastmilk, engorgement, plugged ducts, and mastitis
- "Off to the Best Start" is our main teaching tool
- Every mother should have these
- We have many different languages

Breast Care

- Infant recognizes mother by taste and smell
- No creams, powders, lotion, body spray
- Plain water to clean breast
- Demonstrate use of hand expressed breast milk after nursing
- Use of products: lanolin, soothies, pads, bras

**Milk Production
Mothers Need to Know...**

- Use words carefully: she has milk, it is colostrum
- Counting feeds, voids, and stools for next 10 days
- Importance of frequent nursing to bring in milk supply
- Awareness of changes in breast by day 3-4
- Increased swallowing noted
- Breast softens after a feed
- Infant weight returns to birth weight by day 10
- Infant determines frequency and length of feed always

Feeding Cues

- Skin to skin alerts parent to feed
- Infant sucks tongue, turns head
- Sucks fingers, roots for breast
- Crying is very late sign of hunger
- Skin to skin

Latch, Sucking, Pacifier, Bottles

- No pacifiers or bottle nipples for first 4 weeks until breastfeeding and supply is well established
- Nutritive versus non-nutritive sucking
- Ask mother what she is feeling, a tug or pain
- What does nipple look like after a feed
- Instruct mother to call you to observe her feed

Nutrition

- Water is beverage of choice
- Include 4 basic food groups
- Moderation is the key
- Variety of flavors is beneficial for infant's brain growth.

Basic Breastfeeding Positions

- Football
- Cross Cradle
- Cradle
- Side lying
- AAP statement and reality

Sensory Modulation for the Mental Health Population

June 2006

What is Sensory Integration* ?

- ❖ Ayres defines sensory integration as *"the neurological process that organizes sensation from one's own body and from the environment and makes it possible to use the body effectively within the environment"*. The theory is used to explain why individuals respond in a certain way to sensory input and how it affects behavior. The seven senses:
- ❖ **Touch** - tactile
- ❖ **Sound** - auditory
- ❖ **Sight** - visual
- ❖ **Taste** - gustatory
- ❖ **Smell** – olfactory
- ❖ **Vestibular**- movement and balance sense
- ❖ **Proprioception**- joint/muscle sense

A New Taxonomy

- ❖ A new taxonomy has been established regarding sensory-related disorders within the field of occupational therapy (Miller & Lane, 2002).
- ❖ Established in order to distinguish between the theory of sensory integration, sensory-related disorders and therapeutic intervention.
- ❖ Part of an attempt to develop a classification system for sensory-related disorders and dysfunction

Sensory Processing Disorders

- ❖ Sensory Processing Disorders = Umbrella Term
 - Sensory Modulation Disorder
 - Over-responsivity
 - Under-responsivity
 - Sensory Seeking/Sensory Avoiding
 - Sensory Discrimination Disorder
 - Sensory-based Motor Disorder
 - Postural disorders
 - Dyspraxia

Sensory Modulation for Self- Regulation*

- ❖ Sensory Modulation is the ability to organize and regulate one's reactions to sensory and motor information in a graded and adaptive manner (Bundy, Lane & Murray 2002).
- ❖ Every spirit-mind-body-world experience involves sensory information. How each person responds to that information is unique.
- ❖ Being aware of our own unique system tendencies and preferences help us self-regulate in order to functionally engage in meaningful activities.
- ❖ It is by engaging in meaningful and purposeful activities that we are able to successfully engage in the occupations of our everyday lives.

How do you self-regulate?

- ❖ You are in a boring lecture or meeting...
- ❖ Noisy or crowded places are overwhelming...
- ❖ Touching mushy, wet substances bothers you...
- ❖ Light touch irritates you...

Sensory Modulation Dysfunction

- ❖ Self-regulation difficulties are often seen in people with schizophrenia, trauma history, anxiety and panic disorders, depression, bi-polar disorder, substance abuse, self-injury tendencies.
- ❖ May be a result of an inability to properly integrate sensory input - under responsivity or over responsivity.
- ❖ Results in behaviors that seek out or avoid sensory stimuli.

Sensory Modulation Strategies for Mental Health Problems

- ❖ Sensory input can be used for mental health problems such as:
 - Stress
 - Emotion Regulation
 - Poor Reality Orientation
 - Sensory Distortions
 - Sensory Defensiveness
 - Dissociation and Flashbacks
 - Suicidality
 - Self-injurious behaviors
 - Negative thinking
 - Disorganization
 - Cognitive problems
 - Substance Abuse

Sensory Modulation Program*

- ❖ This program was developed by occupational therapists trained in sensory integration theory, as a tool to promote self-regulation of the spirit-mind-body-world interactions.
- ❖ Successful sensory modulation may result in:
 - Increased self-understanding
 - Increased ability to self-nurture
 - Increased resilience
 - Increased self-esteem
 - Increased ability to engage in therapeutic activities
 - Increased ability to engage in self-care activities
 - Increased ability to engage in meaningful life roles
 - Increased ability to engage in social activities
 - increased ability to cope with triggers

Sensory Modulation Program: Goals

- ❖ **Goal # 1: Facilitating Self-awareness**
 - Awareness of one's own tendencies, patterns and preferences.
- ❖ **Goal # 2: Self Shaping**
 - Exploring, planning and practicing.
- ❖ **Goal # 3: Self-regulation and Repertoire Expansion**
 - Feelings of competence and continued change.

Sensory Modulation Program

- ❖ The sensory modulation program consists of:
 - Assessment
 - Sensory motor activities
 - Sensory modalities
 - Development and active use of a sensory diet
 - Physical environment modifications

Interdisciplinary Assessment

- ❖ Assessment tools may consist of:
 - OT assessment of cognition and sensory preferences/tendencies using standardized tools, checklists
 - The Crisis Prevention and Safety Tool
 - Psychology assessment and testing
 - Goal setting with the team

Sensory motor activities

- ❖ Sensory motor groups (Ross, 1997; Moore, 2005)
- ❖ Yoga/exercise groups
- ❖ Creation of a personalized sensory kit
- ❖ Taking a hot shower/bath
- ❖ Art therapy/crafts
- ❖ Mindfulness activities with a sensory cue
- ❖ Journaling

Sensory Modalities

- ❖ Weighted blanket
- ❖ Weighted vest
- ❖ Music Therapy
- ❖ Sound Therapy
- ❖ Brushing techniques
- ❖ Beanbag tapping
- ❖ Aromatherapy
- ❖ Biofeedback
- ❖ Light Therapy
- ❖ Pet Therapy

Sensory Diet

- ❖ The sensory diet is a carefully designed, personalized activity schedule that provides the sensory input a person's nervous system needs to stay focused and organized throughout the day.
 - ❖ A sensory diet may include:
 - **Prevention strategies**
 - **Crisis intervention strategies**
 - **A personalized sensory kit**
 - **The type and amount of support needed to succeed.**

Environmental Modifications

- ❖ Sensory room use
- ❖ General milieu enhancements
- ❖ Unit modifications

General Qualities of Sensory Input*

- ❖ Calming
- ❖ Alerting
- ❖ Grounding
- ❖ Soothing
- ❖ Organizing

General Qualities of Sensory Input

- ❖ General qualities of *calming* stimulation:
 - Mild/Soft - Expected/Predictable
 - Slow - Soothing
 - Rhythmic - Low demand
 - Simple - Positive Associations
 - Familiar

General Qualities of Sensory Input

- ❖ General qualities of *alerting* stimulation:
 - Strong/Pronounced
 - Fast-paced
 - Non-rhythmic
 - Complex
 - Novel
 - Irritating
 - High Demand
 - Negative Associations

The Sense of Smell

- ❖ The only sense that communicates directly with the limbic system.
- ❖ Has strong affective associations.
- ❖ Can have alerting and calming properties.
- ❖ Can be further explored through aromatherapy.

The Sense of Taste

- ❖ Taste is highly individual and related to different cultures.
- ❖ “Comfort foods”
- ❖ Tastes can be alerting or calming.
 - Surprising
 - Unpredictable
- ❖ Disease, medication or old age can diminish taste.

The Oral Motor Sense

- ❖ Oral motor activities can cause different responses, including:
 - Calming
 - Alerting
 - Organizing
 - Increased breath support

The Sense of Vision

- ❖ Used for orienting ourselves and interacting with the environment.

The Sense of Hearing

- ❖ Sound impacts muscle tone, equilibrium and even the body’s flexibility.
- ❖ Very connected to movement.
- ❖ Studies have shown that music can increase endorphin release, impact respiratory and heart rate and brain waves.

The Sense of Touch

- ❖ According to Ayres, touch is critical for neural organization and without sufficient tactile stimulation, the system becomes imbalanced.
- ❖ The brain interprets touch sensations differently when they are self-initiated.
- ❖ Abnormalities in touch response:
 - Sensory defensiveness
 - Related to a history of physical or sexual abuse
 - Include self-injurious behaviors such as hitting, cutting or burning the body.

The Sense of Touch

- ❖ Touch has a significant effect on emotions:
 - *Pressure touch* can enhance the dopamine system, which positively affects the limbic system.
 - *Light touch* evokes a protective response that can set off sympathetic reactions.

The Sense of Proprioception

- ❖ Defined as the perception of joint and body movement.
- ❖ Provides body awareness and boundaries.
- ❖ Proprioceptive input enhances the serotonergic system by making the system more responsive.
- ❖ If the activity is sustained and strong enough, there can be a release of endorphins.

The Sense of Proprioception

- ❖ Individuals with regulation deficits often seek out or avoid proprioceptive input.
- ❖ Behaviors of high threshold (seekers):
 - Pacing, jumping around, “addicted to jogging”, toe walking, biting and flapping hands
- ❖ Behaviors of low threshold (avoiders):
 - Slouched postures, clumsy, poor body concept and fatigue.

The Vestibular Sense

- ❖ Internal compass that signals changes in head position or motion.
- ❖ Has the longest lasting effects for calming and alerting
- ❖ The strongest powerhouse of modulating sensory stimulation
- ❖ The great modulator of arousal

The Vestibular Sense

- ❖ According to Lorna Jean King, postural abnormalities observed in patients with schizophrenia were due in part to an under active vestibular system.
- ❖ The abnormal vestibular processing contributed to shuffling gait and immobility of the head and shoulder girdle.

Sensory Modulation on Blake-11

- ❖ Use of the Crisis Prevention and Safety Tool
- ❖ OT evaluation of sensory preferences and patterns
- ❖ Use of a sensory diet
- ❖ Patient handbook for self-directed regulation

References

- ❖ Ayres, A.J. (1979). *Sensory Integration and the Child*. Los Angeles, CA: Western Psychological Services.
- ❖ Champagne, T. (2006, 2nd ed.). *Sensory Modulation and Environment: Essential Elements of Occupation*. Southampton, MA: Champagne Conferences & Consultation.
- ❖ Moore, K. (2005). *The Sensory Connection Program: Activities for Mental Health Treatment. Manual and Handbook*. Framingham, MA: Therapro, Inc.



MASSACHUSETTS GENERAL HOSPITAL

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?

- | | | |
|---|--|--|
| <input type="checkbox"/> Suicidal behavior | <input type="checkbox"/> Self injurious behavior | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Withdrawal/Isolation | <input type="checkbox"/> Feeling unsafe | <input type="checkbox"/> Severe agitation |
| <input type="checkbox"/> Striking out | <input type="checkbox"/> Destruction of property | <input type="checkbox"/> Dissociation |
| <input type="checkbox"/> Intrusiveness | <input type="checkbox"/> Verbal abuse towards others | <input type="checkbox"/> Threats of violence |

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

- | | |
|--|--|
| <input type="checkbox"/> Being touched | <input type="checkbox"/> Not being listened to |
| <input type="checkbox"/> People in uniform | <input type="checkbox"/> Being around men/women (Who?) _____ |
| <input type="checkbox"/> Yelling | <input type="checkbox"/> Called names or made fun of |
| <input type="checkbox"/> Loud noise | <input type="checkbox"/> Bedroom door open |
| <input type="checkbox"/> Darkness | <input type="checkbox"/> Being stared at |
| <input type="checkbox"/> Sudden movements | <input type="checkbox"/> Not having choices |
| <input type="checkbox"/> Particular time of day _____ | <input type="checkbox"/> Time of year (When?) _____ |
| <input type="checkbox"/> Being threatened | <input type="checkbox"/> Being restrained |
| <input type="checkbox"/> Contact with family or person who is upsetting (Who?) _____ | |
| <input type="checkbox"/> Nightmares/distressing thoughts at night. If so what? _____ | |
- Other: _____

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Clenching fists | <input type="checkbox"/> Pacing |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Wringing hands | <input type="checkbox"/> Rocking |
| <input type="checkbox"/> Becoming rude | <input type="checkbox"/> Singing inappropriately | <input type="checkbox"/> Swearing |
| <input type="checkbox"/> Loud voice | <input type="checkbox"/> Laughing loudly/Giddy | <input type="checkbox"/> Can't sit still |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Dissociation | <input type="checkbox"/> Withdrawal |
- Other: _____

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

- | | |
|--|--|
| <input type="checkbox"/> Room in ICU area | <input type="checkbox"/> Scheduled time in sensory room |
| <input type="checkbox"/> Listen to music | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Pacing in the halls | <input type="checkbox"/> Writing in a journal |
| <input type="checkbox"/> Relaxation tapes | <input type="checkbox"/> Dark Room (dimmed lights) |
| <input type="checkbox"/> Warm or cold drink | <input type="checkbox"/> Talking to staff |
| <input type="checkbox"/> Writing a letter | <input type="checkbox"/> Talking with peers on unit |
| <input type="checkbox"/> Calling a friend/family member | <input type="checkbox"/> Voluntary time in the quiet room |
| <input type="checkbox"/> Voluntary time in the sensory room with staff | <input type="checkbox"/> Wrap up tight with sheet/thin blanket |
| <input type="checkbox"/> Use of weighted blanket | <input type="checkbox"/> Putting hands in cold water |
| <input type="checkbox"/> Using ice (How?) _____ | <input type="checkbox"/> Lying down with cold face cloth |
| <input type="checkbox"/> Taking a hot/cold shower | <input type="checkbox"/> Hugging a pillow |
| <input type="checkbox"/> Doing artwork (painting/drawing) | <input type="checkbox"/> Bean bag tapping/brushing |
| <input type="checkbox"/> Deep breathing/mindfulness exercises | <input type="checkbox"/> Hot balls/sour candy |
| <input type="checkbox"/> Rocking chair/glider | <input type="checkbox"/> Stress ball |
| <input type="checkbox"/> Exercise/stationary bike | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Sound machines | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Coloring | <input type="checkbox"/> Complete chain analysis |
| <input type="checkbox"/> Reverse checks | <input type="checkbox"/> Use of self-rating scale |
| <input type="checkbox"/> Other _____ | |

Trauma History:Do you have a history of abuse or other type of trauma as a child? ☐ Yes ☐ NoAs an adult? ☐ Yes ☐ NoWhat 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 ☐ NoHave 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): _____

Safety Plan & Goals Revisions/updates

Date	Time	Utilized Strategy	Effectiveness	Revised Strategy	Staff/Patient Initials

Summary of Roles and Responsibilities for Healthcare and Public Health Partners

http://www.mass.gov/dph/cdc/epii/flu/pandemic_plan_4.rtf

Interpandemic and Pandemic Alert Periods

Healthcare facility responsibilities:

- Develop planning and decision-making structures for responding to pandemic influenza.
- Develop written plans that address: disease surveillance, hospital communications, education and training, triage and clinical evaluation, facility access, occupational health, use and administration of vaccines and antiviral drugs, surge capacity, supply chain and access to critical inventory needs, and mortuary issues.
- Develop and submit to MDPH a Continuity of Operations Plan.
- Collaborate with regional partners on the development of an Influenza Specialty Care Unit and outpatient screening and care plan.
- Participate in pandemic influenza response exercises and drills, and incorporate lessons learned into response plans.

State and local responsibilities:

- Develop statewide and local or regional plans to manage an influenza pandemic.
- Assist healthcare facilities to identify Influenza Specialty Care Units (ISCU) sites, process applications, and develop operational plans.
- Assist healthcare facilities in conducting exercises and drills to test healthcare response issues and build partnerships among healthcare and public health officials, community leaders, and emergency response workers.
- Develop a communications infrastructure to facilitate and ensure the timely dissemination and transfer of information between the healthcare and public health sectors.
- Address legal issues that can affect staffing and patient care.

HHS responsibilities:

- Provide ongoing public health guidance on healthcare preparedness for an influenza pandemic.
- Provide healthcare facilities with model protocols for early detection and treatment of influenza among patients and staff; these protocols can be piloted during routine influenza seasons.

Pandemic Period

If an influenza pandemic begins in another country:

Healthcare facility responsibilities:

- Heighten institutional surveillance for influenza and prepare to activate institutional pandemic influenza plans, as necessary.

State and local responsibilities:

- Work with HHS to provide local physicians and hospital administrators with updated information and guidance as the situation unfolds.

If an influenza epidemic begins in or enters the United States:

Healthcare facility responsibilities:

- Activate institutional pandemic influenza plans, in accordance with the “Hospital Pandemic Influenza Triggers” outlined in Table 1.
- Identify and isolate all potential patients with pandemic influenza as possible.
- Implement infection control practices to prevent influenza transmission.
- Ensure rapid and frequent communication within healthcare facilities and between healthcare facilities and health departments.
- Implement surge-capacity plans to sustain healthcare delivery.

State and local health responsibilities:

- Provide healthcare facilities with information on the global, national, and local situation.
- Work with HHS to provide guidance (as needed) on infection control measures for healthcare and non-healthcare settings.
- Work with healthcare facilities to address surge capacity needs.

HHS responsibilities:

- Assist state and local healthcare and public health partners on issues related to hospital infection control, occupational health, antiviral drug use and clinical management, vaccination, and medical surge capacity.
- Provide states with materials from the Strategic National Stockpile for further distribution to healthcare facilities.

MASSACHUSETTS
GENERAL HOSPITAL

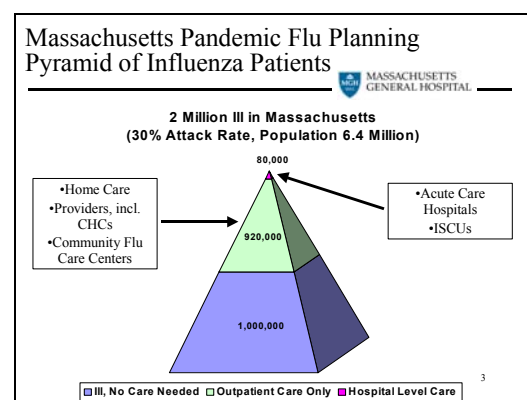
MGH Influenza Specialty Care Unit (ISCU)

ISCU Staffing Meeting
November 28, 2006

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Massachusetts Pandemic Flu Planning Assumptions

- Pandemic likely to occur across Commonwealth simultaneously – at least 2 waves of ~8 weeks duration each
- Medical facilities quickly overwhelmed
- Local, shared response that will force multi-sector collaboration
- February 6th - Governor Romney submitted budget request for \$36.5 million to provide support – has not been approved
 - Assure Availability of Adequate Health Care Personnel
 - Enhance Hospital Surge Capacity
 - Develop State Stockpile of Antiviral Medications
 - Enhance State Laboratory Surveillance Capabilities
 - Develop 30 day Stockpile of Food, Supplies and Medications for State Operated 24 / 7 Hospitals / Programs



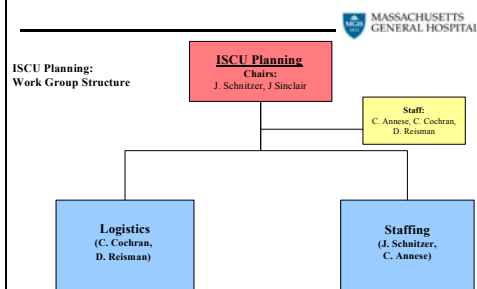
Massachusetts Pandemic Flu Planning

- Acute Care Hospitals: flu patients requiring mechanical ventilation, or those with complex medical management needs
 - Hospitals, Alternate Care Sites, or Influenza Specialty Care Units (ISCUs): flu patients not meeting the criteria for ICU hospital admission but for whom home care is not possible
 - ISCUs will provide:
 - Triage/Outpatient Care
 - Inpatient Care
 - Second highest acuity flu patients only
 - Supportive care only – O2 concentrators, IVs, antibiotics
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Influenza Specialty Care Units (ISCU)

- Licensed as satellite hospitals
 - Planning based on community clusters
 - Clusters determined by hospitals
 - One site per community cluster
 - Regional ISCU bed projections to date:
 - MGH = 80-100 beds, Yawkey Center
 - NSMC = 300 beds, local college gym
 - Newton Wellesley = 100 beds, local school gym
 - Faulkner = 30 beds, in-house
 - BWH/BIDMC/Children's = 240, local college
 - Most hospitals are using schools and other public buildings
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MGH ISCU-Planning Process



MGH ISCU-Supplies and Logistics



- Managed by Craig Cochran and David Reisman
- State will provide/supplement some of the supplies required to operate the ISCU
- MGH will be responsible for providing many of the supplies, and for activating the ISCU once authorized by the state

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MGH ISCU-Staffing



- Managed by Jay Schnitzer and Chris Annese
- Estimate that 40% of the workforce will be unavailable during an influenza pandemic
- Additional personnel may be available
 - Boston Medical Reserve Corps
 - Massachusetts System for Advance Registration (MSAR)
- Need to identify additional personnel to staff the MGH ISCU

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MGH ISCU-Staffing MSAR



- Massachusetts System for Advance Registration: MA version of national ESAR-VHP (Emergency System for Advance Registration of Volunteer Healthcare Personnel) program
- National program based on NIMS, all states developing these programs
- Single, non-redundant database of volunteer healthcare professionals
- Database will register, pre-credential, and activate volunteers

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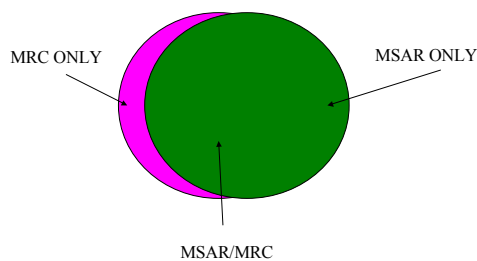
MGH ISCU-Staffing Boston Medical Reserve Corps



- Program under Citizen Corps initiative
- Local units based in communities
- Medical and non-medical volunteers that have been pre-screened
- MRC members participate in practice exercises and drills, and are notified when a need emerges
- MRC units assist local communities with health response needs in non-disaster times
- MRC members encouraged to sign up with MSAR as well

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MGH ISCU-Staffing MSAR and MRCs



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MGH ISCU-Design



- 80-100 bed capacity
- Recommended location in the Yawkey Outpatient Center
 - Floor 2 will be used as the primary location
 - Floor 1, 9 or 10 will be used as a supplemental location
 - Floors will be selected with consideration of the use of the space (clinical, administrative, etc)
 - ISCU will be located in an area where it has the least impact on regular clinical operations
- ISCU beds will be located primarily in the hallways to allow access to many patients
 - Detailed floor plan with bed layout completed₁₂ to assist in planning process

MGH ISCU-Bed Projections			
Yawkey Center			
Floor	Bed Estimate	Occupants	Conf Rm
1	38	Info Desk, Gift Shop, Cafeteria, Coffee South	
2	46	Financial Svcs, Hand Svcs, Ortho, Rheumatology	Satter
9	42	Breast Center, Lymphedema, Chaplain, Fatigue Clinic, Gyn, Brain	
10	49	Tumor, Blood Lab, Neuro Onc and Fibromatosis	Doerr
TOTAL	137		

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MGH ISCU-Next Steps	
<ul style="list-style-type: none"> Approval of concept (Emergency Preparedness Committee 11/21) Department specific ISCU work plans (12/15/06) <ul style="list-style-type: none"> Mission Support required Staffing requirements Interaction with other departments Department specific work plan requirements (from the state) Deliverables: <ul style="list-style-type: none"> Define staffing requirements Develop creative ways to address these requirements 	

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