

# First Do No Harm

Quality and Patient Safety Division, Massachusetts Board of Registration in Medicine

## Message from QPSD Leadership

Julian N. Robinson, MD  
Chair, Board of Registration in Medicine  
Chair, Quality & Patient Safety Committee

Daniela Brown, MSN, RN, CIC  
Director, Quality & Patient Safety Division

Dear Colleagues,

In its autumn 2020 newsletter [download \(mass.gov\)](#), the Quality and Patient Safety Division (QPSD) invited healthcare facilities to share their experiences during the early period of the pandemic. Healthcare facilities in the Commonwealth have adapted and developed innovative responses to meet the needs of patients and staff. In addition to providing prevention and management interventions such as vaccinations and new treatment therapies, there have been creative initiatives developed to meet the needs of an everchanging environment.

The pandemic has created challenges across all aspects of patient care. Specifically, clinician wellness and peer support programs and initiatives have been developed to attempt to support the healthcare workforce which has been greatly impacted in the last two years. Supply chain concerns have created a need to adopt new approaches to address evolving materials management demands. Managing capacity during the pandemic surges has been problematic for most hospitals and ambulatory clinics. The behavioral health crisis, including the lack of inpatient behavioral health beds and lack of outpatient resources, has been exacerbated during the pandemic. There are many more challenges that have been experienced as a consequence of the pandemic such as patients delaying and deferring care, children falling behind in immunization schedules, and staffing shortages.

In this issue, we share a few of the experiences and initiatives being implemented by some of the healthcare facilities that report to the QPSD. Of course, there are many more topics and programs being discussed and developed. Currently, an important topic which has been highly discussed involves the issue of psychological safety in healthcare. In light of the recently publicized Vanderbilt case, concerns have arisen regarding the potential impact to transparency and reporting of adverse events. The QPSD encourages healthcare facilities throughout Massachusetts to continue to focus patient safety efforts on systems-based solutions and approaches.

Finally, we wish to welcome Erin C. Long, MSN, RN, as a new member of the QPSD team. A list of QPSD team members can be found in this issue. Please contact the QPSD with any questions and/or concerns regarding the Patient Care Assessment (PCA) regulations.

Best,

*Julian N. Robinson, MD and Daniela Brown, RN*

### In This Issue

- 1 Message from QPSD Leadership
- 2 Baystate Medical Center
- 2 Boston Medical Center
- 4 MGB Salem Hospital
- 5 Mercy Medical Center
- 6 Signature Healthcare  
Brockton Hospital
- 8 UMass Memorial  
Medical Center
- 9 Trends in SQR reporting
- 9 QPSD staff members

## Baystate Medical Center

### Peer Support through COVID at Baystate Medical Center

**Mary Beth Collins, BSN, RN**

Patient Safety Specialist Baystate Medical Center

[MaryBeth.Collins@baystatehealth.org](mailto:MaryBeth.Collins@baystatehealth.org)

**Amy Moore, MHL, BSN, RN**

Patient Safety Specialist Baystate Medical Center

[Amy.Moore3@baystatehealth.org](mailto:Amy.Moore3@baystatehealth.org)

**Karen M Johnson, RN, BSN, CCMSCP**

Sr. Director, Patient Safety BH

Member, Quality & Patient Safety Committee (QPSC), Board of Registration in Medicine

[Karen.johnson@baystatehealth.org](mailto:Karen.johnson@baystatehealth.org)

Baystate Medical Center has had a Peer Support Program since June 2015 coordinated by the Patient Safety Team. Initially the team was trained by Sue Scott from the University of Missouri. In 2019 we joined the Betsy Lehman Center's Collaborative as one of 15 pilot hospitals in the state working to expand peer support expertise across the state. Our Executive Sponsors for this initiative are the CNO and CMO/CQO. The process is to utilize a Survey Monkey tool and have staff vote for individuals that they would be most comfortable talking to should there be a traumatic occurrence. These individuals are then invited to be trained as a peer supporter. Peer Supporters include physicians, APPs, Nurses, Operation Associates, Patient Care Technicians, Spiritual Services and Patient Safety.

Due to the impact of the pandemic, our areas of focus initially were on the Emergency Department and ICU's that were highly impacted by COVID-19. Training took place in November 2020 in a hybrid format with the Betsy Lehman team on WebEx and BMC staff spread out between 5 large conference rooms. In addition, two other interactive web-based trainings occurred using "train the trainer model" with our own BMC trained peer supporters as faculty. Following the Betsy Lehman Center's methodology Baystate Medical Center was able to train 65 peer supporters over the past 2 years. Since our Peer Supporters are not trained counselors, they have been educated on all the resources available to staff via Employee Assistance Program (EAP). We realized that it was important to also support our Peer Supporters during this stressful time. To that end, a "Support the Supporters" Group was established. This group is led by one of our clinical psychiatrists to allow the peer supporters a safe place to debrief and support one another.

Early in the pandemic when very sick COVID-19 patients were filling up our hospital's units it was recognized that our staff needed a formal peer support program more than ever. By the second week of the COVID-19 surge in the Spring of 2020 peer supporters were dispatched to the COVID-19 ICU's and intermediate care units— rounding several times a day to connect with staff. Peer Support was provided both individually and in groups. Our Spiritual Services Team provided "Tea for the Soul"— an informal small gathering of staff and Spiritual Services that allowed time for discussion, support, and decompression. Staff appreciated talking to their peers during this stressful time. Our Peer Supporters are easily identifiable by the "Peer Supporter" badge buddy on their ID badge and are able to provide real-time support. It was challenging to assure that all staff were aware of this resource. Partnering with our Communication Team was key to our success. Tracking actual cases of peer support has also been a challenge. To identify units and disciplines that are utilizing Peer Support a tracking program was built in RL Solutions along with an easy electronic referral system. Our goal is that Peer Support is delivered within 24-48 hours of referral. We know that more peer support is happening than what is recorded, and we continue to work on this process.

Overall, this program has been successful in adding another level of support during this difficult time for all health care personnel. We continue to expand the program, building on our learnings as we go. We thank the Betsy Lehman Center for Patient Safety for their valuable assistance in expanding our Peer Support program! [Betsy Lehman Center | Clinician and Staff Peer Support Program \(betsylehmancenterma.gov\)](https://betsylehmancenterma.gov)

## Boston Medical Center

### COVID 19 Impact on Supply Chain and Clinical Care

**Scott Rutledge Sr. Director**

Supply Chain Operations

**Supply Chain Operations Leadership Team**

**Diane Hanley, MSN, RN, EJD, NPD-BC**

Associate Chief Nursing Officer Practice, Quality and Education

Member, QPSC, Board of Registration in Medicine

In January 2020, Boston Medical Center (BMC) Supply Chain Operations (SCO) began to receive

reports of supply concerns regarding personal protective equipment (PPE) due to the emerging COVID 19 pandemic and its global spread which had led to a surge of purchases of all available PPE worldwide. Compounding the evolving problem was the pandemic's origin and the initial impact experienced within China, where the majority of the United States PPE and medical supply is produced. In response to the pandemic, China took steps to quarantine, stopping production lines. Further, China took steps to keep supplies within the country as they assessed their own needs.

As the pandemic quickly escalated, the Supply Chain Operations (SCO) found itself in a unique position. Historically, Supply Chain was built on a foundation of forecasting demand. All production and logistical footprints are byproducts of estimating and satisfying that demand. The speed at which COVID 19 spread immediately placed excessive strain on a supply chain that was built around ocean shipments and predictive forecasting. The global reach of the pandemic in an accelerated timeline added volume onto a demand that was well beyond what production capabilities were available at that time. In situations of spikes in demand, most supply chains are able to cope by absorbing the excess from other regions/areas and redirecting. That was not an option due to the global nature of the pandemic. Simply put, the entire world needed the same supplies at the same time; and the source of most of that supply was the hardest hit from the onset. BMC SCO found itself in the middle of a worldwide supply grab.

The SCO suddenly saw a spike in usage and need, as BMC took steps to protect our patients and ourselves during this crisis. There was a 5-fold increase in PPE consumption in two weeks' time. The SCO worked with its primary vendors in an effort to secure more supply. The SCO started to exhaust communications and connections with all of our traditional vendors.

Vendors found themselves in a difficult situation, as they had all the stateside supplies and thousands of customers trying to buy anything and everything. Yet they, to their credit, did their best to distribute the supply in an equitable manner based on each customer's pre-pandemic usage. They had to restrict supplies based on allocation, so that

everyone received their fair share. They also had to identify and create alternative supply options. The complexity of this work, in the time it was needed, is difficult to convey. However, despite the vendor's best efforts, there was not enough supply.

BMC extended its efforts past the traditional supply chain. The SCO began a tireless effort of identifying any and all manufactured PPE, their supplier, and the location of production. At the same time, the SCO started receiving hundreds of first-time contacts from unknown parties claiming to have supplies. The problem was in determining what opportunities were genuine, which were misguided, and which were malicious in intent. The SCO conducted phone interviews, background checks, business validations, and forensically investigated all options.

Once an opportunity was secure enough for consideration, the SCO brought in the product to determine if its quality met the standards required. The SCO collaborated with clinical colleagues throughout BMC to examine the effectiveness and safety of the product. This led to hundreds of samples being reviewed and denied. Then the SCO had to consider and negotiate the price. Some prices increased by thousands of percentages. The SCO had to consider each one while measuring the current supply position.

Once the right opportunity was presented, the SCO bought in bulk. This now required the SCO to identify storage space for the influx of materials. The SCO did not have the available space to store hundreds of pallets of excess inventory, therefore the focus shifted to creating a third-party storage/warehouse, and the processes required to maintain that inventory. The SCO consistently monitored usage, trending, changes in clinical practices, and ever-changing guidelines. Daily status meetings helped the SCO coordinate and communicate with the clinical settings across BMC. Clinical partnerships continued to evolve as the challenge to the supply chain expanded. Daily meetings were held to address the growing back orders, and identification of appropriate substitutes to assure patient safety and quality care.

The SCO was not alone. The entire BMC community came together to assist each other. All departments participated in this effort. Donations were a critical part of the supply. At a time when we needed it most, the community came together

and offered their own supplies to help BMC and its patients. BMC received calls from former patients who wanted to donate supplies they had to help. Vendors, philanthropists, our neighbors... all reached out and contributed whatever supply they had available.

The SCO created processes that were executed ad-hoc, under extreme time constraints. The SCO devised emergency strategies nobody would have conceived as required. BMC faced the same situation as the rest of the world, and thanks to their great work, the SCO efforts resulted in no shortages throughout the pandemic. The SCO would say they were only a small piece of the COVID 19 response puzzle. Together, we witnessed the best from everyone within BMC and outside as well. Due to each one of these individuals and teams, we were able to succeed.

### **MGB Salem Hospital**

#### **Capacity Management During COVID-19 Surges**

**Angela M. Schrage, MS, RN**

Quality Improvement Specialist

Capacity management throughout the COVID-19 pandemic has been incredibly difficult for hospitals, as they have been forced to juggle an emerging pandemic, an all-time-high census, and a staffing crisis simultaneously. Salem Hospital was hit incredibly hard during the first COVID-19 surge in spring 2020. The influx of COVID patients led to the need to approach capacity management in unprecedented ways. Many of these same strategies adopted early on have remained with us, and evolved, over the past two years as pandemic, capacity and staffing issues have continued to present themselves.

The "Daily Safety Huddle," which was initiated approximately 4 years ago, is a 15-minute weekday morning meeting with a leader or representative from each hospital department expected to be present and report out any actual or potential safety issues with a 24-hour look back and look ahead. The Safety Huddle has helped to bridge gaps in communication related to safety concerns. Over the past two years, as capacity surges have risen to the forefront of patient safety, we have added scripting for Patient Access Services (PAS) to report current census, number of available beds, number of patients waiting for beds in the Emergency Department (ED), and the number of

beds closed due to staffing. The ED also reports out the previous day's number of patients seen admissions, transfers, and the number who left without being seen.

The twice daily bed meetings are another process that Salem Hospital already had in place to manage capacity that has served us well throughout the pandemic. The bed meetings are a forum for the charge nurse from each unit and PAS to come together to reflect on census, bed availability, planned discharges, and patients needing beds on a unit-by-unit level. Each unit is then given a "red," "yellow," or "green" status based on the projected number of patients in and out. A discussion is held for any "red" unit and a plan is put in place. The information discussed at the bed meeting is then sent to hospital leadership in the form of the morning and evening "Capacity Report."

Additional processes have also been put into place to enhance communication during capacity surges, including daily capacity calls and weekly capacity management huddles. The weekly capacity management huddle included leaders and representatives from Operations, Patient Care Services, Behavioral Health, Occupational Health, Infection Control, Materials Management, Laboratory, Pharmacy, ED, Surgical Services, and Human Resources. This weekly report out and discussion has allowed for routinized reflection of the issues at play affecting organizational and system-wide capacity.

Managing patient beds across the Mass General Brigham (MGB) system, rather than each institution acting as a silo, has become a strategy for capacity management that we have begun to take more advantage of since the initial COVID surge. For example, it has been a long-time practice to send high acuity critically ill patients from the community hospitals to Massachusetts General Hospital (MGH) or Brigham and Women's Hospital (BWH); however, we now have a system in place to identify and transfer lower acuity ICU patients from our MGB affiliates to Salem Hospital. This system-level approach to bed management helps to better serve our patients, manage capacity, and support our hospitals.

Reducing or canceling elective procedures, in response to the state's mandates, allowed for the redeployment of staff and reduced the number of

inpatient beds needed for post-operative patients. Physicians, nurses, and staff from Surgical Services, as well as outpatient departments such as Cardiology and Radiology, have taken redeployment assignments over the past two years. Redeployment allowed the institution to leverage all resources to address the crisis at hand. Nursing staff have been redeployed to Med/Surg units and the "Prone Team," created and utilized in spring 2020 during the initial COVID surge. Anesthesiologists have also been deployed to the ICU to assist with procedures.

Finally, keeping our staff healthy, quickly identifying when they aren't, and getting them back to work as soon as appropriate, has been essential when managing surges in patient volume during times of peak COVID illness. Salem Hospital successfully opened and managed two employee COVID vaccination clinics, an asymptomatic employee COVID testing clinic, and a symptomatic/close exposure employee COVID testing clinic. These clinics required project management, IT support, space, logistics, managerial oversight, volunteers, and redeployed staff to administer vaccinations and testing.

While the past two years have been incredibly difficult, and there will continue to be capacity issues we must face going forward, we have learned here at Salem Hospital that if we keep the patient at the center of our decision-making, we can overcome these challenges. We will take the lessons we have learned along the way and use them to shape the future of the care that we provide.

## **Mercy Medical Center**

### **Behavioral Health Crisis in Emergency Department Settings**

**Edna Rodriguez, LP-Psy.D.**

Director of Behavioral Health

**Robert Roose, M.D., M.P.H.**

Chief Medical Officer

Behavioral Health patients boarding in Emergency Departments awaiting inpatient psychiatric care is a full-blown crisis for hospitals across Massachusetts. Prior to the COVID-19 pandemic, boarding was a significant concern, and now there are greater numbers of patients in need of higher levels of psychiatric care. Patients are presenting with increased severity of symptoms, including violence and psychosis in combination with new onset

psychiatric or substance use disorders (SUD), including depression, anxiety, or alcohol use disorder. This has been compounded by shifts within the behavioral health system of care towards largely delivering services via telehealth and less access to services that allow people to seek support, treatment, and remain safe in the community.

At Mercy Medical Center, we have taken a proactive, integrated approach to addressing these challenges with the goals of improving quality and timeliness of care for behavioral health patients in our Emergency Department. We believe our approach has been successful in leading to relative reductions in boarding times per patient due through 1) bolstering a skilled multidisciplinary team, 2) focusing on enhanced assessments, reassessments, and treatment in place, 3) education of our ED team, 4) empowering patients and families, and 5) building a network of community connections.

In addition to the Emergency Service Providers (ESP, aka "crisis") present 24/7 for evaluations, at Mercy our multidisciplinary behavioral health team is comprised of experts that supplement assessments, collaborate on disposition planning, initiate medications, and offer brief interventions or follow-up. This team is comprised of a psychiatrist or psychiatric trained-APRN, an addiction medicine specialist physician, and two Behavioral Health Specialists (licensed Social Workers), overseen by a licensed clinical psychologist.

The focus of our team is on appropriate assessments, reassessments, and treatment of patients. A daily review of ESP reports through a psychiatric lens can increase the accuracy of disposition determinations as well as improve the clinical competencies of the ESP clinician over time. Having a diverse group of clinicians at different levels of expertise with capacity to conduct culturally appropriate assessments in Spanish also helps our team leverage a true strengths-based approach. When reassessing patients each day, we don't just accept the initial determinations day after day, but rather focus on the potential for discharge to the least restrictive level of care and resolving barriers to transition patients to services such as Community Crisis Stabilization (CCS) or substance use disorder treatment directly.

Behavioral health patients benefit from appropriate medication to stabilize patients for acceptance to an inpatient facility or becoming stable to discharge to less restrictive levels of care. Our team huddles daily and identifies patients for whom medication can be initiated or titrated to reduce acute symptomatology and the likelihood for restraints. For patients with chronic symptoms and that receive services through DMH, we have developed a process to accommodate the administration of Long-Acting Injectable medications in the ED and coordinate their return to group living environments, avoiding the inpatient hospitalization all together.

As the success of each of these interventions requires the engagement of the entire team in the ED, we recognized that education of the entire team is critical. Our team has provided broad-based education on psychiatric evaluation and treatment, and individual case discussions in real-time continue to support the training and empowerment of ED providers. By educating everyone on how to appropriately triage which patients need a psychiatric assessment and who may be better directed to the substance use disorder team or other resources.

Similarly, engaging, and empowering patients and families in their assessment and recovery can enhance the power of therapeutic interventions. We focus on providing psychoeducation and support to family members of the patient as well. In many cases, the stabilization of patient follows from stabilizing their support system, including parents, partners, and care takers. Lastly, one of the defining features of our approach to this crisis has been taking a collaborative approach by building a network of community relationships supported by leadership. Our team has developed working relationships and streamlined processes with local facilities to review, accept, and transfer patients in need of care. We meet monthly with many of our primary placement options to review, troubleshoot, and enhance collaboration opportunities with the goal of serving as many individuals in our communities as possible. At Mercy, we foster a culture that "behavioral health patients are everyone's patients and deserving of the best care", with an eye towards eliminating stigma and enhancing recovery. We believe that teamwork paired with consistent assessment, treatment, and community engagement is critical to support patients with

behavioral health needs succeed in their journey towards living a life worth living.

### **Signature Healthcare Brockton Hospital Creative Strategies to Address the Behavioral Health Beds and Resources Crisis**

**Laura Griffin, MD**

Chief of Emergency Medicine

**Christine Rowan, LICSW**

Director of Social Work

Situation:

Prior to the COVID-19 pandemic, boarding of behavioral health patients in the Emergency Department waiting for inpatient psychiatric beds was a pervasive problem. Behavioral health boarding causes a tremendous amount of strain on the ED in terms of quality and safety. The COVID-19 pandemic has made this complex issue even more difficult and unsustainable, creating a behavioral health crisis.

Background:

On both a state and national level, the behavioral health system has battled access to care and workforce shortages (MA Behavioral Health Boarding Metrics, Massachusetts Health and Hospital Association, March 2022). The gravity of the situation has intensified given the increased level of acuity in patients presenting in crisis. Since the pandemic began in March 2020, both adult and pediatric behavioral health patients have had a significant increase in their Emergency Department length of stay. The average length of stay for an adult behavioral health patient in our Emergency Department has increased from 0.67 days in 2019 to 1.05 days in 2021. Our pediatric behavioral health patients' average length of stay has increased from 1.1 days in 2019 to 2.5 days in 2021. There have been days throughout the pandemic where the hospital has had up to 30 behavioral health patients waiting for placement at any given time.

These worrisome changes were primarily due to significant staffing challenges resulting in the loss of inpatient psychiatric beds. In addition to this, some psychiatric units were forced to stop admissions due to their COVID positivity rates of their existing inpatient population. The lack of inpatient beds for COVID positive patients awaiting placement was another challenging barrier. Of these factors, workforce shortages remain the most serious ongoing concern.

**Assessment:**

In order to combat this trend, the team at Signature Healthcare Brockton Hospital looked to provide and implement changes within their span of control.

A morning huddle via Zoom that includes representation from the Emergency Department, the inpatient psychiatric unit, and local Emergency Service Provider (ESP) was established. The purpose of this brief daily huddle is to review the number and status of boarders waiting for placement and to communicate potential discharges from the inpatient unit in an effort to maximize workflow and efficiency. Any potential issues that surfaced within the last 24 hours are also discussed for rapid problem solving.

The addition of a new Psychiatric Coordinator role has streamlined the referral and communication process for patients from the Emergency Department to our inpatient psychiatric unit. We created a new surveillance report. This report pulls all of the patients in the hospital and in the Emergency Department in real time who are identified as needing inpatient psychiatric level of care and also notates the status of medical stability. As a result of these combined efforts, we have been able to facilitate admissions to our inpatient unit earlier in the day, freeing up that capacity in the Emergency Department earlier than in the past.

Any patient in need of inpatient psychiatric treatment is evaluated by a psychiatrist after 24 hours to evaluate for medication initiation and/or medication adjustment. Treatment is initiated to attempt to stabilize the patient from their acute crisis state and potentially advance their disposition from inpatient to voluntary placement (with potential to board from home), or to discharge. Psychiatrist follow-up in the Emergency Department is scheduled at regular intervals following the initial consultation.

Emergency Departments were not designed to include the resources for socialization or social activities particularly for our pediatric behavioral health patients. Pediatric patients are regularly evaluated for "at home boarding" based on a safety and risk assessment, as well as existing informal and formal community supports.

**Recommendations:**

The pandemic has drawn increasing levels of attention needed to address the gaps in care for those in behavioral health crisis, including but not limited to additional space in the Emergency Department, occupancy for inpatient treatment, as well as improved outpatient and community resources.

In order to expand capacity for behavioral health patients in our ED, we have begun renovations to increase the dedicated area for these patients from 4 to 12 beds. We have also participated in Zoom meetings with external psychiatric hospitals to best determine how referral processes can be improved, with such suggestions as daily morning phone calls versus in-person screenings for potential patients in need of inpatient care.

The state continues to examine ways in which to address these complex and persistent needs. Through partnership with the Governor's office and the Legislature, the inpatient psychiatric system will add more than 300 new inpatient psychiatric beds in 2021-2022, including beds both in psychiatric units at acute care hospitals and in freestanding psychiatric facilities (MA Behavioral Health Boarding Metrics, Massachusetts Health and Hospital Association, March 2022).

The Executive Office of Health and Human Services (EOHHS) is seeking to expand the way behavioral health services are delivered to include a network of Community Behavioral Health Centers (CBHCs). [Roadmap for Behavioral Health Reform | Mass.gov](#) These centers will function as a central point to provide routine and urgent outpatient services, crisis services for adult and pediatric populations, and community crisis stabilization services. This initiative also seeks to broaden insurance coverage for behavioral health and has targeted interventions to address the workforce shortages.

Questions and comments may be directed to  
Mali Gunaratne  
Administrative Assistant  
Quality & Patient Safety Division  
Massachusetts Board of Registration in Medicine

[mali.gunaratne@mass.gov](mailto:mali.gunaratne@mass.gov)

## UMass Memorial Medical Center Caring for Caregivers

### **Meghna C. Trivedi, MD, FACP, FHM**

Associate Professor of Medicine  
Physician Quality Officer, Department of Medicine  
UMass Chan Medical School  
Member, QPSC, Board of Registration in Medicine

### **Kimiyoshi J. Kobayashi, MD, MBA, SFHM**

VP, Chief Quality Officer  
Center for Quality and Safety  
UMass Memorial Medical Group and Medical  
Center

### **Steven B. Bird, MD, FACEP, FACMT**

Clinician Experience Officer (CXO)  
Professor of Emergency Medicine  
UMass Chan Medical School

Burnout is a work-related syndrome that involves emotional exhaustion, depersonalization, and a sense of reduced personal accomplishment.<sup>1</sup> Several studies have shown that close to 50% of physicians report burnout.<sup>2,3</sup> This prevalence is accentuated by the COVID-19 pandemic. Stressors accelerating burnout during the pandemic include high patient census, staffing challenges, concerns regarding safety of their family, unpredictable childcare, and school availability, constantly changing protocols, and a large sense of unknown.

At UMass Memorial Healthcare, we are fortunate to have a Clinician Experience Office (CXO) supported by UMass Chan Medical School, UMass Memorial Medical Center, and UMass Memorial Medical Group. The central focus is to advance caregiver wellness and professional fulfillment. During the pandemic, the above organizations came together to form a "Caring for Caregivers" group to support caregivers during the pandemic. The activities and resources are aimed at enhancing emotional, financial, social, academic, physical, and spiritual well-being. Some of the specific programs developed are highlighted below.

The Center for mindfulness provides eight weeks of structured virtual classes exploring the mind-body connection to impact one's mental well-being positively. The mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT) involves psychoeducation, meditation, and movement practices that increase awareness of the present moment and emotional regulation. The Peer support group is an incredible resource for fellow clinicians who can discuss any adverse or

unexpected patient event or traumatic personal events in a safe, confidential, and non-judgmental manner.

The existing Employee Assistance Program (EAP) and Employee Assistant Support for Employees Fund (EASE Fund) have experienced broader uptake during the pandemic. Support has been proactively offered to caregivers after stressful events such as a Covid 19 surge or a serious safety event. A new position of a caregiver wellness specialist was created to make weekly rounds at the frontline of care with the "Wellbeing Wagon," which includes sensory items like aromatherapy, lotions, refreshments, and stress balls to provide self-care to all the caregivers. The wagon is a big hit with our residents! In addition to this, reiki, hand massage, and tips for stress management are also exchanged.

We also utilized technology to reach caregivers and offer words of support. Care texts were sent to caregivers during the pandemic for additional support. In addition, we leveraged My Health Matters which is an online platform that encourages physical well-being and fitness goals. The site provides tracking of activities which can be redeemed for monetary rewards.

Our institutional leaders have been highly supportive to the clinicians who needed help with childcare and eldercare during school and facility closures in the first and second COVID-19 waves. Backup childcare, tuition discounts, sitter search, eldercare services, and housekeeping services are only some examples of services offered.

The Clinician Experience Office has also hosted Zoom experiences like a virtual visit to Napa and Porto while providing complimentary wine to caregivers who can enjoy the tour from their homes. The Wellness grand round series welcomes renowned speakers who discussed important wellness topics such as compassion, self-care, and financial wellness. Finally, the ten days of Doctor's Day celebration held this year was a fun and innovative way of acknowledging physicians. There was a significant engagement in yoga, meditation, scavenger hunt, goat hikes, and trivia.

Our patients, Our People, Our Discoveries, and Our long-term financial health are the four foundational pillars of the UMass Memorial organizational



structure. We firmly believe that taking care of "Our People" positively impacts the other three pillars.

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This newsletter is issued by the Board of Registration in Medicine (BORIM), Division of Quality and Patient Safety (QPSD). The newsletter allows BORIM to share the practices and experiences of the healthcare clinicians and facilities that report to the Board. It does not necessarily include a comprehensive review of literature. Publication of this newsletter does not constitute an endorsement by the BORIM of any practices described in the newsletter and none should be inferred.

### Recent Trends noted in Safety and Quality Review (SQR) reporting to the QPSD

- **Discharge of patients against medical advice (AMA) who do not have the capacity to consent (age, mental status, mental capacity)**  
Ensure there is awareness of policy and a collaboration with resources available (behavioral health service, legal department, risk management) when there are questions or concerns.
- **Performing new procedures, especially in high-risk settings/situations**  
Consider risk assessment, development of policies and competencies, utilization of pre-procedure huddles, and management knowledge and approval prior to new procedures being implemented.
- **Lack of supervision of trainees especially in high-risk areas** (insertion of central lines with inadvertent cannulation of artery rather than vein, guidewire retention, imaging interpretation not confirmed by attending or radiology especially in OB areas, and discharge process with medication reconciliation related errors.
- **Failure to reconcile lines/tubes**  
Oral solutions and oral medications inadvertently given via peripheral and central line. Incorrect intravenous medication administered via IV pump due to lack of reconciling lines and tubing.
- **Oxygen tanks running empty, specifically in ED and outpatient areas such as radiology**  
Consider low-volume alarms which are a stronger intervention than signage and policy review/awareness.

#### QPSD Staff

Daniela Brown, MSN, RN, CIC, Director [daniela.brown@mass.gov](mailto:daniela.brown@mass.gov)

Dorothy T. Doweiko, MHA, BSN, RN, Quality Analyst [Dorothy.T.Doweiko@mass.gov](mailto:Dorothy.T.Doweiko@mass.gov)

Trinh Ly-Lucas, MSN, AGNP-BC, Quality Analyst [Trinh.Ly-Lucas@mass.gov](mailto:Trinh.Ly-Lucas@mass.gov)

Erin C. Long, MSN, RN, Quality Analyst [Erin.C.Long@mass.gov](mailto:Erin.C.Long@mass.gov)

Mali Gunaratne, Administrative Assistant [mali.gunaratne@mass.gov](mailto:mali.gunaratne@mass.gov)

Daniel J. Kumin, Assistant General Counsel