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TRANSFORMING Care at the Bedside

Placing the Patient at the Center of Care

Making changes in one of four focus areas.

This is the ninth in a series of articles from Massachusetts General Hospital in Boston describing one general medical unit's experiences with Transforming Care at the Bedside (TCAB). An initiative begun by the Robert Wood Johnson Foundation (RWJF) and the Institute for Healthcare Improvement, TCAB was developed as a way to improve care on medical–surgical units, patients' and family members' experience of care, and teamwork among care team members and to increase nurse satisfaction and retention. The TCAB philosophy engages all care leaders, but empowers bedside nurses to generate ideas and solutions for change. Mass General is one of 68 hospitals participating in a two-year TCAB initiative led by the American Organization of Nurse Executives and funded with a grant from the RWJF. For more information on TCAB, go to www.rwjf.org/pr/product.jsp?id=31512.

Our general medical unit at Massachusetts General Hospital is participating in the Transforming Care at the Bedside (TCAB) initiative for a variety of reasons, one of which is to create a more healing environment. The changes we have made can be categorized into four "focus areas": patient-centered care, value-added processes, safe and reliable care, and vitality and teamwork.

Each change we've made so far has fit into at least one of these categories, and sometimes into several. For example, giving nurses a formal role in morning care rounds (see "Nurses Participate in Presenting Patients in Morning Rounds," November 2008) is both a patient-centered and safe and reliable care change. We, like other participants in the TCAB program, have noticed that in our 20-bed unit—called White 10—changes happen only when we focus on all four of these areas.

In this and the next several articles, I'll describe these efforts.

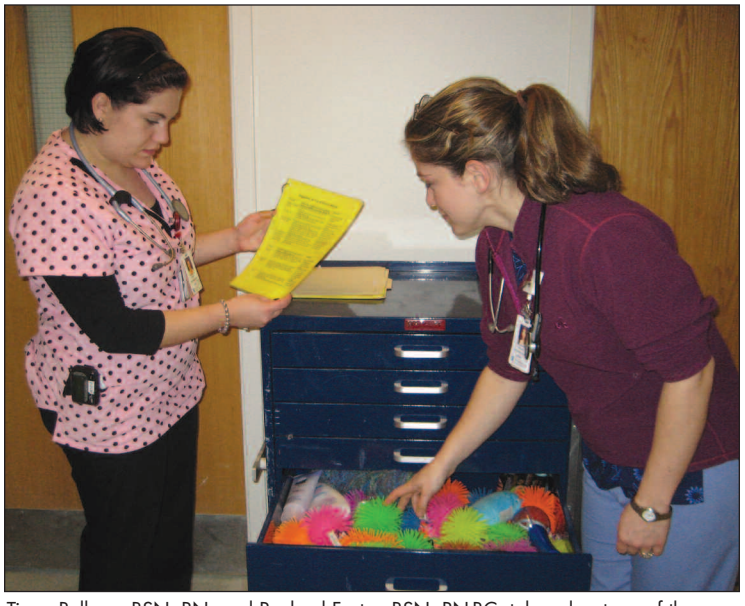
SENSORY CART: A HIT

This has been one of our unit's most successful innovations. Meaghan Rudolph, MS, RN, first suggested that we use a sensory cart. She began working full-time on our unit in 2004, but was soon splitting her time between White 10 and the inpatient psychiatry unit while pursuing a graduate degree in psychiatric nursing. Her expertise has been invaluable on our unit, where it's not uncommon for patients to show signs of altered mental states. Her work on the psychiatric unit showed her that such patients benefit from sensory interventions, such as music therapy, aromatherapy, and tactile stimulation. Meaghan championed our effort to create a mobile unit to house the items used in these approaches.

The sensory cart is an old, metal "code cart" painted navy blue. It's stored in the hallway, so staff can easily retrieve the necessary tools. Meaghan organized the directions for using the sensory tools by behavior and posted them on top of the cart. Thus, if a patient is agitated or pulling at lines, the nurse looks up this type of behavior to find a list of suggested interventions. To track the items' effectiveness, the staff records the patient's initials and behavior, intervention used, and outcome in a log stored in the top drawer of the cart.

The effectiveness of almost every item in the cart is well documented. Patients who are pulling at IV tubing or cardiac monitor wires might be given a ball (made of foam or rubber and perhaps having tentacles or bumps) to hold and squeeze to keep their hands occupied and distract them.[1] Lavender lotion is used to massage patients who are exhibiting anxiety. A lightly weighted stuffed animal placed on a confused patient's lap can discourage her or him from rising from the chair or bed, preventing falls.

Nurses have responded well to using the cart and its contents, which provide alternatives to more restrictive interventions, such as the use of restraints. How often the cart is used depends on our patient population, but the staff reports that when sensory interventions are employed, patients are more relaxed and occupied, and less likely to climb out of bed or pull at wires and tubes. The families of patients have also provided us with positive feed-



Tiana Bellone, BSN, RN, and Rachael Foster, BSN, RN-BC, take advantage of the sensory cart as part of their unit's participation in the TCAB initiative. Photo courtesy of Amanda L. Stefancyk.

back. They've told the nurses that they're relieved to find their loved ones occupied and soothed by coloring, playing cards, or folding a soft piece of felt.

QUIET TIME: A MISS

Establishing a quiet hour during the afternoon should have been successful based on the experiences of other institutions participating in the TCAB initiative, as well as the benefits we saw from the decreased noise level that resulted from an earlier change (see "One-Hour, Off-Unit Meal Breaks," January). Several nurses who had heard about other facilities' success suggested in our brainstorming sessions that we incorporate an additional quiet hour into the day shift. We would meet patients' needs and then not disturb them, dimming the lights in the halls and in patients' rooms and even closing their doors, if requested. We set quiet time for 3 PM and started our usual process of planning for and communicating the impending change. We displayed signs about the quiet hour throughout the unit, explaining why the lights would be dimmed and requesting that the staff, patients, and visitors use soft voices. When quiet time began, the unit secretary announced it on the overhead speaker system and then dimmed the lights.

After almost three weeks of attempting to create quiet time each afternoon, we were still unsuccessful. Sometimes the problem was initiating the quiet hour, and other times the problem was maintaining it. I've thought quite a bit about this and believe the reason quiet time never gained acceptance was that it was difficult to enforce when so many providers and visitors were on the unit. The signs and dimmed lights communicated our goal—to reduce noise and other stimuli to create a more healing environment—but just one person speaking at regular volume often caused everyone else to do the same. We were left with a dimly lit medical unit in which everyone was going about business as usual, speaking at a normal conversational volume.

LEARNING FROM OUR MISSES

When our unit began participating in the TCAB initiative, we expected to learn from each change we instituted, even the unsuccessful ones. The concept of quiet time is one the staff liked, but we couldn't regularly achieve it. Yet on those days when the quiet hour was successful, patients and visitors commented favorably. One nursing supervisor, for example, walked onto the unit and immediately remarked about the "calming" atmosphere. And so we haven't given up on the idea. We plan to try it at another time during the day shift and to broaden our communication about quiet time by asking visitors for their help in keeping the noise level down.

Today I walked onto the unit at 3 PM and found the lights dimmed and the nurses reminding everyone it was quiet time. I smiled and hoped we might learn something from our unsuccessful first attempt that would help us try again. ▼

Next month I'll discuss our experience making changes to another TCAB focus area: value-added processes.

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REFERENCE

1. Mayers K, Griffin M. The play project: use of stimulus objects with demented patients. *J Gerontol Nurs* 1990;16(1):32-7.