TL 2: How nurses at every level – the Chief Nursing Officer (CNO), Nurse Administrators, and direct care nurses – advocate for resources, including fiscal and technology resources, to support unit/division goals.

The role of advocate is fundamental to nursing. The American Nurses Association includes advocacy in its definition of nursing, which it describes as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (Nursing Social Policy Statement, 2003 & 2010).

Advocacy in nursing finds its theoretical basis in nursing ethics. For instance, the ANA’s Code of Ethics for Nursing includes language relating to patient advocacy, “The nurses primary commitment is to the patient, whether and individual, family, group or community; The nurse promotes, advocates for, and strives to protect the health safety, and rights of the patient” (ANA Code of Ethics for Nurses, 2010)

At MGH, the importance of advocacy is grounded in our Mission, Vision and Guiding Principles (OOD 1):

**MGH Mission:** “Guided by the needs of our patients and their families, we deliver the very best health care in a safe, compassionate environment; we advance that care through innovative research and education; and, we improve the health and well-being of the diverse communities we serve.”

**PCS Vision & Values:** “We believe in creating a practice environment that has no barriers, is built on a spirit of inquiry, and reflects a culturally-competent workforce supportive of the patient-focused values of this institution.”

**MGH Patient Care Services Guiding Principles:** “We are ever alert for opportunities to improve patient care; we provide care based on the latest research findings.”

Throughout these statements, there is a commitment to doing whatever it takes to provide high quality and safe care to MGH patients and families. Nurses at all levels in the organization have a strong advocacy component to their role. The role component of advocate incorporated into their position descriptions.

<table>
<thead>
<tr>
<th>Role Description</th>
<th>Advocacy (reflected in position description)</th>
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</thead>
<tbody>
<tr>
<td><strong>Senior Vice President for Patient Care and Chief Nurse</strong> is accountable for assuring that competent, compassionate patient care is uniformly provided to patients in ambulatory, inpatient and community settings; directing, developing and advocating for the organization and operations of departments for which responsible; leading the management team toward attainment of identified short- and long-term goals and objectives; executing strategies and plans designed to achieve said objectives; and collaborating with other</td>
<td>5.1: Sets priorities and <strong>advocates</strong> with administrative peers for allocation of resources.</td>
</tr>
<tr>
<td>Role</td>
<td>Responsibilities</td>
</tr>
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<td>------</td>
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</tr>
<tr>
<td><strong>Hospital executives to meet Institutional goals and objectives.</strong> (OOD 2.a)</td>
<td>4.0: <strong>Advocates</strong> for resources necessary for patient care.</td>
</tr>
<tr>
<td><strong>Associate Chief Nurse (ACN)</strong> is responsible for direct patient care for a designated group of units/programs. The ACN assures that competent, compassionate patient care is uniformly provided to patients in inpatient, outpatient, and community settings. The ACN develops, implements, and evaluates policies, programs, and services consistent with the hospital’s mission and the department’s vision and philosophy. The ACN provides direction and support to the unit-based leadership toward attainment of short- and long-term goals and objectives. As a member of the nursing executive management team, the ACN participates in the efficient and effective management of the department of nursing, and the development of its strategic plan (Attachment TL 2.a).</td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Director</strong> is accountable for the delivery of consistent, high quality patient care, promoting the development and satisfaction of nursing and support staff, providing operating efficiencies and insuring compliance with hospital and regulatory policies and standards of practice. This role is an essential leadership position in the hospital organization encompassing patient focused management, personnel management and development, business administration of the unit, development of collaborative and team partnerships within units and interdisciplinary settings, and participation in the Department of Nursing and MGH groups and committees. (Attachments TL 2.b).</td>
<td>3.3: Promotes, develops and evaluates processes and systems for patient care; <strong>advocates</strong> for resources and systems improvements when necessary.</td>
</tr>
<tr>
<td><strong>Clinical Nurse Specialist</strong> is a master’s prepared nurse with an area of specialization who promotes competent, compassionate and professional nursing care for patients/families across the continuum. The role includes patient care, teaching, consultation and research (Attachment TL 2.c).</td>
<td>1.1: Supports independent nursing practice of professional nurses through collaborative, <strong>advocacy</strong>, consultative and role modeling activities.</td>
</tr>
<tr>
<td><strong>Nurse Practitioner</strong> develops, implements and evaluates a program of specialized health care for a select patient population. Promotes a collaborative relationship and effort between</td>
<td>Collaborates with unit staff and physicians to <strong>advocate</strong> for and facilitate a comprehensive plan of care and coordinate resources.</td>
</tr>
</tbody>
</table>
the medical staff and professional nurses toward continuity of patient care and efficient use of resources. Serves as a role model for professional nursing practice (Attachment TL 2.d).

**Staff Nurse** is a registered nurse who is responsible for assuring competent, compassionate, individualized, nursing care for specific patients and families, including delegation to and supervision of non-professional clinical and support staff. The staff nurse is responsible and accountable for the overall nursing care management of a designated group of patients. She/he collaborates with the Nursing Director and members of the Patient Care Team to achieve optimal patient outcomes. She/he also collaborates with the patient toward meeting the needs and expectations of the patient and family. Staff nurses ensure that care is safe, efficient, effective, timely and meets the cultural, spiritual, and ethnic needs of each patient and family (Attachment TL 2.e).

1.g.: Helps define standards of excellence for patient care; participates in, and advocates for, improvement of patient care services in a cost-effective way.

A major component of advocacy at MGH focuses on securing the necessary resources to deliver care that is patient-centered safe, effective, timely, efficient, and equitable. The formal process in the Hospital that support requests for resources, fiscal and technology, is the MGH Budget process. This is conducted annually and has both operating and capital components.

**Budgeting in Patient Care Services**

In MGH Patient Care Services, the Senior Vice President and Chief Nurse (CNO) leads the PCS Executive team in the budget process. The budget is discussed in formal meetings such as the Patient Care Services Executive Committee (Attachment TL 2.f) and Nursing Executive Operations (Attachment TL 2.g). The Executive Team works with their respective leadership to identify and prepare budgetary requests for existing and new programs. The CNO also meets individually with her direct reports to discuss budget requests.

The FY 2013 operating budget process was launched on March 19, 2012 with an email from the Executive Director of Finance which outlines the context, key timelines, and assumptions for completing the budget (Attachment TL 2.h). The Patient Care Services Financial Management Systems staff provide support in completing this process.

The FY 2012 capital budget process was launched on June 18, 2012 with an email from the Director of PCS Clinical Support Services outlining the process and key dates: August 1, 2012 for renovation requests and August 31, 2012 for all requests (attachment TL 2.i). MGH capital items must have a unit cost of greater than $5000. Drop-in sessions are sponsored by PCS Clinical Support Services to assist leadership in preparing their respective capital requests. A template (attachment TL 2.i) is provided to ensure key information about the request is provided.
The Senior Vice President for Patient Care/Chief Nurse consistently demonstrates her unwavering commitment and support for staff and patient care needs. The following examples illustrate her advocacy for staff by providing additional personnel, enhanced capital and operating budgets, and improved systems that support nurses providing direct patient care. This chart reflects the growth in Total FTEs and overall budget from 2010 to 2012.

### Patient Care Services Operating Budget Summary
**Fiscal Years 2010 - 2012**

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total FTEs</td>
<td>4170.9</td>
<td>4229.6</td>
<td>4392.3</td>
</tr>
<tr>
<td>Salary and Wages</td>
<td>$366,107,356</td>
<td>$370,705,801</td>
<td>$387,883,779</td>
</tr>
<tr>
<td>Fringe Charge</td>
<td>$111,507,716</td>
<td>$125,604,702</td>
<td>$134,893,040</td>
</tr>
<tr>
<td>Non-Salary Expense</td>
<td>$35,103,930</td>
<td>$33,681,784</td>
<td>$33,281,938</td>
</tr>
<tr>
<td></td>
<td>$512,719,002</td>
<td>$529,992,287</td>
<td>$556,058,757</td>
</tr>
</tbody>
</table>

On July, 22, 2012, the CNO sent out the following email sharing that the FY 13 Operating budget requests for Patient Care Services were approved. This includes:

- 143.4 FTEs for current clinical areas
- 80.8 FTEs for two new clinical areas opening in FY'13
  - Bigelow 7 Short Stay Unit
  - Yawkey 7 First in Human Infusion Center

-----Original Message-----
From: Ives Erickson, Jeanette, R.N.,D.N.P.
Sent: Sunday, July 22, 2012 10:12 AM
To: PCS Assoc Chiefs and Directors; McCarthy, Nancy J., R.N.
Subject: Budget

Dear Colleagues,

For us, the budget process is done. Given our good financially picture, you have permission to hire into the FY 13 adds now. If you are not clear about your adds, please contact Nancy McCarthy.

Many thanks,
Jeanette

**New Program: First in Human**

The vision for the First in Human Unit was articulated by Jose Baselga, MD PhD, Associate Director, Cancer Center in late 2010. [Attachment TL 2.k](#) outlines the vision for the Center for Targeted Cancer therapies to become a leader in targeted therapies and role in facilitating drug development to deliver advances in cancer treatment and cures. He identified that dedicated space should be allocated for this initiative. [Attachment TL 2.l](#) includes a project description to renovate space on Yawkey 7 to house the entire Targeted Therapies Infusion Center. The Associate Chief Nurse overseeing the Cancer Center advocated for unit and nursing staffing resources totaling $3,698,451 which were approved [Attachment TL 2.m](#).
The budget also includes non-Patient Care Services FTEs for Pharmacist (4.5 FTEs) and Pharmacy Technicians (2.5 FTEs).

**New Unit: Bigelow 7 Short Stay Unit**

Patient throughput and efficient care delivery are priorities that are articulated in the strategic plans for Partners HealthCare, MGH, and Patient Care Services (attachment TL 1.g). The MGH Executive Team identified the urgent need to improve access and care to the high volume of patients is the institution's highest priority. It identified that a Short Stay Observation Unit should be opened in late summer, 2012 which will provide high quality, focused care for patients who need observation for less than 24 hours in an environment that enhances and optimizes patient safety. Ideally the Short Stay Observation Unit would be geographically close to the Emergency Department (Lunder 1, White 1, Ellison 1) however this was not feasible in the existing floor plate.

The Associate Chief Nurse and the MGH Emergency Department Nursing Director advocated for nursing resources to staff the Bigelow 7 Short Stay Unit. Key excerpts from their proposal include:

**Patient Population**

The patient population will include current observation admissions and short stay patients who meet observation criteria. Greater than 50% of these observation patients are anticipated to have a chest pain related diagnoses; other diagnosis will include asthma, renal colic, cellulitis and DVT. It is expected that 85% of these patients will be discharged home, with an average LOS of 14-16 hours. The remaining 15% of patients will most likely need to be admitted to the hospital due to their illness after being medically observed. The following patients will be excluded from the unit:

- Patients with behavioral and/or alcohol (ETOH) related diagnosis
- Patients from Acute Psychiatric Services (APS)
- Patients requiring NPIR (Negative Pressure Isolation Room)

Patients who meet predetermined clinical criteria may be admitted to this unit from any treatment area within the Emergency Department. The estimated daily activity of patients is 18-27.

**Physical Space**

Bigelow 7 is an excellent location for patient care. It was previously occupied by an inpatient care unit for the OB/GYN Service (18 patients). The adjacent inpatient units in White, Blake and Ellison are inpatient medical and surgical beds. Public elevators, toilets, telephones and cafeteria are all available for visitors. MGH provides patients and families with parking on site at discounted rates as well as valet services. Bigelow 7 physically exists as a nursing care unit with patient rooms and accompanying support space, so construction was not necessary. The Short Stay Observation Unit will provide for 18 patients -- 8 double rooms (16 patients) and 2 single rooms (2 patients). The double patient rooms have cubicle curtained separation with hand washing sinks in each. The nurse station, nurse call system, pneumatic tube system, soiled utility and clean supply are all in place. Each patient will have their own television. Suremed/Omnicell systems are the standard medication administration and inventory system at MGH. Bigelow 7 will be spackled, painted, and cleaned before being occupied by patients. The only change to the physical environment is some new medical equipment and furniture to supplement that already existing in place.

**Staffing and Support**

The unit will be medically managed by the Emergency Department's physicians with additional clinical management by Emergency Department Nurse Practitioners.
New Unit Proposal: Blake 12 ICU

In fall of 2010, an interdisciplinary team, comprised of physician, nursing and leadership developed a proposal to open a new 18-bed medical surgical intensive care unit. This proposal was in response to the growing need for inpatient capacity, including critical care services, based on national trends and a two-year review of quality and safety indicators.

A new MGH ICU would increase the number of critical care beds and would represent approximately fifteen percent of the total number of inpatient beds, consistent with the Advisory Board recommendations and national averages for peer institutions. Following review, the proposal outlining the unit concept, patient populations and staffing requirements was approved (Attachment TL 2.o).

In 2011, an interdisciplinary planning group was formed which included the following members:
- Blake 12 Medical Director
- Blake 12 Nursing Director
- Surgical ICU Nursing Director
- Surgical ICU Clinical Nurse Specialist
- Associate Chief Nurse
- Director of Clinical Support Services
- Associate Director of Clinical Support Services
- Executive Director of the Institute for Patient Care
- Director of the Norman Knight Nursing Center for Clinical & Professional Development
- Staff Specialists (Project Managers)

The group embarked on the next phase of planning (Attachment TL 2.p contains an example of minutes) which focused on the following key topics:
- The Blake 12 ICU Vision
- Target Opening Date
- Project Timeline
- Leadership Recruitment
- Recruitment and orientation of Staff (Physician, Nurse Practitioner, Registered Nurses, Critical Care Technicians, Respiratory Therapists, Operations Associates and Unit Service Associates)
- Capital requests (Unit renovations, patient care equipment and information technology)

The unit’s physical location was determined to be Blake 12, a recently-vacated Neurosciences ICU, which moved to the Lunder Building a month prior. In addition to significant efforts dedicated to hiring and educating staff, much of the planning group’s efforts focused on determining the renovations required, capital equipment needs as well as non-capital equipment requirements.

The Director of Clinical Support Services coordinated the infrastructure upgrades, maintenance and construction working closely with the Associate Chief Nurse, Nursing Director
and Medical Director (Attachment TL 2.q). The Nursing Director and Clinical Nurse Specialists from the Surgical ICU played key roles in the development of the capital and non-capital equipment lists due to the similar patient population seen in the SICU, including liver transplant donor and recipient, trauma, vascular and neurosurgical patients. The capital and non-capital equipment requests were based on the SICU staff’s current experience and patient care needs. Prior to submission, the capital requests were reviewed and agreed upon with the entire planning group.

Capital requests for FY 2012 were not likely to be approved until November/January of 2011, the expected timeframe for the MGH capital approval process. Given the unit opening was planned for December of 2011, the Director of Clinical Support Services and the Associate Chief Nurse arranged a meeting with the Senior Vice President, Patient Care Services and Chief Nurse to request approval in advance of the standard capital approval process. Both reviewed how the capital requests were formulated including the patient care capital equipment necessary to care for the diverse population Blake 12 ICU would serve.

The Senior Vice President and Chief Nurse advocated for the necessary capital requests during meetings with the Finance Department and Chief Executive Officer. The Director of Clinical Support Services and Associate Chief Nurse were asked to refine the requests. Following adjustments and review with the planning group, the capital requests were approved as noted in a series of emails (Attachment TL 2.r). All items were ordered and receipt and deployment were coordinated by the planning team. Blake 12 ICU successfully opened on the planned target date of December 6, 2012.

Advocating for Additional Staffing Resources: Lunder 9 Oncology Unit

Another example of an Associate Chief advocating for additional resources is the Associate Chief Nurse for the Cancer Center advocating for additional FTEs for Lunder 9 Oncology. Here’s her description of this request:

In February, 2012, 5 months after moving into the new Lunder building, Barbara Cashavelly, Nurse Director for Lunder 9 Oncology, was feeling that the budget for the unit did not meet the current patient workload. Having moved from a 21-bed unit to a 32, the budget had been adjusted for the increase in beds, however the patient population had changed to a more short-stay, acutely-ill patient. The length of stay decreased from 7.5 to 5.3. As a result, the activity (admissions, discharges and transfers) has increased significantly for this new unit. Also, the occupancy was much higher than the anticipated 85%.

Barbara discussed her concerns with me. I asked her to work with Nancy McCarthy, RN, MSN, MBA, Staff Specialist in PCS Financial Management Systems to describe her concerns using the available data that we had through the Quadramed productivity management system.

I then met with the nursing staff and Barbara to also hear staff concerns about the patient workload because there may also be other interventions that we could assist them to ease the patient workload – not just adding more staff. They described the increase in patient deaths on the unit, many being young patients. This was new and very taxing on them. We talked about some interventions (Palliative care nurse practitioner, huddle after patient deaths, etc.). The staff then described other challenges of the new unit, all contributing to their workload; many new staff, a change in unit geography, etc.

I described to Jeanette Ives Erickson, Chief Nurse, the workload issues on Lunder 9 and shared the Quadramed data with her (attachment TL 2.s). I shared that the second column scenario of numbers is the actual census and hours per workload index (HPWI) and recommends the addition of 2.2 FTEs RN and 0.4 FTE PCA. The third column is a scenario that reflects current staffing targets but raises the HPWI recommending the addition of 5.4 RN FTEs and 1.0 PCA FTE. Because this was mid-year and there would not be a “formal” increase in staffing until the new fiscal year, we discussed what Barbara should do as an interim plan. Barbara hired agency staff to meet the staffing needs, increased acuity, activity level and patient workload for the unit. She also hired several per
diem Patient Care Assistant (PCA) nursing students to help with the workload and provide support on each shift. For the FY 13 budget, 3.1 RN FTEs and 0.9 PCA FTE were approved.

Advocating for Additional Staffing Resources: Anticoagulation Management Unit

During the FY 13 Operating budget process, Wally Moulaison, RN, MSN, MBA developed a budget request proposal (attachment TL 2.t) to request additional staffing in the Anticoagulation Management Service Unit. In his proposal, he articulates the goals for the program, current status and issues. The goals for the program include:

- To maintain and continue program development while providing anticoagulation management to patients enrolled at MGH.
- To maintain continuity of care standards and quality of anticoagulation practice across MGH care facilities.
- Improve staff satisfaction while remaining responsive to demands for service.
- Assure AMS staff attain new core competencies related to a rapidly changing anticoagulation landscape.

He cites that there are growing demands for enhancements for the service and that the volume of patients, particularly test-testers, is growing. He notes that the current AMS nurse panel size for 1.0 RN FTE is 431 patients. It is estimated that 400 patients per FTE is the preferred target per INR in order to effectively assess, counsel, educate, schedule and communicate to patients in the panel. Based on the proposal, a budget request was submitted for 1.7 RN FTE and 1.3 clerical (Patient Care Coordinator) FTEs. In the FY ’13 budget, 1.1 RN FTEs and 1.0 FTE were approved.

Justification for Additional Positions: MGH North Ambulatory Care Center

The Nursing Director of the MGH North Ambulatory Surgery Center prepared two justifications to secure additional staff. The process is to fill out a justification template and respond to questions related to the position being requested. One must justify if the position can or cannot be eliminated or delayed. If so, for how long; if not, why? In addition, the requester must note if the position would result in net reduction of expenses along with an explanation. Justifications are submitted to the Executive Director for the Ambulatory Care Center who advocates for the requests with the Senior Executive Team.

The Nursing Director advocated for these positions:

- **Block RN** (Attachment TL 2.u): The Block area was not a staffing consideration for the original staffing of the ACC in Danvers Day Surgery. At the main campus, the Block Area has dedicated nurses who are trained and competent in the Block Area as well as dedicated anesthesia residents. If approved it will allow for standardization; enhanced communication and confidence in nursing by orthopedic surgeons allowing for proficiency; faster turn around which will lead to increase volume and physician satisfaction.

- **PSC II** (Attachment TL 2.v): This position will increase RN efficiency and improve patient discharge and length of stay in PACU by freeing RNs from clerical/phone responsibilities in the PACU and Pre-op areas which interrupt continuity of patient care.

These two requests are in alignment with the framework that day surgery at the ACC is a hybrid model of care. A high level of efficiency is required to grow volume. Adding these positions will meet the goals of increasing production volume and maintaining efficiencies to maintain the high quality and standard of care delivered.
Request for Equipment: Dolphin mats

In 2010, the MGH recognized that the overall pressure ulcer prevalence rate was trending upward from 3.2% in March, 2009 to 3.5% in March, 2010. The Patient Care Services Executive Committee incorporated a target in the 2011 Strategic Plan (OOD 3.x and TL 3 EO) to reduce hospital-acquired pressure ulcers (HAPU). An interdisciplinary Tiger Team was convened and conducted a gap analysis, benchmarking against the best practices of PU programs developed by hospital associations, healthcare systems, and other agencies from across the United States. A hospital-wide pressure ulcer prevention program was launched, including safety reporting and other data requirements for Stage II PU and greater. By March, 2012, the pressure ulcer prevalence rate dropped to 1.1% (N=9 / 796). Ongoing efforts are directed at further reducing the pressure ulcer prevalence rate to < 1% or 0%.

Ginger Capasso, PhD, APRN, Nurse Practitioner and Co-Director of the MGH Wound Center led the effort in re-examining patient care and resources in the intensive care unit, using the framework of the SKIN Bundle and proposed evidence-based solutions. Several alternative options emerged, including an innovative pressure relieving surface – the Dolphin Mat (Joerns). The Dolphin Mat was highlighted by the Advisory Board as a best practice for preventing pressure ulcers in its publication, Safeguarding Against Nursing Never Events (2009, pp. 71-73.) The Dolphin Mat was developed by Biologics, Inc. in collaboration with the U.S. Navy, to simulate immersion in a fluid environment, in order to avoid pressure ulcers during transport of dolphins, by aircraft, to war zones. Research on the Dolphin Mat is very limited, involving only two studies: 1) a study of healthy human subjects (N=10), who were immobilized on the Dolphin Mat or a standard operating room (O.R.) table / gurney, where preservation of perfusion pressure was compared at baseline and after a prolonged period of immobility. After being immobilized on the Dolphin Mat, perfusion pressure was maintained at 87% of baseline as compared to just 16% on a standard OR table / gurney, and 2) a case series conducted at the V.A. Medical Center in Memphis, TN which revealed that, after purchasing and using 44 Dolphin Mats on a 60-bed spinal cord injury unit, the incidence of pressure ulcers among patients with spinal cord injuries dropped from 11% to zero percent and the annual expenditures for rental surfaces dropped $13,000 from $31,000 for air fluidized Clinitron beds to $18,000 for the Dolphin Mats. To date, there are no studies comparing the effectiveness of the Dolphin Mat to other high-end alternating air mattresses in the prevention of HAPUs. Recognizing that the evidence supporting the effectiveness of the Dolphin Mat is thin, but given the importance of pressure ulcer prevention, the challenges of preventing pressure ulcers in our sickest patients, and the favorable impact of the Dolphin Mat on reduction of pressure ulcer incidence (patient outcome) and expenditures for rental surfaces (cost of care outcome), the MGH allocated $112,000 in the 2012 Capital Budget (Attachment TL 2.w) for the initial purchase of seven Dolphin Mats for use in the adult intensive care units and in the Respiratory Acute Care Unit (RACU).

Equipment Request: Biopatch dressings for Blake 8 Cardiac Surgical ICU patients

The Nursing Director of the Blake 8 Cardiac Surgical ICU recounts the following request for specialized dressings to prevent central line associated bloodstream infections (CLABSI).

In Spring of 2012, our 18-bed Cardiac Surgery ICU received confirmation from our Infection Control Department that two chronically critically-ill patients had positive blood cultures with Enterococcus faecalis and Co-ag negative Staphylococcus. This was of great concern to the staff because of the vulnerability of the patient population to acquire a central line associated bloodstream infections (CLABSI), given the widespread use of pulmonary artery catheters, large introducers and even larger central catheters used for dialysis access. After careful review of our clinical practice related to insertion and care of central venous catheters, an interdisciplinary team of caregivers met and formed a Comprehensive Unit-based Safety Program (CUSP) to improve patient care. Central line care was the number one priority.
Staff Nurses from both shifts, the Nursing Director, Clinical Nurse Specialist, Intensivist, Pharmacist, and Respiratory Therapist met to strategize on improving care and decreasing/eliminating CLABSI. An education blitz was provided by our intensivist/anesthesiologist who inserts many central line catheters. Reinstitution of the use of the central line insertion checklist was accomplished with Staff Nurses taking the lead in protecting their patients by reinforcing sterile technique throughout the insertion process. Several Staff Nurses, who had worked at other facilities, asked if we could acquire the Biopatch, a chlorhexidine gluconate-impregnated protective dressing which may remain in place for up to seven days, thereby decreasing dressing changes and potential for the introduction of bacterial organisms. The Clinical Nurse Specialist (CNS) who was also familiar with Biopatch advocated for transitioning to this dressing for the vulnerable cardiac surgery patient population. Several meetings were held with our Infection Control Department which approved our request for implementing the Biopatch central line dressing for our long term (greater than 2 days) central access catheters. The Infection Control Department has previously corresponded with the Nursing Director of the IV Team in late 2011 that Biopatch dressings were approved for use by her team with all PICC lines with a budget increase of $108,000:

From: Wright, Paula J., R.N.
Sent: Monday, November 21, 2011 8:00 PM
To: Mulligan, Janet L., R.N.; Sheridan, Robert M.
Cc: Hooper, David C., M.D.; Whitney, Kevin B., R.N.; Nicholson, Britain W., M.D.
Subject: $$$ for Biopatch approved

Hi Janet and Robert,

Dr. Hooper learned late today from Dr. Brit Nicholson, CMO - that implementing the use of Biopatch for all PICC lines has been approved. You have the go-ahead to begin implementation.

Thanks,
Paula
Paula Wright RN, BSN, CIC
Director, Infection Control Unit
Massachusetts General Hospital

We discussed this issue at monthly Staff Meetings (Attachment TL 2.x) as we proceeded to change our practice as well as at our monthly interdisciplinary CUSP meetings. Our CNS developed a resource sheet (Attachment TL 2.y) that was sent to all staff RNs and placed in bedside books to reinforce best practice related to care of central venous lines. We reinforced the importance of good hand hygiene before and after patient contact for all disciplines and continue to enjoy success in this endeavor.

Since this focused effort to improve interdisciplinary practice surrounding care of central venous lines, we have not had any CLABSI! Great for our team but even greater for the safety of our critically-ill patients!

Equipment Request: Neo-Blues for Blake 13/Ellison 13 Family Newborn Units

The Staff Nurses and Clinical Nurse Specialist on Blake 13 and Ellison 13, the two Family/Newborn Units, made a capital request to purchase Neo-Blues to decrease admissions to Level 2 Special Care Nurseries, which the Nursing Director submitted on their behalf in the FY 2011 capital budget process.

The staff and CNS presented the following evidence-based request: Neonatal jaundice is a common problem encountered in newborns. Approximately 60% (MGH = 2100) of infants develop jaundice and about 8% (MGH = 280/year) of these infants go onto require treatment. Intensive phototherapy is required to treat hyperbilirubinemia. Intensive phototherapy is defined as levels of irradiance at 430-490nm band (30-35 uW/cm²/nm) delivered to as much of the infant’s body as possible (American Academy of Pediatrics (AAP), 2004). Vreman, Wong, Stevenson et al. (1998) noted that the peak absorption wavelength 458 nm is the most efficient for
the breakdown of bilirubin. Recently, the American Academy of Pediatrics (AAP, 2004) determined that the blue-green light spectrum is the most efficient at penetrating the skin and metabolizing the bilirubin. The Neoblue Phototherapy Device from Natus Medical easily achieves the recommendations from the AAP. Although research is scarce regarding a decreased length of stay with the Neoblue a case study has shown a decrease of up to 2 days with the Neoblue lights versus conventional lights (Patel & Johnson, 2003). In addition, anecdotal evidence at MGH indicates that infants utilizing the Neoblue light have a significant decrease in bilirubin within the first 24 hours of initiating treatment. Further discussions with colleagues across the Boston area have highlighted the same sentiment “bilirubin decreases faster using the Neoblue lights”. In addition, the Neoblue light affords the opportunity of utilizing the lights over an open crib. The AAP (2004) determined that distance of the light source has a significant effect on spectral irradiance which significantly effects metabolism of the bilirubin. It is well known that conventional lights emit heat and become hot which has the potential for increasing an infant’s temperature. Due to the possibility of an increased temperature, the conventional lights are kept 18-20cm from the infant and used in conjunction with an isolette, thereby protecting the infant from the lights. The Neoblue does not emit heat, reduces the risk of insensible water loss and can be place up to 10 cm of the infant (AAP, 2004). The Neoblue lights provide us the opportunity to change our practice by allowing us to place hyperbilirubin infants in the level I nursery versus the level II nursery. In turn this frees up much needed level II bed space while normalizing the hospital course for the hyperbilirubin infant.”

The Nursing Director and Clinical Nurse Specialist have been successful in securing four Neobluess which have helped to improve patient throughput. The purchase order information is as follows:

08/29/2011 PO No. 0004686098
Neobluess Req: 0002748986
Date: 08/19/2011 PO(s)
4.0000 EACH 3,550.00000

Enhancing Communication: VOALTE

Following a nurse and support staff-driven decision to select VOALTE as MGH's new inpatient communication technology, VOALTE was initially rolled out to five inpatient units in the newly-opened Lunder Building. These areas were fast tracked to address staff-identified communication challenges exacerbated by the size and layout of the new floors. The implementation of VOALTE received very positive acceptance from staff in the new building (Attachment EP 12.l). The CNO and Director of Clinical Support Services met with the MGH Chief Information Officer (CIO) on February 9, 2012 to secure support for fast-tracking VOALTE roll out to 10 innovation units (TL 4EO). Once again VOALTE proved successful. With all areas endorsing it as a positive support to their practice, the CNO met with CIO again on June 19, 2012 to discuss the resources required and technology hurdles to be cleared to enable further roll out. The CNO successfully secured priority IT support for implementation to all inpatient care areas beginning this fall. Funding will be requested for the VOALTE devices in the FY 13 capital budget. Attachment TL 2.z outlines initial planning by Director of Clinical Support Services with the Nursing Executive Operations Team to prepare for this roll-out.

Collaborative Governance Champions: Voice in Product Decisions

The Policy, Procedure and Products Committee, a committee of the Collaborative Governance communication and decision-making structure at MGH (SE 1) is charged reviewing and approving polices and procedures to ensure they are appropriately vetted and evidenced based. Champions (members of the committee) review and approve products that are brought into the practice environment, including the plan for product roll-out.
Attachment TL 2.aa and Attachment TL 2.bb contain abbreviated minutes from this committee where Ed Raeke, Director of Materials Management, engages the Champions regarding equipment/supply options to get their informed input. In Attachment TL 2.bb, the Champions select gloves that realize a cost savings.
MASSACHUSETTS GENERAL HOSPITAL

Job Title: Associate Chief Nurse 
Date: 3/21/03

Job Code: 293 Grade: 135 FLSA Status: Exempt

Department/ Unit/ Section: Patient Care Services Reviewed By: Human Resources

Reports To: Directly to the Senior Vice President for Patient Care and Chief Nurse

Date Description last revised: March 2012

GENERAL SUMMARY/ OVERVIEW STATEMENT: Summarize the nature and level of work performed.

The Associate Chief Nurse is responsible for direct patient care for a designated group of units/ programs. S/he assures that competent, compassionate patient care is uniformly provided to patients in inpatient, outpatient, and community settings. The Associate Chief Nurse develops, implements, and evaluates policies, programs, and services consistent with the hospital’s mission and the department’s vision and philosophy. S/he provides direction and support to the unit-based leadership toward attainment of short- and long-term goals and objectives. As a member of the nursing executive management team, the Associate Chief Nurse participates in the efficient and effective management of the department of nursing, and the development of its strategic plan.

PRINCIPAL DUTIES AND RESPONSIBILITIES: Indicate key areas of responsibility, major job duties, special projects and key objectives for this position. These items should be evaluated throughout the year and included in the written annual evaluation.

1.0 Leadership and Strategy

1.1 Participates in formulating the department’s, Patient Care Services and the organization’s vision and strategic plan.

1.2 Communicates and operationalizes the strategic plan.

1.3 Attracts, retains and develops the best and brightest Nursing leadership team

1.4 Establishes and maintains an environment conducive to excellence in patient care

1.5 Establishes and maintains an environment that is supportive of professional nursing practice

1.6 Promotes multidisciplinary collaboration

1.7 Identifies, encourages, and provides mechanisms for participation of the nursing staff in collaborative governance

1.8 Ensures that the environment addresses needs of a diverse patient population and workforce
1.9 Provides input into development and implementation of information systems needed to support patient care

1.10 Engages in professional development activities.

1.11 Guides the ongoing development and implementation of the Clinical Recognition Program.

2.0 Operations

2.1. Directs the development and implementation of standards, policies, and programs to ensure excellence in nursing practice.

2.2 Develops collaborative relationships with department heads, the medical staff, and colleagues in the nursing community.

2.3 Communicates the role of nursing and issues of patient care to the organization and community.

2.4 Designs and directs the implementation of programs and processes to support organizational mission and goals.

3.0 Compliance

3.1 Assures care and unit functions are in compliance with applicable local, state, and federal regulations and accrediting agencies.

3.2 Develops and ensures compliance with nursing policies and procedures, standards of patient care and nursing practice.

3.3 Supports a system that encourages the identification and analysis of errors and near misses in the context of a “just” culture.

3.4 Promotes an environment where employees are alert to opportunities for the enhancement of patient care through utilization of the latest research findings, systems analysis and performance improvement principles.

3.5 Initiates multidisciplinary and interdepartmental forums to insure the promotion and protection of patient/family rights.

4.0 Fiscal

4.1 Participates in establishing financial plans, integrating the institution’s mission and goals.

4.2 Collaborates with other members of the nursing executive management team in financial planning, and in setting priorities for allocation of resources.

4.3 Advocates for resources necessary for patient care.

4.4 Establishes and maintains a cost effective patient care environment.

4.5 Communicates nursing’s contribution to the financial success of the organization.
**QUALIFICATIONS:** (MUST be realistic, neither overstated nor understated, and related to the essential functions of the job.)

Current licensure as a registered nurse in the Commonwealth of Massachusetts
Minimum of 5 years of clinical practice.
Evidence of progressively responsible nursing management experience.
Master’s degree required. One of the required degrees should be in Nursing.

**SKILLS/ ABILITIES/ COMPETENCIES REQUIRED:** (MUST be realistic, measurable, objective, and related to the essential functions of the job.)

Demonstrated leadership qualities including the ability to inspire a vision and to empower and motivate others toward realization of that vision. Strong communication, negotiation and conflict management skills. Systems and financial, computer skills. Presentation skills – both oral and written. Attention to detail and follow up along with the ability to conceptualize. Ability to prioritize in a changing environment and to flexibly move among multiple projects.

**WORKING CONDITIONS:** Describe the conditions in which the work is performed.

Hospital setting.

**SUPERVISORY RESPONSIBILITY:** List the number of FTEs supervised.

**FISCAL RESPONSIBILITY:** Indicate financial “scope” information, i.e.: size of budget, volume, revenue, etc.

**APPROVAL:**

(NAME)
Department Mgr. __________________________ Title: ___________________
Date: __________

(NAME)
Other, As Appropriate __________________________ Title: ___________________
Date: __________

*The above is intended to describe the general contents and requirements of work being performed by people assigned to this classification. It is not intended to be construed as an exhaustive statement of all duties, responsibilities or skills of personnel so classified.*
MASSACHUSETTS GENERAL HOSPITAL

Job Title: NURSING DIRECTOR  
Job Family:  
Job Code: 457  Grade: 61  
FLSA Status: Exempt  
Department: Nursing  
Reviewed By: Nursing Executive Operations  
Position Reports To: Associate Chief Nurse  
Date Description last revised: 3/2012

GENERAL SUMMARY/ OVERVIEW STATEMENT: Summarize the nature and level of work performed.

The Nursing Director is accountable for the delivery of consistent, high quality patient care, promoting the development and satisfaction of nursing and support staff, providing operating efficiencies and insuring compliance with hospital and regulatory policies and standards of practice.

This role is an essential leadership position in the hospital organization encompassing patient focused management, personnel management and development, business administration of the unit, development of collaborative and team partnerships within units and interdisciplinary settings, and participation in the Department of Nursing and MGH groups and committees.

PRINCIPAL DUTIES AND RESPONSIBILITIES: Indicate key areas of responsibility, major job duties, special projects and key objectives for this position. These items should be evaluated throughout the year and included in the written annual evaluation.

1. Provides an environment for effective patient-focused nursing care.
   1.1. Responsible for high quality care with positive patient outcomes.
   1.2. Responsible for implementing and evaluating approved policies, procedures and standards of care necessary for the coordination and delivery of excellent patient-focused care.
   1.3. Collaborates with the registered nurse, physician, other health care professionals and assistive personnel to plan the delivery of care on the unit and to create joint protocols for patient care.
   1.4. Promotes an environment that is sensitive to the culturally diverse needs of patients and employees.
   1.5. Evaluates the outcomes of patient care; uses patient satisfaction information to recommend and integrate appropriate changes.
   1.6. Facilitates placement and progression of staff nurses in the clinical recognition program.
   1.7. Actively participates on committees for ongoing development of nursing practice.
   1.8. Responsible for direct clinical nursing practice; preserves the integrity of provider/patient relationship.

2. Personnel Management
   2.1. Interviews, hires, and evaluates unit based staff.
2.2. Manages and supervises direct patient care providers, assistive and support personnel on the patient care unit.
2.3. Promotes the development of patient care teams engaging unit based staff in decision-making process.
2.4. Delegates responsibility and authority to appropriate staff.
2.5. Implements corrective action according to hospital policy.
2.6. Collaborates with nursing and hospital educational resources to facilitate learning experiences for staff and students assigned to the unit.
2.7. Maintains confidentiality, as appropriate, related to personnel management issues.

3. Administration/Business
3.1. Accountable for applying the unit budget and meeting financial targets; uses data to evaluate LOS, HPWI, etc. to balance resource expenditures with workload.
3.2. Seeks and acts upon patient, families and staff feedback and initiates appropriate action.
3.3. Promotes, develops and evaluates processes and systems for patient care; advocates for resources and systems improvements when necessary.
3.4. Accountable for compliance with hospital and regulatory standards.
3.5. Negotiates interdepartmental resources, communicates and plans with managers of other patient care units and other department’s directors and managers to ensure effective level of service to the unit.

4. Operations Management
4.1. Maintains a safe environment for patient/staff.
4.2. Directs day-to-day activities of unit based staff.
4.3. Reviews the appropriate use of equipment, supplies, and physical facilities; holds staff accountable for safe and efficient practice.
4.4. Participates in planning and carrying out to completion projects to improve the physical environment.

5. Collaboration
5.1. Forms partnerships with department heads, physician leaders and other disciplines.

6. Leads and/or participates in performance improvement activities.
6.1. Continually evaluates quality and safety performance, identifies improvement opportunities, and plans and implements programs for improvement.
6.2. Seeks collaboration with community health organizations to achieve positive outcomes and enhance the hospital’s community presence.
7. Professional Development

7.1. Engages in self-performance appraisal on a regular basis, identifying areas of strength as well as areas for professional/ practice development

7.2. Identifies learning needs and goals on a regular basis and designs a plan to meet them.

7.3. Maintains necessary clinical and managerial skills through continuing education and direct clinical practice.

7.4. Establishes self as a resource in areas of the hospital where expertise may be required.

7.5. Participates in Nurse Manager and Department of Nursing leadership groups and institutional committees.

7.6. Collaborates with leadership in identification of current and future service needs and shares responsibility for meeting these needs.

7.7. Holds membership in one or more national nursing organizations.

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<tr>
<th>SKILLS/ABILITIES/COMPETENCIES REQUIRED:</th>
<th>Must be realistic, objective, measurable and related to essential functions of this job.</th>
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Demonstrates ability in domain of nursing practice.
Demonstrates leadership/managerial skill, which includes interpersonal competence, organizational skills, financial management, personnel management, hardiness and adaptability.

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<th>LICENSES, CERTIFICATIONS, and/or REGISTRATIONS (if applicable):</th>
<th>Specify minimum credentials and clearly indicate if preferred or required</th>
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Current licensure as a registered nurse in the Commonwealth of Massachusetts.

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<th>EDUCATION:</th>
<th>Specify minimum education and clearly indicate if preferred or required</th>
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Masters degree required; either Bachelors or Masters degree must be in nursing.

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<th>EXPERIENCE:</th>
<th>Specify minimum creditable years of experience and clearly indicate if preferred or required</th>
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<th>SUPERVISORY RESPONSIBILITY (if applicable):</th>
<th>List the number of FTEs supervised.</th>
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<th>FISCAL RESPONSIBILITY (if applicable):</th>
<th>Indicate financial “scope” information, i.e.: size of budget, volume, revenue, etc.; Indicate total physician/non-physician FTE scope</th>
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<th>WORKING CONDITIONS:</th>
<th>Describe the conditions in which the work is performed.</th>
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(NAME)
Department Mgr.  ________________  Title: ____________  Date: ______

(NAME) __________________________________________

Other, As Appropriate, Nursing Executive Operations Team__  
Date: ______

The above is intended to describe the general contents and requirements of work being performed by people assigned to this classification. It is not intended to be construed as an exhaustive statement of all duties, responsibilities or skills of personnel so classified.
MASSACHUSETTS GENERAL HOSPITAL

Job Title: Clinical Nurse Specialist  Date: 06/06
Job Code: 000436  Grade: 59  FLSA Status: Exempt
Department/ Unit/ Section: Patient Care Services  Reviewed By: Nursing Executive Ops.
Reports To: Nursing Director  Date Description last revised: 3/12

GENERAL SUMMARY/ OVERVIEW STATEMENT: Summarize the nature and level of work performed.

The Clinical Nurse Specialist is a master’s prepared nurse with an area of specialization who promotes competent, compassionate and professional nursing care for patients/families across the continuum. The role includes patient care, teaching, consultation and research.

PRINCIPAL DUTIES AND RESPONSIBILITIES: Indicate key areas of responsibility, major job duties, special projects and key objectives for this position. These items should be evaluated throughout the year and included in the written annual evaluation.

1.0 Demonstrates excellence in professional nursing practice.

1.1 Supports independent nursing practice of professional nurses through collaborative, advocacy, consultative, and role modeling activities.

1.2 Analyzes clinical and non-clinical variables to anticipate patient care needs and predict responses.

1.3 Identifies current trends in health care and their implication for nursing practice.

1.4 Promotes the progression of patients along the clinical pathway continuum.

1.5 Applies new technology, nursing theories, research findings and experiential knowledge to improve nursing practice.

1.6 Responds to change in clinical practice by planning, designing, implementing and evaluating guidelines, protocols and standards in collaboration with the Nursing Director and others.

1.7 Identifies ethical issues in nursing practice and guides staff and other providers in application of ethical concepts to patient care issues.

1.8 Applies innovative approaches to solving complex problems.

2.0 Develops, implements, and evaluates educational programs based upon assessed learning needs of patients, families, and staff.

2.1 Identifies learning needs and develops and implements programs for patient education within the area of specialization.
2.2 Supports, participates, and contributes to educational programs for staff at the unit/service/interdepartmental.

2.3 Facilitates the acquisition of advanced clinical skills in staff nurses, and graduate students through role modeling, practice, and consultation in the clinical setting.

3.0 Provides expert consultation to patients, families, nurses, and other health care providers to promote positive patient care outcomes.

3.1 Initiates, facilitates and develops interdisciplinary collaboration.

3.2 Provides consultation at the unit, program, service, administrative, and community level(s).

3.3 Acts as a resource to colleagues and consumers.

3.4 Analyzes and evaluates the effectiveness of the consultative process.

4.0 Participates in research activities that will positively affect patient care and patient care outcomes.

4.1 Uses nursing theories and research findings to plan, design, evaluate nursing practice and to generate researchable clinical problems.

4.2 Initiates, or participates in quality assurance and performance improvement activities for evaluation of structure, process and outcome criteria as it relates to clinical practice.

4.3 Promotes staff and student utilization of the research process.

4.4 Participates in and supports research.

4.5 Utilizes scientific method in collecting data on clinical practice issues.

5.0 Demonstrates accountability for ongoing personal/professional development.

5.1 Maintains and updates clinical knowledge and skills based on current nursing and health care practices

5.2 Identifies own learning needs and goals, and designs a plan to meet them.

5.3 Takes responsibilities for leadership and participation on committees and task forces of the DON, hospital, and Partner’s.

5.4 Participates in activities that foster peer support and networking.

5.5 Fulfills professional role through involvement in professional organization activities, presentations, and publications.
5.6 Continually evaluates quality and safety performance, identifies improvement opportunities and plans and implements programs for improvement.

**QUALIFICATIONS:** (MUST be realistic, neither overstated nor understated, and related to the essential functions of the job.)

Master’s degree in Nursing.
Current licensure as a registered nurse in the Commonwealth of Massachusetts
Relevant professional experience in clinical nursing specialty
Certification in specialty area, if available, is desired.

**SKILLS/ ABILITIES/ COMPETENCIES REQUIRED:** (MUST be realistic, measurable, objective, and related to the essential functions of the job.)

Fluent in verbal and written language skills.
Cultural competence and language skills for patient population is desired.

**WORKING CONDITIONS:** Describe the conditions in which the work is performed.

**SUPERVISORY RESPONSIBILITY:** List the number of FTEs supervised.

**FISCAL RESPONSIBILITY:** Indicate financial “scope” information, i.e.: size of budget, volume, revenue, etc.

**APPROVAL:**

(NAME)
Department Mgr. __________________________ Title: ______________________

Date: ____________

(NAME)
Other, As Appropriate ______________________ Title: ______________________

Date: ____________

The above is intended to describe the general contents and requirements of work being performed by people assigned to this classification. It is not intended to be construed as an exhaustive statement of all duties, responsibilities or skills of personnel so classified.
MASSACHUSETTS GENERAL HOSPITAL

Job Title: Nurse Practitioner (MSN) Date: 3/2003
Job Code: 000455 Grade: FLSA Status: Exempt
Department/ Unit/ Section: Patient Care Services Reviewed By: Human Resources

Reports To: The Nurse Practitioner is accountable to the Nursing Director or Associate Chief Nurse as appropriate, and to the collaborating physician.

Date Description last revised: March 2012

GENERAL SUMMARY/ OVERVIEW STATEMENT: Summarize the nature and level of work performed.

Develops, implements and evaluates a program of specialized health care for a select patient population. Promotes a collaborative relationship and effort between the medical staff and professional nurses toward continuity of patient care and efficient use of resources. Serves as a role model for professional nursing practice.

PRINCIPAL DUTIES AND RESPONSIBILITIES: Indicate key areas of responsibility, major job duties, special projects and key objectives for this position. These items should be evaluated throughout the year and included in the written annual evaluation.

Provides direct care to a select patient population in collaboration with the physician.

- Performs and records the patient history and physical exam.
- Utilizes advanced nursing knowledge to identify, prevent or solve complex and/or recurring patient care problems.
- Follows and manages patients (in collaboration with MD) enhancing continuity of care.
- Performs (oversees/assures completion of) specialized procedures particular to the select population mutually agreed upon with collaborating physician.
- Performs medically delegated aspects of patient care as agreed upon by nursing and medical administrators according to practice guidelines.
- Collaborates with unit staff and physicians to advocate for and facilitate a comprehensive plan of care and coordinate resources.
- Writes orders which are in accord with current guidelines.
- Maintains and practices in accord with practitioner guidelines per state and hospital regulations.
Provides consultation to both nurses and physicians.

- Serves as a resource to staff in area(s) of expertise.
- Serves on appropriate intra and interdepartmental committees.

Participates in the development of formal and informal educational programs for the unit-based nursing staff.

- Develops educational programs within area of expertise.
- Collaborates with unit staff, Clinical Educators, Clinical Nurse Specialists, Staff Specialists and other health care professionals to meet staff and patient educational needs.

Monitors patient outcomes in accordance with defined standards of patient care.

- Collaborates with nursing staff and leadership, and medical staff to plan, implement and evaluate pertinent change in practice and health care delivery.
- Identifies system-wide factors contributing to undesirable outcomes, such as complications, increased length of stay and over utilization of services.
- Facilitates patient movement through the system and efficient use of resources through interdepartmental collaboration.

Supports research efforts to advance knowledge and to promote research-based practice.

- Evaluates own practice and program effectiveness.
- Identifies pertinent nursing and health delivery problems for investigation.
- Evaluates current research findings for clinical specialty and determines applicability to unit practice.
- Assists nursing and medical colleagues in research efforts.
- Conducts own research.

Responsible for own professional growth and maintenance of required credentials.

- Maintains the standards and educational requirements specific to the position and licensure.
- Identifies own learning needs and goals.
- Takes responsibilities for leadership and participation on committees and task forces of the DON and the hospital.
- Maintains and updates clinical knowledge and skills based on current health care practice/research.
QUALIFICATIONS:  (MUST be realistic, neither overstated nor understated, and related to the essential functions of the job.)

Current licensure in the Commonwealth of Massachusetts as a registered nurse in the expanded role  

Master’s Degree in Nursing.

SKILLS/ ABILITIES/ COMPETENCIES REQUIRED:  (MUST be realistic, measurable, objective, and related to the essential functions of the job.)

Demonstrated competence in specialized area.

WORKING CONDITIONS:  Describe the conditions in which the work is performed.

Inpatient hospital setting

SUPERVISORY RESPONSIBILITY:  List the number of FTEs supervised.

N/A

FISCAL RESPONSIBILITY:  Indicate financial “scope” information, i.e.: size of budget, volume, revenue, etc.

N/A

APPROVAL:

(NAME)  
Department Mgr.  _____________   Title:  ___________________   Date:  ____________

(NAME)  
Other, As Appropriate  Nursing Operations Executive Team ______   Date:  

The above is intended to describe the general contents and requirements of work being performed by people assigned to this classification.  It is not intended to be construed as an exhaustive statement of all duties, responsibilities or skills of personnel so classified.
Massachusetts General Hospital

Job Title: STAFF NURSE

Job Code: 430, 424, 442, 449, 1925, 1928

Grade: 55   FLSA Status: Professional Exempt

Department: Nursing

Reviewed By: Nursing Executive Operations

Position Reports To: Nursing Director/nurse leader of the specific area.

Date Description last revised: 3/12

General Summary/Overview Statement:

Summarize the nature and level of work performed.

The staff nurse is a registered nurse who is responsible for assuring competent, compassionate, individualized, nursing care for specific patients and families, including delegation to and supervision of non-professional clinical and support staff. The staff nurse is responsible and accountable for the overall nursing care management of a designated group of patients. She/he collaborates with the Nursing Director and members of the Patient Care Team to achieve optimal patient outcomes. She/he also collaborates with the patient toward meeting the needs and expectations of the patient and family. Staff nurses ensure that care is safe, efficient, effective, timely and meets the cultural, spiritual, and ethnic needs of each patient and family.

Principal Duties and Responsibilities:

Indicate key areas of responsibility, major job duties, special projects and key objectives for this position. These items should be evaluated throughout the year and included in the written annual evaluation.

1) Provides competent, compassionate patient- and family-centered nursing care based on scientific principles and the use of the nursing process and interdisciplinary teamwork.

a) Provides and maintains a therapeutic environment for patients and families.

b) Articulates the professional nursing role to the patient, family and health team members.

c) Identifies, facilitates, and evaluates outcomes of nursing care for an individual patient or group of patients.

d) Coordinates involvement of the patient, family and health team members in patient care, including patient/family teaching and discharge planning.

e) Documents relevant patient information.

f) Communicates the plan of care and other pertinent information to/from other health care team members. Promotes continuity of care through effective hand-offs.

h) Helps define standards of excellence for patient care; participates in, and advocates for, improvement of patient care services in a cost-effective way.

h) Performs specific functions as described in the unit Scope of Service.
Attachment TL 2.e continued

i) Provides care appropriate to age group of patients on assigned unit(s) as described in relevant unit Scope of Service.

j) Participates in, and contributes to, performance improvement activities.

k) Integrates the six aims of performance improvement into care delivery:
   (1) Safety — no needless death, injury, pain or suffering for patients or staff.
   (2) Effectiveness — care and service will be based on best evidence, informed by patient values and preferences.
   (3) Patient Centeredness — all care and service will honor the individual patients — their values, choices, culture, social context and specific needs.
   (4) Timeliness — waste no one’s time; no unnecessary waiting.
   (5) Efficiency — remove all unnecessary processes or steps in a process; streamline all activities.
   (6) Equity — all care and service will be fair and equitable — the system will treat all patients equally.

l) Exhibits compliance with regulatory and quality and safety requirements.

2) Collaborates with other professionals and directs nonprofessional nursing personnel in maintaining recognized standards.
   a) Teaches and directs all nursing personnel for whom she/he is responsible.
   b) Participates in orientation of new permanent and temporary staff members.
   c) Appropriately utilizes nursing resources.
   d) Interprets hospital and departmental policies and procedures to nurses and other health team members.

3) Participates in daily operational activities necessary for safe patient/staff environment.
   a) Utilizes resources efficiently to facilitate optimal patient care.
   b) Provides input to the Nursing Director regarding unit needs.
   c) Participates in unit and departmental committees for formulation of nursing and hospital policies and procedures.
   d) Professional Development:
      i) Maintains and updates clinical knowledge and skills based on current nursing education practices.
      ii) Within the framework of the nursing Scope of Service (1.32.02) and The Clinical Recognition Program (See guidelines, http://pcs.mgh.harvard.edu.), collaborates with nurse manager /clinical nurse specialist to identify his/her developmental level of practice (attached); with clinical leadership, identifies appropriate learning experiences to enhance development.
iii) Adheres to Department of Nursing requirements for required training.

iv) Identifies specific learning needs and goals and develops a plan to meet them.

v) Contributes to relevant committees, professional meetings, continuing educational and/or formal academic programs.

**SKILLS/ABILITIES/COMPETENCIES REQUIRED:** Must be realistic, objective, measurable and related to essential functions of this job.

**LICENSES, CERTIFICATIONS, and/or REGISTRATIONS (if applicable):** Specify minimum credentials and clearly indicate if preferred or required

Current licensure as a Registered Nurse in the Commonwealth of Massachusetts

**EDUCATION:** Specify minimum education and clearly indicate if preferred or required

Graduation from an accredited nursing program.
New graduates must have a BSN degree.

**EXPERIENCE:** Specify minimum creditable years of experience and clearly indicate if preferred or required

**SUPERVISORY RESPONSIBILITY (if applicable):** List the number of FTEs supervised.

**FISCAL RESPONSIBILITY (if applicable):** Indicate financial “scope” information, i.e.: size of budget, volume, revenue, etc.; Indicate total physician/non-physician FTE scope

**WORKING CONDITIONS:** Describe the conditions in which the work is performed.

**APPROVAL:**

(NAME)  
Department Mgr.  ____________________  Title:  _____________  Date:  ________

(NAME)  
Other, As Appropriate  ___________________  Title:  _____________  Date:  ________

* This Job Description is in reference to the following job codes: 424, 442, 449, 1925, 1928

The above is intended to describe the general contents and requirements of work being performed by people assigned to this classification. It is not intended to be construed as an exhaustive statement of all duties, responsibilities or skills of personnel so classified.
Patient Care Services Executive Committee  
March 28, 2012  
2:30 to 3:00 p.m.  
Massachusetts General Hospital  
Trustees Room  

MINUTES

Presiding: J. Ives Erickson, RN, DNP  
Present: D. Burke, RN, D. Colton, M. Ditomassi, RN, DNP, R. Evans, 
T. Gallivan, RN, M. E. Gioiella, MSW, LICSW, 
L. Holden, RN, PhD, R. Kacmarek, PhD, R. Lipkis-Orlando, RN, 
S. Millar, RN, S. Sabia, M. Sullivan, DPT, D. Tenney, RN, 
C. Vega-Barachowitz, MS, CCC-SLP, K. Whitney, RN  

Staff Support: K. Marple, M. Greenberg

(D) For Review and Approval: APRN and PA OPPE/FPPE Credentialing Policies—G. Banister, RN, PhD
• J. Ives Erickson, RN, DNP, shared that the six strategic goals have now been reworded into five.
• M. Ditomassi, RN, DNP, announced that the newly written goals have incorporated all signals, input, and suggested changes since the last PCSEC Retreat.
• The five strategic goals are:
  1. Develop an efficient and effective patient- and family-centered model of care delivery advancing a relationship-based care philosophy
  2. Lead Patient Affordability and Care Redesign initiatives
  3. Design and implement new programs to improve patient and family satisfaction
  4. Advance the culture of Excellence Every Day
  5. Design and implement clinical and business information systems that support patient care, education and research
• J. Ives Erickson, RN, DNP, asked for a vote on the revised wording of the strategic goals, and the vote was unanimous in favor.

(I) For Review: Safety Events Dashboard – L. Holden, RN, PhD
• L. Holden, RN, PhD, announced a milestone in Safety Reporting with 100,000 reports filed.
• The numbers are trending upward in residents’ and attendings’ reports which is a positive sign that this group is willing to report in a safe environment without fear of reprisal.
• J. Ives Erickson, RN, DNP, shared that this information provides excellent content over time.
• The Center for Quality and Safety triages about 65 reports per day.
• Actual investigated reports are those reportable to the DPH such as pressure ulcers or wrong site procedures.
• There continues to be issues surrounding the tracking of specimens.
• Disruptive patients and families are also a high level of concern, and this should be a multidisciplinary effort to resolve these issues.
• The Center for Quality & Safety will be disseminating reports to staff, with the hope that this will encourage open discussion. Talking openly reflects on the leaders to provide that level of comfort in a non-punitive environment.
• L. Holden, RN, PhD, reminded the group about the Safety Culture Survey.

(I) Updates – All
• J. Ives Erickson, RN, DNP, shared that the latest budget gap in the budget process is close to $50 million. Gap must be closed before requests for new FTEs are considered.
• Cooley Dickinson work continues with Peter Slavin, MD, and David Torchiana, MD.
• J. Ives Erickson, RN, DNP, will create a document on due diligence—what do I want to know about Nursing and Patient Care Services. This document will need a quick turnaround.
• D. Colton shared the new design of The Fruit Street Physician. It looks more like an academic publication.
• D. Burke, RN, announced that the move from Bigelow 7 to Phillips 21 is complete.
• L. Holden, RN, PhD, announced that Gregg Meyer, MD, will be leaving the MGH on May 1, 2012.
• M. Ditomassi, RN, DNP, shared that the first of the chaplain candidates will visit the MGH on March 29, 2012, and another candidate will be here on April 13, 2012.
• M. Ditomassi, RN, DNP, will give an update on the Volunteer Department, Information Desk Ambassadors, and the Gift Shop at the next PCSEC meeting.
• D. Burke, RN, announced the summary of credentialing for nurses in the expanded role and physician assistants in preparation for committee review on March 28, 2012. New appointments: 3 new CRNAs, 3 new PAs, 10 new NPs, and 5 NPs for re-appointment. The total is 21 candidates for review and approval. The list is attached.
MINUTES

Presiding:  J. Ives Erickson, RN
Present:  D. Tenney, RN, G. Banister, RN, S. Millar, RN, S. Taranto, D. Burke, RN,
M. Ditomassi, RN, G. Reardon

1.  Budget
J. Ives Erickson, RN, and S. Millar, RN, distributed a budget Review Information Sheet
compiled by Financial Management Systems to capture all Patient Care Services’ budget requests.
It will be a helpful guide for budget discussions with Finance.

G. Reardon presented an update regarding non-salary budget requests. He
also distributed a handout outlining $2M projected MGH savings related to the
following non-salary initiatives:

- Advanced wound care: Standardize advanced wound care products and dressings
- Linen utilization: Develop a comprehensive linen utilization policy that encourages
  conservation of resources and eliminates waste
- Pulse Oximetry: Reduce waste by optimizing reusable probes as clinically appropriate.
- IV products: Reduce spending through standardization and utilization of best
  practices
- Gloves: Reduce spending and waste.

Discussion revolved around the feasibility of realizing the projected savings. G. Reardon will
work with his team to determine feasibility and develop plans to address the initiatives outlined
above.

2.  Innovation Units
M. Ditomassi, RN, distributed the results of a self-assessment conducted by the leadership of
the 12 Innovation Units regarding the roll-out status of each of the 12 interventions. Overall,
implementation has gone smoothly. It was noted that some of the Attending RNs have opted
not to use the Toughbooks. There are some system issues that have been identified: slow to
boot up; slow to navigate; does not reflect desktop build so Attending RN needs to move
between Toughbook and desktop computers. J. Ives Erickson, RN, suggested that iPad
technology be tested. G. Reardon will follow-up with Information Systems to obtain iPads on
loan to trial.

3.  AACN CSI start for Region 3: Boston
J. Ives Erickson, RN, distributed information about an exciting opportunity for an MGH unit to
participate in the AACN Clinical Scene Investigator initiative. The program is designed to
empower bedside nurses as clinician leaders and change agents whose initiatives measurably
improve patient outcomes with bottom-line impact to the hospital. J. Ives Erickson, RN,
suggested it may help to review nursing sensitive indicator data to determine a unit that will
benefit from this program.
MEMORANDUM

TO: Department Heads and Executive/Administrative Directors
FROM: Cindy Aiena, Executive Director of Finance
DATE: March 19, 2012
SUBJECT: FY’13 Operating Budget Development
cc: Senior Management

In order to provide some additional context for the FY’13 process, the drivers of our current activity and implications it may have for the next year’s budget follow. The operating results through February FY’12 are significantly ahead of budget driven by large one-time revenues, strong payer rates/intensity, and favorable outpatient volume (particularly in January and February) which is running 3.9% over budget YTD.

While inpatient volume is currently running slightly behind budget, it is 2.7% ahead of the prior year. We are unique compared to other Boston hospitals, which are experiencing year-over-year declines. Opening the Lunder Building provided opportunity/capacity for growth, but this creates a tension between the market outlook, which dictates a declining need for inpatient utilization and the current experience at the GH. In addition to volume risks, there are also service mix risks (e.g., volume is growing faster in lower-reimbursed service lines.)

We are anticipating that the FY’13 inpatient volume budget will be ~2% over the current run rate and are anticipating growth of ~2% over current activity on the outpatient side. While these are strong volume assumptions, they are combined with minimal rate lifts from commercial payors and declines on the government side. Therefore, they are expected to produce only a small amount of incremental revenue in the FY’13 budget, which will largely be used to cover increases in fixed or “uncontrollable” expenses. Ideally, there would be no new requested positions or non-salary expenses, however we do think there will be some volume-driven requests, some non-salary overages in FY’12 that must be addressed, and some new requests related to regulatory changes that cannot be fully offset by other cuts/tradeoffs.

The cost reduction plan implemented last year through the budget review process was the first of a three-phased process being implemented across the Partners System. The goal of this effort was to reduce our overall unit cost to improve our competitiveness in the marketplace. In order to prepare for anticipated changes in the market and proactively manage our costs, for FY’13, the GH must identify an additional $32M in savings to be achieved. We expect that there will be multiple sources for these reductions including items reviewed as “needs discussion” earlier this year, savings generated through the Partners engagement with Huron consultants, as well as new ideas. The FY’13 budget templates will be the methodology for recording reductions and contain the same columns as last year’s workbooks to accommodate submission.

We are anticipating that this year’s process will be smooth and efficient. As always, the budget office staff will continue to be available to provide any assistance you may need.

The following attachments will outline key timelines, assumptions, and requirements necessary to completing the budget, including:

- Volume assumptions
attachment TL 2h continued

- FTE & Salary Budgeting
- Budgeting Approved Bonus & Supplemental Pay Programs
- Explanations required for new expenses or growth in existing expenses
- On & Off-campus rent budget reminders
- New Programs and Lunder Building budgeting

Detail of the FY’13 Operating Budget Process

Each department should submit its FY’13 operating budget request using Business Objects Planning (SRC), the GH’s electronic budget system. Department budget contacts can gain access to the budget system beginning on March 19th by clicking on “Business Objects Planning” within the Partners Applications on their PC desktop. Please contact your Budget Office liaison if you have any issues logging into Business Objects Planning (SRC).

We are strongly recommending that everyone attend one of the training sessions held between March 20th and March 27th. In addition, a detailed instruction manual can be accessed electronically by clicking the link on the opening page of each workbook. Department budget contacts should complete all applicable worksheets in the workbook. For FY’13 Non-Salary Expense budgeting, please input any decreases compared to your FY’12 budget as a negative number in the column called “FY’13 Reductions” and please input any increases or shifts (both of the offsetting positive and negative numbers associated with reclassifications) in the column called “FY’13 New Requests & Shifts” and be sure to use the “Comments” column on each tab to provide an explanation for any account with a red flag.

The deadline for FY’13 budget submissions is 5:00 pm on Friday, April 6th, when the Budget Office will close department access to Business Objects Planning (SRC). Please be sure to obtain your Vice President’s approval of your submission before this time.

Thank You for Your Help.

We recognize that preparing and balancing the operating budget each year is a major effort for everyone in the hospital. We appreciate your cooperation both in helping us to achieve a balanced budget and in meeting our April 6th submission deadline. If you have questions about the budget process, or if you need assistance in completing your budget submission, please your Budget Office liaison (complete listing is provided on the last page of Attachment A).
I. **Volume**

We are currently working to finalize detailed volume budgets by service. The initial submission from departments indicates that inpatient volume will grow 1.9% compared to the FY’12 budget (an increase of about 2.2% compared to YTD activity). On the outpatient side, we are currently ahead of budget by 3.9%. While actual budgeted FY’13 volume will depend on departmental submissions, we are anticipating growth of about (2%) over the run rate.

II. **Expenses**

- **Wage & Salary Program – Do not include in your submission**

  Again this year, FTEs will be submitted at the employee level. The templates will provide preliminary position management numbers for your budgets that will ultimately be used to manage positions in PeopleSoft and various reporting systems. While the proposal for the FY’13 Wage Program has not yet been communicated, HR will continue to monitor changes in the labor market to determine the appropriate assumption for wage programs. Once complete, the assumptions will be incorporated centrally into the wage modeling.

  - **Weekly Salaries** -- For weekly-paid employees, please budget FTEs at the employee level. It is important that you align the job codes of Budgeted FTEs with their assigned standard hours in PeopleSoft to ensure an accurate salary budget.

  - **Monthly Salaries** -- For staff paid on a monthly basis, we are asking you to submit a budget both in terms of FTEs and dollars at the employee level. The FY’13 workbook will provide current and historical actuals. As in previous years, please do not budget for a Wage and Salary Program; the Budget Office will do that centrally. If you have any questions about how to budget monthly salaries, please contact your Budget Office liaison.

- **Fringe Benefits – Do not include in your submission**

  The Budget Office will calculate the FY’13 fringe benefit budget centrally and then allocate fringe expenses by cost center at the end of the budget process.

- **FTEs**

  If you are proposing new FTEs, those requests will need to be prioritized against existing expenses and programs in the base and you will need to choose from the classification listing in Business Objects Planning (SRC) that best describes the reason for the request. You must also provide an explanation of and justification for any such FTEs. Please send to your budget office representative via email by **April 6th**.

We have provided your employee level detail for both February month-to-date actual and FY11 budget. Please use the information provided in your workbooks to align your FTEs. For example, if you have FTEs currently working in job code 001234 who are budgeted in job code 005678, please move the budget for these people to job code 001234.

Since the actuals provided are specific to February, it is important to note that they may reflect something unique that happened in February only. Please keep this in mind as you are budgeting. If you
have any questions, please contact your budget liaison. Also, if changes have been made to PeopleSoft after February, please use the more recent data when making adjustments.

- **Previously Approved Bonus & Supplemental Pay Programs**

If you have a VP and budget office approved bonus or supplemental pay program, do not enter these dollars in your workbook. Please contact your budget liaison with the annual dollar amount and description of the program. They will then add the request to your workbook through a central process. Any program not submitted to your liaison will not be considered budgeted. If you are requesting a new program, you must have VP and HR approval BEFORE submitting this request.

- **General Inflation**

Although we are likely to experience price increases on the many goods and services we purchase, continued proactive non-salary expense management is an important component of the strategy for closing our budget gap. Consequently, please consider all options to control costs before submitting inflationary increases.

- **Space Rental Expenses**

Federal law requires that the hospital charge fair market rates for on-campus space used by private physicians and other entities including the MGPO. The space rental chargeback rate is set at $43 per s.f. for FY’13.

- **External Rent (Breakout of Base Rent versus Operating Expense/Taxes)**

Rental expense for off-campus space is broken out between Base Rent and the Operating Expense and Taxes associated with the space. For the FY’13 budget process, if you have off campus space and pay rent to a landlord, please be sure your budget accounts for the Base Rent in account 955204 and the Operating and Tax expenses in 955200. The budget office has received FY’13 information from the Real Estate department and your budget liaison can provide this breakout to you.

- **Consulting requests**

If you will need consulting services in FY’13, please submit your request on the Expenses tab of the FY’13 Budget Workbook. Include a brief description of the proposed consulting project, a short explanation of why you will need consulting services, the name of the consulting company, if known, and the amount of money that you will need. Any Consulting approved in the final budget will be moved to a central cost center at the end and will be reviewed before actually being expensed.

- **Marketing**

Consistent with last year, all marketing requests will be centralized in the Marketing budget. Therefore, any requests should be sent to Richard Averbuch to include in the Marketing budget.

- **Non-“Capital” Equipment and Computers**

The capitalization policy defines capital equipment as having a unit cost of $5,000 or greater and a minimum useful life of two years. Consequently, departments with equipment needs that do not qualify as capital, i.e. less than $5,000 per item, need to budget for these items in their FY’13 operating budget submission. Equipment needs cannot be bundled together to meet the $5,000 threshold. Please use FY11 YTD actual activity as an indicator of your non-capital equipment needs, keeping in mind any one-time purchases that may not be repeated.
We will create a central budget managed by MGH IS for standard computer and peripheral purchases, such as standard PCs and printers. Consequently, departments should not ask for standard PCs and printers in their FY’13 operating budget request. If you have a major computer equipment request for FY’13 or have questions about what qualifies to be funded from this central PC budget, please contact Gigi Gilman in MGH/MGPO IS Management and Planning to determine if you should submit a separate request.

However, departments that need other non-capital equipment items, including laptops and fax machines, should submit these requests in the Non-Capital Equipment account (930700) as part of their FY’13 operating budget submission. If you have any questions about this topic, please contact Esther Maycock-Thorne.

New Programs

New Programs — If you are proposing a new program with significant FTE and/or expense requests, please contact your budget liaison after getting approval from your VP. In order to identify program-specific volume and expenses, the Budget Office will create a temporary central workbook to house the request throughout the budget process. In keeping with our efforts to level fund any new requests, please indicate what offsetting decreases will be used to fund the program. If approved, we will either create a new cost center or fold the approvals into other existing ones. Please contact your budget liaison for more information.

Lunder Building — The Lunder building is now open and will therefore be open for a full year in FY’13. Please remember to budget for any ramp up of your activity in your FY’13 submission and leave a comment identifying this growth.
Cindy Aiena  
Phone: 726-2221  
Fax: 726-2838  
Executive Director of Finance

Beth Chase  
Phone: 724-9822  
Fax: 726-2838  
Budget Manager

Andree Bouillot  
Phone: 726-8110  
Fax: 726-2838  
Action O/I

Greg Depatie  
Phone: 726-6125  
Fax: 726-2838  
Primary Care, Health Centers, Pharmacy, Department of Medicine, MGH Corp  
VPs: Gregg S. Meyer, M.D., Britain W. Nicholson, M.D.

Letitia Harris  
Phone: 726-2135  
Fax: 726-2838  
Materials Management, Environmental Services, Food & Nutrition Services, Buildings and Grounds, Parking and Security, Other Operational Support Departments, Pathology, Radiology, Radiation Oncology, Research, HIS  
VPs: Jean R. Elrick, M.D., Harry Orf, PhD

Esther Maycock-Thorne  
Phone: 726-4356  
Fax: 726-2838  
Capital Budget/Reporting  
Pediatrics, Neurosciences, Psychiatry, Dermatology, OB/GYN, Human Resources, Administration  
VPs: Jeff Davis, Joan Sapir, Peter Slavin, M.D.

Christina (Chrissie) Thomas  
Phone: 726-3221  
Fax: 726-2838  
Volume & Statistical Budget/Reporting, Charge Code/Revenue Budgeting/Analysis  
Cancer Center, Admitting, Marketing, Danvers ACC, Customer Service, Urology, Orthopaedics  
VPs: Sally Mason Boemer, Greg Pauly

Prashant Zemse  
Phone: 724-9793  
Fax: 726-2838  
Personnel Budgeting/Analysis, FTE Analysis, Fringe Benefits, ACD Compensation Model  
Surgery, OR, Anesthesia, Transplant, ED  
Patient Care Services: Nursing Services, Therapies, Social  
VPs: Jeanette Ives Erickson, R.N., Ann L. Prestipino
Good afternoon,
The attached power point outlines the PCS '13 capital process.

Key Dates:
- **August 1:** All renovation requests identified
- **August 31:** All requests due

As referenced in the document PCS Capital Budget drop-in sessions will take place on June 28, July 10, August 9, and August 21. Please use the attached excel spreadsheet template to email all capital requests to Kim Chelf. Same format as last year. Please reach out to Kim Chelf or George Reardon with any questions. If at all possible, please do not wait until August 31st to submit your requests. Early requests help us identify global needs and provide time to address any questions.

Thanks,

George and Kim
'13 PCS Capital Request Process

June 18, 2012

'13 Capital Budget

Reminders:
- MGH Capital items must have a unit cost of greater than $5000.
- Expect that capital funding will be tight this year.
- It is essential that any operating budget impact of the capital request be clearly documented. Examples include supplies, training, preventive maintenance, and warranties.
- Any requests identified after the '13 submission cycle closes will have to wait 12 months for the '14 budget. MGH reserves a very limited amount of contingency capital for unanticipated emergency needs only.

'13 Capital Budget Schedule

- June - August:
  - Research & develop detailed requests (see slides 6 for renovation request deadline)
  - Attend PCS Capital Budget Drop In Sessions as needed
  - By August 31: email requests to Kim Chelf, PCS Clinical Support Services
- The '13 capital schedule has not been set, but based on discussion with the Budget Office we anticipate that it will look something like:
  - Sept. 15 - Oct 30: MGH Ops. Group review & decision making
  - November: MGH FY '13 capital budget presented to and approved by MGH Board
  - December: Partners Board Review
  - Late January: New capital account numbers released

PCS '13 Capital Budget Drop-In Sessions

- Thursday, June 28th @ 12-1pm
- Tuesday, July 10th @ 2-3pm
- Thursday, August 9th @ 12-1pm
- Thursday, August 21st @ 2-3pm
- All sessions will be held in the Founders 627 conference room

PCS Central Requests

The items below will be centrally requested in the PCS FY '13 submission:
- Visitor Lounge Furniture
- Communication Technology (VOALTE)
- Innovation Unit Support
- Unit Task Chairs
- Patient furniture (recliners, sleep chairs, and bed side cabinets)

Renovation Requests

Revised Process This Year

- For B&G renovation requests please contact Kim Chelf no later than August 1st. Kim will facilitate a site visit meeting with Unit Leadership and John Duffy and/or Brian Coates from B&G. Examples include office renovations, locker rooms, staff lounges, etc. Please do not reach out directly to specific B&G shops.
- Major renovation requests require a feasibility request signed off by Sr. VP before Planning can review the need and draft a capital estimate. Please contact George Reardon for assistance with coordinating any major renovation requests no later than August 1st.
---

### Biomed Related Requests

- If your area is requesting medical equipment that is Biomed-related, please touch base with Mike Cusack for consultation and assistance with obtaining quotes.

- Please contact Biomed by **August 10th** to request assistance.

### Request Submission Process

We need your input on all local needs:

- Requests to be submitted via email using the attached Excel template.

- Submit requests to Kim Chelf.

- George & Kim available to answer questions.

- Four PCS Capital Budget drop in sessions scheduled for June-August.

- Non capital equipment needs (unit cost less than $5,000): Please separately email Kim any identified non-capital equipment needs by **August 15th**.

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### Capital Request Template

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<td>Justification:</td>
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<td>Unit Cost:</td>
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<td>Operating Budget Impact:</td>
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### Completing the Template

- Include a complete description of the item that clearly explains what the item is.

- Include a strong justification as to why this item is needed, as well as what the impact will be if it is not funded.

- Include the unit cost and it is helpful to get a quote if possible. Please contact Kim, George, or Biomed early if you need help in gathering specific pricing information.

- It is also essential that you review, and if needed, comment on the operating budget impact. Many capital items require new supplies with an increased price and/or have accessories and components that are purchased through operating budget funds. Please include information on all training, preventive maintenance or warranty costs. In years past, we have incurred unanticipated non-salary expenses due to the purchase of a capital items. The requestor needs to document plans to address any increased operating expenses.

---

### Request Early!!

- Please do not wait until August 31st to request capital items. It helps us identify global needs early and provides time to address any questions.
## CAPITAL BUDGET FORM

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<td>Operating Budget Impact <em>(if any):</em></td>
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Targeted Therapies Advances: Uniquely Positioned

- Watershed moment in cancer history
- Hundreds of new anti-cancer agents in pipeline for development
- One size does not fit all
- Genotyping revolutionizing drug development in selecting patients that will respond
- MGH first to conduct genotyping in clinical setting and key contributor to early drug development

We are positioned to be world leaders in targeted therapies

Current State Needs

- Existing Phase I Program
  - 5 Chairs in Yawkey 8
  - 53 Phase I trials
    - 26 coordinated in Phase I chairs today
    - 27 coordinated in disease center general infusion chairs
  - Approximately 25 Phase I/II trials should be handled in specialized chairs but are not today

- Current Issues
  - Inadequate staffing and chairs given complexity
  - Insufficient hours of operation
  - Significant scheduling issues due to overall Yawkey infusion processes and capacity constraints
  - No dedicated physicians and lack of coordinated coverage
  - Inadequate pharmacy and cell processing support
  - Lack of leverage with industry to obtain novel agents and downstream development

Our goal will be to double the participation in phase I clinical trials within 2 years

Vision for Center

- MGH Cancer Center will be the leader in targeted therapies and will facilitate drug development to deliver advances in cancer treatment and cures

We will achieve this vision through the establishment of a distinctive and innovative Center for Targeted Cancer Therapies

Organization and Leadership

- Under leadership of Jose Baselga, MD, PhD
- An onsite medical director role will be established
- Each disease centers will appoint 1-2 faculty who will conduct trials in Center
- Patients will transfer to care to Center oncologists to ensure complete focus on experimental treatment
- Primary oncologists will stay connected through shared decision making, social visits, and followup visits.

Create culture of integration and hope, rather than treatment of last resort
State of the Art Facility and IT

- Dedicated specialized facility is essential
  - 10 Infusion Chairs
  - 5 Exam Rooms
  - 1 Team Room
  - 2 Blood Draw Stations
  - 1 Procedure Room (biopsies)
  - Pharmacy Satellite with 2 Hoods
  - Cell Processing Lab Satellite
  - Nutrition Station
  - Office/Support Areas for faculty/staff
  - Telemedicine for remote monitoring of orals
  - Relational databases for trial matching

Total Staffing Estimates

Program Staff
- Staffing will include current resources which will be shifted
- Most funding will be supported through the protocol office
- Staffing will reflect a 16-18 hour day, which is a culture change

Protocol Office Funding
- Today
  - Research Nurses: 1.5
  - CRAs: 2.0
  - CRCs: 2.0
  - Lab Techs: 1.0
- Incremental
  - Research Nurses: 3.0
  - CRAs: 2.5
  - CRCs: 4.0
  - Lab Techs: 1.0

Hospital Funding
- Infusion Nurses: 3.0
- Pharmacists: 2.0
- Nurse Practitioner: 0.25

Example: Breast Cancer

Neoadjuvant model

- PI3K/mTOR
- IGF-1R
- Novel anti-HER2
- Hypothesis-driven combinations

Sophisticated Processing and Monitoring

- Access to specialized resources to advance trials
  - Cell Processing Facility and Operations: Onsite PK/PD or coordination with sponsor
  - Circulating Tumor Cell Technology: Monitor progression (unique technology not available elsewhere)
  - MGH Imaging: Access to PET CT, MRI
  - Cell line screening: Access to Center for Molecular Therapeutics 1000 cell line program
- Attractive to industry partners

Signature Relationships

- Develop signature relationships with industry and foundations
- Establish preferred relationships for first in human trials
- Important for leading downstream in Phase II/III trials
- Industry lacking depth of specialized resources like CTCs and CMT
- Necessary given declining NCI funding
- Leverage relationship for investment in other research efforts in Cancer Center
**Potential Space Options: Pros/Cons**

### Cox 1: Ideal Size
- **Pros:**
  - Expand on current 5 chair program
- **Cons:**
  - Not separate facility
  - No room for onsite ancillary spaces/officing
  - Need to decant more primary oncology offsite (e.g., MG West)

### Yawkey 8
- **Pros:**
  - Freestanding
  - Close to disease programs
- **Cons:**
  - Decant other spaces/programs
  - Potentially not enough space for all ancillaries/officing
  - Donor issues

### Yawkey 10: Ideal Location
- **Pros:**
  - Currently built out for infusion/practice
- **Cons:**
  - Disconnected fromYawkey programs/resources
  - Need to wait for BMT decant

**Notes:**
- These have not been reviewed with Facilities/Real Estate; there may be other options

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**Conclusions**

- The Center for Targeted Cancer Therapies will advance our vision to conquer cancer
  - We will create an unparalleled center that offers hope to patients and physicians
  - We will employ and facilitate the enormous clinical and scientific resources of MGHCC, including our multidisciplinary faculty, staff, genotyping, CTCs, and cell processing
  - We will focus these quaternary, high-cost, activities at MGHCC to build our overall cancer program in this era of health reform
  - We will engage industry and foundation to achieve these goals given declines in NCI funding post-stimulus
  - We will build the MGH and MGH Cancer Center brand through extraordinary advances in targeted therapies

*We will work actively to find targeted cures for cancer patients and beat resistance to drugs*

---

**Cancer Center Volume Analysis**

- New patient Medical Oncology visits are up by 14% at Boston but Infusion starts are down by 25%
- Infusion capacity is the major issue impacting the decline in infusion starts
  - Current capacity is 165 treatments and we are treating up to 180 patients per day routinely
  - Physicians are referring many treatments back to the community due to capacity issues
  - There are frequently caps on new patients due to safety concerns and pharmacy capacity as well
  - The decrease in new starts can also be attributed to oral chemotherapy, but this is around the margins
- After researching the issue, we have identified several root causes to our capacity constraints:
  - Longer infusions due to more complex patients
  - Increase in research protocols and more complex Phase I/II protocols handled in general chairs
  - General increase in clinic volume and survivorship

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**Cancer Center Capacity Solutions**

- Expand infusion unit capacity
  - Decant experimental therapeutics from infusion center and practices (5 chairs)
  - Create new infusion unit and medical oncology practice at MGH West for common cancers (20-30 chairs)
  - Expand capacity at Danvers which as increased its news by 12% this year, open weekend/evening hours
- **Why is this Critical?**
  - Ensure continuity of care
  - Preserve accruals to clinical trials downstream in disease process
  - Maintain chemo margins in MGH
  - Maintain reputation as a full service, high quality provider
  - Competition from DFCI’s new facility bringing on incremental 150 bays
Project Narrative
July 7, 2011

Center for Targeted Therapies
Massachusetts General Hospital
Yawkey Center for Outpatient Care, 7th Floor
32 Fruit Street
Boston, MA 02114

Project Area 4,580 GSF

Massachusetts General Hospital (MGH) is proposing to renovate 4,580 square feet of space on the 7th floor of the Yawkey Center for Outpatient Care (YCOC) into a 10-station cancer infusion suite. The YCOC building is centrally located on the MGH campus in downtown Boston with convenient access to public transportation (bus & subway) and contains a 6-level below grade parking garage restricted to patient and family use.

The project scope area on Yawkey 7 is currently occupied by four conference rooms, support spaces, two associated restrooms and 10 offices. The existing rooms and finishes will be demolished as part of this project. The space will be fitted out as a cancer infusion suite to support patient care and clinical drug trials. The new suite will include a reception/waiting area, phlebotomy room, seven “open” infusion bays, three “closed” infusion exam/treatment rooms, nurse’s station, nourishment station, medication dispensing, medication alcove with secured drug distribution station, equipment storage, clean supply room, soiled utility room, team room, four doctor consult/offices, four staff offices and a housekeeping closet. The seven infusion bays will have one open side with a retractable curtain for patient controlled privacy. Three existing restrooms will be incorporated into the suite to serve public, staff and patient populations. Staff lounge and lockers are located on the same floor and will be shared with another clinic. A waiver request is included in this submission. Minimum corridor width of 5’-0” clear will be used. Ceiling height will be 8’-9” throughout. Doors for patient use will be a minimum of 3’-0” wide and doors in the path of emergency stretcher movement will be 3’-8” wide.

This unit is necessary to accommodate the growing needs of translational and first in human research in the Cancer Center. An increasing number of patients are coming specifically to the MGH Cancer Center seeking to participate in a growing number of successful clinical trials that are offered here.

By design, patients who participate in the clinical trials that will be conducted on this unit will have an increased length of stay and acuity. Appropriate patient selection and importantly, patient care during administration of the study require the expertise of medical and nursing staff familiar with the intricacies and specialized care involved in these complicated trials. Patients will require increased nursing needs for frequent physiologic and pharmacokinetic monitoring. Evaluation and monitoring of adverse events is more demanding of staff time because of the potential of unknown toxicities.

The proposed unit will be located using existing space on Yawkey 7. Space will be renovated to house the entire Targeted Therapies Infusion Center. Space will be designed with the intent that recognizes patients will require an extended outpatient length of stay than patients treated on standard chemotherapy regimens.
Attachment TL 2.1 continued

There will be 3 infusion exam/treatment rooms with stretchers and 7 infusion bays that are separated by a wall allowing for privacy. The three patient rooms will serve both exam and treatment functionality. Each stretcher/chair area will be equipped with physiologic monitors, thermometers, O2 and air flow meters, NG suction, sufficient electrical outlet for computer, phone and ECG capacity.

The clinical trials conducted on this unit will include administration of both chemotherapy and biological drugs. These drugs will be given by all routes of administration, most commonly intravenous, intraperitoneal and oral routes. In addition all pre and post medications specifically required by a particular study will be administered. Uncomplicated procedures such as skin and nail biopsies will be done if required by the study. These procedures will not require procedural conscious sedation.

The Targeted Therapies Medication Dispensing will be approximately 300 square feet and will be used for the purpose of providing research medications to study patients. The service will be to fill prescriptions for study supplied medications only. There will be no sterile compounding in the new facility as this will all be supplied from the existing pharmacy on Yawkey 8. Chemotherapy drugs from Yawkey 8 will be delivered to Yawkey 7 via an extension of an existing pneumatic tube system. Medication Dispensing will also provide drug information to the nursing staff on Yawkey and will act as a resource for the pharmacists who work on Yawkey 8.

Anticipated hours of operation include Monday thru Friday from 7AM to 8:30 PM and Saturday from 8AM to 6PM. The Nurse Manager for Research will manage all the research nursing staff and CRCs. A Nurse Director will manage all nursing staff and medical assistants. The ND will be responsible for overseeing unit operations with the practice manager. The practice manager will also work with the Nurse Director and Research Nurse Manager to develop a schedule in IDX. An existing locker room on Yawkey 7 will be used by the Center staff to store their personal belongings. See attached plans for location.

Construction barriers will be located to separate construction areas from occupied spaces. The construction will have negative air pressure with respect to the adjacent department spaces. New finishes will include acoustic ceiling panels, GWB soffits, GWB partitions, plastic laminate counters and cabinets. All new and existing walls to remain in the project scope will have a painted finish. Carpet will be installed in offices and the reception area. Clinical care spaces will receive resilient flooring.

Modifications will occur to the existing HVAC, electrical and plumbing systems to support the new layout (see MEP drawings). Hand washing station equipment will include soap dispensers, hand-drying provisions and wrist controls throughout on new fixtures. The project will be submitted as an abbreviated two-part application, with an OP7: Free-Standing Cancer Treatment Facilities checklist. The project application has been included in this submission. Thank you for your help in applying the regulations to our submission. Please feel free to call if you have any questions on (781) 444-2747.

George Takoudes AIA,  
Principal  
Isgenuity, LLC
## Proposed Center for Targeted Cancer Therapies - Infusion Area (13 hours)

<table>
<thead>
<tr>
<th>DAY</th>
<th>TIME</th>
<th>HOURS</th>
<th>SLOTS</th>
<th>HOURS</th>
<th>TOTAL</th>
<th>RN STAFF</th>
<th>RN STAFF</th>
<th>DIRECT</th>
<th>PCA (1:5)</th>
<th>PCA</th>
<th>DIRECT</th>
<th>#</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>MON-FRI</td>
<td>7A-8A</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>251</td>
<td>1,506</td>
<td>0.75</td>
<td>1,130</td>
<td>0.5</td>
<td>0.20</td>
<td>301</td>
<td>0.1</td>
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<tr>
<td>MON-FRI</td>
<td>8A-10A</td>
<td>2</td>
<td>8</td>
<td>16</td>
<td>251</td>
<td>4,016</td>
<td>0.75</td>
<td>3,012</td>
<td>1.4</td>
<td>0.20</td>
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<tr>
<td>MON-FRI</td>
<td>10A-6:30P</td>
<td>8.5</td>
<td>10</td>
<td>85</td>
<td>251</td>
<td>21,335</td>
<td>0.75</td>
<td>16,001</td>
<td>7.7</td>
<td>0.20</td>
<td>4267</td>
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<td>MON-FRI</td>
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<td>1</td>
<td>8</td>
<td>8</td>
<td>251</td>
<td>2,008</td>
<td>0.75</td>
<td>1,506</td>
<td>0.7</td>
<td>0.20</td>
<td>402</td>
<td>0.2</td>
<td>6.0</td>
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<td>MON-FRI</td>
<td>7:30-8:30P</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>251</td>
<td>1,004</td>
<td>0.75</td>
<td>753</td>
<td>0.4</td>
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<td>201</td>
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<tr>
<td><strong>SUBTOTAL</strong></td>
<td></td>
<td>119</td>
<td></td>
<td></td>
<td></td>
<td>10.8</td>
<td></td>
<td></td>
<td>2.9</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>RN</th>
<th>PCA</th>
<th>PSC</th>
<th>USA</th>
<th>LEAD</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIRECT FTEs</strong></td>
<td>10.8</td>
<td>2.9</td>
<td></td>
<td></td>
<td></td>
<td>13.6</td>
</tr>
<tr>
<td><strong>RESOURCE</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>PSC SUPPORT</strong></td>
<td></td>
<td></td>
<td>2.6</td>
<td></td>
<td></td>
<td>2.6</td>
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<tr>
<td><strong>USA SUPPORT</strong></td>
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<td></td>
<td>2.2</td>
<td></td>
<td></td>
<td>2.2</td>
</tr>
<tr>
<td><strong>CNS</strong></td>
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<td></td>
<td>0.2</td>
<td></td>
<td></td>
<td>0.2</td>
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<tr>
<td><strong>OM</strong></td>
<td></td>
<td></td>
<td>1.0</td>
<td></td>
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<tr>
<td><strong>INDIRECT</strong></td>
<td>4.75%</td>
<td>0.6</td>
<td>0.1</td>
<td></td>
<td></td>
<td>0.7</td>
</tr>
<tr>
<td><strong>SUBTOTAL DIRECT</strong></td>
<td>12.9</td>
<td>3.0</td>
<td>2.6</td>
<td>2.2</td>
<td>1.2</td>
<td>21.9</td>
</tr>
</tbody>
</table>

|                  | 13.8%  | 16.5% | 14.0% | 15.1% |
| **BENEFIT TIME** | 1.8    | 0.5   | 0.4   | 0.3   | 2.3  |
| **BENEFIT FTEs** | 14.7   | 3.5   | 3.0   | 2.5   | 1.2  | 24.9  |

|                  | 1.5    |       |       |       |      |       |
| **14.7**         |        |       |       |       |      |       |
| **TOTAL FTEs**   | 13.2   |       |       |       |      |       |

|                  | $ 1,653,544 | $ 157,816 | $ 152,107 | $ 75,675 | $ 106,042 | $ 2,145,183 |
| **SALARY $$**    | $ 595,276  | $ 56,814  | $ 54,758  | $ 27,243  | $ 38,175  | $ 772,266   |
| **FRINGE $$**    | $ 2,248,820 | $ 214,629 | $ 206,865 | $ 102,918 | $ 144,217 | $ 2,917,449 |
| **TOTAL S&W**    |          |         |         |         |         |         |

<table>
<thead>
<tr>
<th>Other Non-PCS FTEs</th>
<th>FTEs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist</td>
<td>4.5</td>
<td>$ 253,779</td>
</tr>
<tr>
<td>Pharmacy Tech</td>
<td>2.5</td>
<td>$ 299,173</td>
</tr>
</tbody>
</table>

| Estimated Differentials | $ 19,800 |
| Estimated Non-Salary | $ 208,250 |
| **$ 3,698,451** |         |

1 RN to 1.5 Patient Assignment; 1 PCA to 5 Patient Assignment
F'12 Salary $$; 80% of Salary Grade Maximum; Fringe at 36%

Yawkey 8 Offset

<table>
<thead>
<tr>
<th>DAY</th>
<th>HOURS</th>
<th>SLOTS</th>
<th>HOURS</th>
<th>DAYS</th>
<th>HOURS</th>
<th>/ HOUR</th>
<th>HOURS</th>
<th>RN FTEs</th>
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</thead>
<tbody>
<tr>
<td>MON-FRI</td>
<td>10</td>
<td>5</td>
<td>50</td>
<td>251</td>
<td>12,550</td>
<td>0.75</td>
<td>9,413</td>
<td>4.5</td>
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<tr>
<td>MON-FRI</td>
<td>10</td>
<td>5</td>
<td>50</td>
<td>251</td>
<td>12,550</td>
<td>0.50</td>
<td>6,275</td>
<td>3.0</td>
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</table>

-1.5

Differentials based on Yawkey 8 FY'12 of $116,400
Non-salary based on Yawkey 8 FY'12 of $1,225,000
PSC Staff shared between Infusion Area and Practice

PCS MS: 8/4/2012
attachment TL 2.n

Massachusetts General Hospital
Patient Care Services

Proposed Short-Stay Unit (Bigelow 7)

<table>
<thead>
<tr>
<th>Description</th>
<th>FY'12 - New Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds</td>
<td>18</td>
</tr>
<tr>
<td>Occupancy</td>
<td>85%</td>
</tr>
<tr>
<td>Midnight ADC</td>
<td>15.3</td>
</tr>
<tr>
<td>Classification ADC</td>
<td>15.3</td>
</tr>
<tr>
<td>Classification Acuity</td>
<td>1.30</td>
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<tr>
<td>Total Acuity</td>
<td>1.45</td>
</tr>
<tr>
<td>Classification Workload Index</td>
<td>19.9</td>
</tr>
<tr>
<td>Total Workload Index</td>
<td>22.2</td>
</tr>
<tr>
<td>Hours / Workload Index</td>
<td>5.50</td>
</tr>
</tbody>
</table>

| Shifts / 24 Hours                        | 15.3              |
| Indirect Time                            | 4.75%             |
| Benefit Time RN                          | 14.0%             |
| Benefit Time Non-RN                      | 9.5%              |
| Direct Care FTEs - WI                    | 25.4              |

| Staff Nurse                              | 21.3              |
| Non RN Direct                            | 4.1               |
| **Total Direct Care FTE**                | **25.4**          |

| Nursing Director/ Resource               | 1.0               |
| CNS                                      | 1.0               |
| OM                                       | 1.0               |
| Op. Assoc.                               | 7.4               |
| Unit Assist/ USA                         | 7.4               |
| Physical Therapist                       | 1.0               |
| **Total Other FTEs**                     | **18.8**          |

| **Total FTEs**                           | **44.2**          |
| % RN Direct Care                         | 84.0%             |

| Estimated Diff $$                        | $ 281,416         |
| Estimated Non-Sal $$                     | $ 150,000         |
| **Estimated Total $$**                   | **$ 3,967,957**   |

Assumptions:
- Acuity based on FY 2011 actual for lower acuity units
- Hours per Workload Index based on Quadramed national data
- RN Mix per MGH General Care
- Estimated Diff Based on ED Observation Unit FY'12 Budget
- Nonsalary based on ED Observation Unit FY'12 Budget
Proposal for Blake 12: Reanimation Unit: ICU of the Future

In FY12, the Hospital will open a new 18-bed intensive care unit (ICU) on Blake 12 to address the growing need for inpatient critical care services, based upon national trends and a systematic, multidisciplinary, 2-year review of quality and safety indicators. As a result of creating this new ICU, the number of ICU beds at the MGH will increase to ~15% of the total number of inpatient beds, consistent with advisory board recommendations and national averages for peer institutions.* Successful integration of advances in intensive care will be dependent upon the sciences of reanimation and health engineering, which motivates us to name this the Reanimation Unit, the first of its kind in the United States (see Appendix 1). As an “ICU of the Future”, the Reanimation Unit is a unique resource, providing a living laboratory for multi-specialty, patient-centered learning. This focus on integrated expertise and operational excellence will help break down the silo mentality that has traditionally hampered multi-disciplinary care for the critically ill and injured. To these ends, this proposal presents key features of the Reanimation Unit, including expected patient populations, administration and governance, staffing, and financial planning. Projections are based upon the important contributions and teamwork provided by the ICU of the Future Task Force: Hasan Alam (Chair, DOS), Uli Schmidt (DACCMP), Walter O’Donnell (DOM), and Theresa Gallivan and Dawn Tenney (PCS).

Patient Populations

Multidisciplinary staffing of the Reanimation Unit makes it an ideal destination for critically ill patients benefitting from multidisciplinary care. The Reanimation Unit will be the primary assignment for

- Liver and kidney transplant patients, both before and after surgery
- PACU patients as overnight "decompression" of patients with signs of clinical deterioration (organ failure)
- Acute-care surgery overflow from Ellison 4 SICU
- Neurosciences ICU (Lunder 6) patient overflow
- Critically ill or injured patients in the Emergency Department assigned to ICU’s that are currently at capacity (“full”)

Administration and Governance

The organizational chart for the Reanimation Unit is diagrammed below. The administration will include

- Medical Director: Dr. Hasan Alam (DOS)
- Nursing Director: TBN (PCS)
- Associate Medical Director: TBN (DACCMP or DOM)
- Assistant Medical Director: TBN (DACCMP or DOM)
- Lead clinical Pharmacist(s): TBN


May 1, 2011
Staffing

Attending Physician (Intensivist) Staffing

The 18-bed Reanimation Unit will be covered 24/7 by a multidisciplinary team of intensivists, including surgeons, anesthesiologists, internists, and emergency medicine physicians. There are variances across Departments with respect to clinical commitments. For the purposes of this proposal, the following assumptions are made:

- 1.0 FTE = ~182 shifts per year
- 2.5 intensivists per day staff the Reanimation Unit, 1.5 during the day and 1.0 at night (the 0.5 additional day attending is provided for emergency coverage, possibly shared with other ICU’s, such as the Ellison 4 SICU)
- 913 intensivist shifts per year are required (2.5 FTE x 365 days), conservatively

Thus, a total of 5.0 FTE Intensivists are required to cover the Reanimation Unit.

It is expected that current faculty and new recruits across the DOS, DACCPM, DOM, and DEM can provided the necessary personpower.

Critical Care Fellows and Physician Residents-in-training Staffing

While long-term expectations include clinical responsibilities for fellows and residents from all disciplines, current staffing is expected in the Reanimation Unit only from the critical care fellowship and residency training programs in Surgery and Anesthesia. Residents and fellows from other departments will be integrated as they become available. Due to limited numbers, it is expected that residents and fellows will (at most) cover only half of the patients in the Reanimation Unit at any one time. The remaining care responsibilities will be provided by mid-level providers.
Mid-level Provider Staffing

This group includes critical care nurse practitioners (CCNP’s) and physician assistants (PA’s). The motivation to hire mid-level providers includes the advantages of consistency of care (thereby providing a quality advantage), fewer handoffs, and sustainability of the practice model. The Reanimation Unit expects 2 mid-level providers during the day and one at night, 7 days a week:

- 252 hours of total coverage per week, given 168 day hours (12h x 7 days x 2 providers) and 84 night hours (12h x 7 days x 1 provider)
- 40 hours/week/provider covering 252 hours = 6.3 providers
- Restructuring fellow and resident coverage across the Ellison 4 SICU and Reanimation Unit creates a deficit in the SICU of 3.5 FTE.
- **A total of 10.0 FTE mid-level providers are required to staff the Reanimation Unit and the SICU Ellison 4 (6.5 FTE assigned to the Reanimation Unit and 3.5 FTE assigned to the SICU to complement the 2.0 FTE that are already there).**

Nurse Staffing and Training

**Dozens of new nurses have been hired to staff the Reanimation Unit.** Justification for the required number of nursing positions is provided in Appendix 2; a detailed budget for staffing is included in the financial plan (submitted separately). A novel Nurse Residency Program was created by the Knight Nursing Center for Clinical and Professional Development to transition these new-graduate nurses from student to staff. The Program is designed to promote, foster and cultivate the concepts of caring in newly-graduated nurses in order that they meet the unique and varied needs of critically ill patients and their families. The most innovative aspect of the Program is the use of Clinical Nurse Specialists as Faculty, who provide a 960-hour curriculum divided into three-phases of transition from new graduate to independent clinical practice (see Appendix 3 for more details). Training began on April 4th, 2011 and will continue for the following six months. Additional nursing staff will be hired as needed over the next six months to fully prepare for opening of the Unit at the beginning of October 2011.

Respiratory Therapist Staffing

As is the standard in all ICU’s, one respiratory therapist will need to be assigned to the unit 24 hours/day, 7 days per week. **In order to accomplish this staffing standard in the Reanimation Unit, 5.0 FTE respiratory therapists were added to the FY 2012 respiratory care departmental budget.** These individuals will need to be hired on or before July 1, 2011, since they will each require a 3-month orientation to ready them to assume clinical responsibilities.
Clinical Pharmacy

Clinical pharmacy recommends covering the Reanimation Unit 7 days a week as follows:

- Monday - Friday 7:30 am -10:30 pm
- Sat and Sun 7:30 am -8 pm

Pharmacy technicians will be available to manage missing meds, delivery, out-of-stocks, etc. Thus, the total request is 3.0 FTE ICU Clinical Pharmacist positions and 1.0 FTE Pharmacy Technician position.

Timeline

Given the number of new staff, the Center proposes that the 18-bed Reanimation Unit open in October 2011 to partial capacity (potentially as few as 6 beds depending upon staffing capacity), adding additional beds monthly to reach full capacity by early 2012. A robust quality assessment and improvement program will be implemented as part of the Critical Care Center to insure optimal patient outcome and resource utilization.
MORE for multiple organ dysfunction syndrome: Multiple Organ REanimation, REgeneration, and REprogramming*

J. Perren Cobb, MD

Those who care for the critically ill and injured rightfully celebrate the advances made by our field over its first 50 yrs. Advances in systems, tissue, and molecular engineering, together defined as “health engineering,” will provide unprecedented opportunities to treat multiple organ dysfunction syndrome in the 21st century. In the future, Multiple Organ REanimation, REgeneration, and REprogramming will be responsible for new treatment approaches for those with multiple organ dysfunction syndrome; several examples are presented here. Thus, as we spent the first 50 yrs of care for the critical ill and injured learning how best to hook humans up to machines, we will spend the next 50 yrs understanding better how to liberate patients from mechanical support. It is difficult to know when these advances will be realized given that the rate of change continues to increase and the seemingly impossible goal of reprogramming fully differentiated cells was accomplished recently by manipulating a few transcription factors. It is not unrealistic to expect that in the next couple of decades that it will be possible to dedifferentiate dysfunctional somatic cells in vivo to a more robust, resistant cell phenotype. Our future should be aimed in part at refining our skill sets and refocusing (even rebranding) critical care as health engineering aimed at Multiple Organ REanimation, REgeneration, and REprogramming. (Crit Care Med 2010; 38:2242–2246)

Key Words: MODS; stem cells; critical care; ICU; intensive care; future

O

n the golden anniversary celebrating Dr. Peter Safar and the founding of intensive care at Baltimore City Hospital (1) (now known as Johns Hopkins Bayview Medical Center, Baltimore, MD), we recognize some of the remarkable contributions to patient care made by multidisciplinary teams over the decades. In the 1950s, the coupling of output from invasive instruments, video display technology, and computer analysis provided the requisite tools for early specialists to measure physiological and biochemical parameters, interpret changes in real time, and titrate therapy accordingly (the “MIT” approach, Dr Max Harry Weil, personal communication). Early advances thus depended not only on finding the right “place” to practice care for the critically ill and injured, but also “the ability to understand mechanisms, translate what was happening in real time, and react to it.” Innovations in airway management and cardiopulmonary resuscitation narrowed the gap between scientific knowledge and its application to treat the critically ill and injured (1). Drs Safar, Weil, and William Shoemaker gained visibility for the specialty with the establishment of an inclusive, dedicated organization that created standards of practice, education, and research (2). For example, mechanical ventilatory support for acute respiratory distress in adults improved as a result of technologic advances and a better understanding of the potential for ventilators to induce lung injury (3). More recently, application of molecular approaches in clinically relevant animal models defined the pathways responsible for myocardial dysfunction during sepsis (4) and guided the pursuit of new strategies to optimize outcomes after brain injury (5). Finally, renewed interest in understanding the organizational factors that contribute to improved outcomes has refocused efforts on patient safety, resource use, and care delivery models (6–10).

On this 50th anniversary of multidisciplinary intensive care in the United States, we are motivated to reflect on the future of care for the critically ill and injured, recognizing that we are at an important point in its evolution. The patient lies (literally) at the interface of technology and procedural advances. As clinicians, we celebrate the fact that the vast majority of patients (>90%) survive critical illness or injury. For those who do not, we take pride in practicing the caring art of ushering in death with dignity, relieving patient suffering, and providing comfort to family members and loved ones. Many of those who die after days to weeks manifest the clinical phenotype called multiple organ dysfunction syndrome (MODS). The imperative to improve patient safety and outcomes is driven by the recognition that past standards are no longer acceptable and the process needs to change (11). Improved access to team-based acute care services, strategic plans for nationwide clinical trials, and novel transdisciplinary training programs all demand better communication and synergy (11, 12). “The time has come for critical care to reinvent itself and deliver on the promise of quality and safety in every ICU” (13). Our colleagues in France suggest one approach, réanimation, by which to reinvent, redefine, and refocus our specialty. This is not a new concept; indeed, Dr Safar recommended the term réanimation in the 1950s together with reanimation as the...
Table 1) that integrate to catalyze advances in reanimation, regeneration, and reprogramming.

Health engineering relies on the interaction of multiple, complementary, engineering skill sets (see Table 1) that integrate to catalyze advances in reanimation, regeneration, and reprogramming.

Multiple Organ REanimation

We propose that reanimation, a term that has been used for decades in Europe, refer to resuscitation, vital organ support, and rehabilitation for the critically ill and injured (Fig. 1). Today, MORE can be defined as the aggregate efforts provided to support failing organs and to create an environment that is optimal for recovery. To insure the best care tomorrow, MORE will couple today's best clinical practices with innovations derived from systems engineering and stem cell biology.

For example, systems engineering at the microlevel is being used to develop new diagnostic technology that leverages advances in genomics and molecular cartography (15). One recent report described the riboleukogram, which quantitatively maps host immunity as a function of changes in leukocyte transcriptional profiles, “an EKG for immunity” (16). The tracing of the riboleukogram and its end point described the return to health in critically ill patients and in normal volunteers with systemic inflammation (15, 16). Deviation from the expected healing trajectory was associated in critically ill patients with the development of ventilator-associated pneumonia, suggesting that bifurcation point identification may offer a novel diagnostic approach. The potential for riboleukograms to inform clinicians regarding the immune trajectory of critically ill patients was validated recently in a population of trauma patients at risk for ventilator-associated pneumonia (17).

Systems engineering at the macrolevel, on the other hand, provides a framework to enhance the care delivery process. Happily, many champions for improved systems to avoid medical errors and unnecessary deaths have been heard recently, spurred by a recent report from the Institute of Medicine (10, 18–23). Critically ill patients are, by definition, the most unstable (fragile) patients in the hospital. They are simultaneously the most invaded, medicated, and monitored. It is logical to expect that these high-risk patients in a data-rich environment would be cared for using the most sophisticated information systems, including patient care pathways with automated decision guidance, evidence-based protocols, computerized medication entry and retrieval, comprehensive and automatic data exchange during physician and nurse signout, automated drug interaction searches, etc. The fields of both process improvement and system engineering have contributed for decades to enhanced performance in business and industry, yet the healthcare sector has been slow to embrace this approach because of the lack of resources, difficulty of identifying quality metrics and controlling for measurement variance, and, perhaps most importantly, the belief that medical systems are “unique” and not amenable to systems science. (24, 25) The irony is that our thirst for new technology has not been mirrored by an equal interest in medical informatics and systems analysis. Nevertheless, advocates have recently demonstrated the impressive impact of systems engineering on both outcomes and cost reduction. For example, a statewide, team-based approach to make simple system interventions (for example, monitoring of patient safety actions and goal-directed improvements in communication) was very effective in reducing the incidence rate ratios of catheter-related bloodstream infections (26). Likewise, a simple checklist was used in operating rooms in eight major cities worldwide to significantly decrease death rates from 1.5% to 0.8% (27). The study of how best to apply systems science to accumulating evidence from clinical trials, and thereby establish “best practice,” is the science of implementation. The nature of care for the critically ill or injured and its dependence on multidisciplinary interactions across space and time make it an ideal subject for implementation science and applied systems engineering (28).

MORE for the Future

As shown in Table 1, the MORE approach seeks to leverage engineering skill sets not only for multiple organ reanimation, but also for organ regeneration (tissue engineering) and cellular reprogramming (molecular engineering).

Multiple Organ Regeneration. The regenerative capacity of human tissue is limited, but the potential for regrowth, as observed in amphibians and in the mammalian fetus, motivates the field of regenerative medicine. Studies at the interface of the fields of injury and development have catalyzed current interest in tissue engineering, in many cases altering the notion that most adult organs are terminally differentiated. As a case in point, several recent observations provide new insight into the biology of heart regeneration (29–31). For example, injected bone marrow cells were reported several years ago to generate new myocardium in adult hearts at sites of injury, prompting
several prospective clinical trials. The results of these trials have been mixed (29, 32), but recent reports from preclinical models provide new paradigms to explore. In a mouse model of heterozygous genetic (Hecs) deficiency, the fetal heart demonstrated an impressive capacity to regenerate that compensated for an effective 50% loss of differentiated, cardiac tissue (33). Similarly, the characterization of resident cardiac stem cells in adult hearts has expanded interest in what has been called cardiomyoplasty, the concept of repairing lost myocardium by cellular therapy (30, 34). At the organ level, decellularized rat hearts that were repopulated with newborn rat cells could be coaxed to contract on their own ex vivo, a step toward a bioartificial heart (35). The promise of cellular therapy and regenerative medicine is to leverage these tissue engineering advances to provide hope to those with (multiple) failing organs, including failure of other organs like the lung and kidney, which account for a large fraction of intensive care unit morbidity and mortality. For instance, acute kidney injury may result in selective death of tubular stem cells that are normally responsible for regeneration. Alternatively, the niche that these cells occupy could be altered by injury to produce an “infertile” environment for otherwise healthy stem cells. Careful analysis should distinguish between these possibilities and provide potential opportunities for intervention. This approach might avoid the need for whole organ transplantation, immunosuppressive drugs, and their attendant perioperative complications.

Bone marrow–derived mesenchymal stromal cells are another therapeutic approach to multiple organ regeneration, in this instance aimed at restoring immune health. Mesenchymal stromal cells are a heterogeneous, nonhematopoietic subset of marrow cells that can differentiate into cells of the mesodermal lineage such as bone, cartilage, and fat (36). Mesenchymal stromal cells also are relatively immunoprivileged and can interact with effector cells of both the innate and adaptive immune systems to significantly dampen inflammatory responses and promote tissue repair. For example, in a mouse model of endotoxin–induced lung injury, intratracheal treatment with mesenchymal stromal cells decreased lung water and endothelial/epithelial permeability and improved survival (37). More recently, intravenous injection of bone marrow stromal cells was reported to “reprogram” macrophages and improve survival in a mouse abdominal sepsis model (38). These findings are consistent with the hypothesized in vivo role of mesenchymal stromal cells as pericytes that stabilize blood vessels and promote immune homeostasis (39). The therapeutic plasticity of mesenchymal stromal cells likely stems from their ability to release anti-inflammatory cytokines (such as interleukin-10) and trophic molecules that inhibit leukocyte activation and stimulate healing (36, 38). These intriguing results notwithstanding, the safety profile of mesenchymal stromal cells in critical illness and injury is poorly characterized, because their tumor–promoting potential and long–term effects on immune health are not known.

Multiple Organ Reprogramming. Pancreatic cells are not dead in patients dying with MODS; instead, increased cell death of only a few cell types that normally die by apoptosis appear to be primarily affected (for example, lymphocytes and intestinal epithelial cells) (40). If the vast majority of cells are truly dysfunctional but not dead, why do patients with MODS die (assuming the goal of therapy remains “cure”)? Observations in animal models suggest that sequential insults of usually well–tolerated stimuli can produce unexpected cellular dysfunction and/or death (41–43). This has led some to suggest that critical illness or injury requiring vital organ support more closely resembles a state of aggregate “cellular arrest,” “hypometabolism,” or hibernation (44) analogous to myocardial stunning after ischemia (45). This paradox of cellular dysfunction without death of the patient presents an opportunity to apply exciting new knowledge of molecular engineering. This therapeutic approach, described as genetic or molecular reprogramming, was touted recently as Science magazine’s “Breakthrough of the Year” (46).

The molecular wizardry for cellular reprogramming works in mice and humans and is based on overexpression of a few DNA transcription factors previously described to be central to control of embryonic stem cell fate: Oct4, Sox2, and Nanog, among others (47, 48). The reprogramming efficiency, and the importance of better quality control and technical limitations, including a lack of understanding as to how a few transcription factors can fully reprogram differentiated cells, the need in many instances to use retroviruses to introduce transcriptionally active factors (thereby permanently altering the cell’s genome), the importance of better quality control and reprogramming efficiency, and the long–term consequences of these alterations on the health of the organism (for example, carcinogenesis) (46).

<table>
<thead>
<tr>
<th>Table 1. The future of multiple organ dysfunction syndrome: Ongoing Organ REanimation</th>
<th>Engineering Skill Sets</th>
<th>Examples</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple organ REanimation</td>
<td>Microsystems engineering</td>
<td>Riboleukogram (16)</td>
<td>Now</td>
</tr>
<tr>
<td>Multiple organ REprogramming</td>
<td>Macrosystems engineering</td>
<td>Performance improvement (26)</td>
<td>Now</td>
</tr>
<tr>
<td>Multiple organ REgeneration</td>
<td>Tissue engineering</td>
<td>Bioartificial heart (35)</td>
<td>Next 10 yrs</td>
</tr>
<tr>
<td>Multiple organ REprogramming</td>
<td>Molecular engineering</td>
<td>β–cell transdifferentiation (50)</td>
<td>Next 25 yrs</td>
</tr>
</tbody>
</table>
Health Engineering

The dependence of quality patient care on advances in engineering has been recognized since the birth of organized care for the critically ill and injured (2). Realizing the restorative potential of multiple organ reanimation, regeneration, and reprogramming as described here will require more fully integrating training in the biomedical and engineering sciences. We proposed recently that the term health engineering refer to the integration of critical care, systems sciences, and molecular engineering to engineer health from critical illness or injury (11). Knowledge of computational biology and applied mathematics will also play a key role. Health engineering is distinct from bioengineering in that the latter does not typically concern systems of interacting humans (such as patients, clinicians, and hospital units). Development of a curriculum for health engineering will be aided by the broad acceptance of systems biology, because the critically ill or injured human can be considered the most complex of systems at the point of system failure (death). This observation is coupled with the fact that care for the critically ill or injured is practiced in the most data-rich environment in medicine, wherein multiple practitioners must respond optimally to maximize the likelihood of a good outcome. The realization that preventable complications are common and expensive in the critically ill or injured (both for the patient and the hospital) should further motivate clinicians and administrators (11). Finally, the US government’s recent emphasis on improving health information systems to enhance efficiency and safety provides an additional incentive.

Table 2. Therapeutic potential of cellular reprogramming

<table>
<thead>
<tr>
<th>Study variance in organ dysfunction</th>
<th>Example: create iPSCs in vitro to determine why one person’s kidneys fail after injury while another patient’s does not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of iP or other stem cells as cellular therapies</td>
<td>Example: bone marrow-derived cells to treat lung and trachea injury Example: iPSC cells replace lost pancreatic acinar cells</td>
</tr>
<tr>
<td>Identify pathways that regulate cell proliferation, differentiation, and death</td>
<td>Example: boost endogenous stem cells to make their differentiated offspring Example: discover stem cell environments in situ that are “fertile” vs. “infertile,” that is, environments that are conducive versus nonconductive to stem cell growth and tissue regeneration</td>
</tr>
<tr>
<td>Identify new healing factors (like erythropoietin) to improve solid organ healing</td>
<td>Example: discover stem cell environments that are conducive versus nonconductive to stem cell growth and tissue regeneration</td>
</tr>
</tbody>
</table>

iPSC, induced pluripotent stem.

CONCLUSIONS

As described here, advances in systems, tissue, and molecular engineering will provide unprecedented opportunities to treat MODS in the 21st century. As we spent the first 50 yrs of care for the critical ill and injured learning how best to hook humans up to machines, we will spend the next 50 yrs understanding better how to liberate patients from mechanical support. Reanimation, regeneration, and reprogramming are expected to usher in a new era of optimism for the critically ill or injured. When will our patients realize these advances? It is difficult to know given that the rate of change continues to increase. The seemingly impossible goal of reprogramming cells was accomplished by manipulating only four transcription factors; one group reported recently that oct4 alone may be sufficient (52). Using current approaches, it is now clear that simply injecting stem cells into animals or patients will not regenerate injured or dysfunctional organs. However, it is not unrealistic to expect that in the next couple of decades it will be possible to dedifferentiate dysfunctional somatic cells in vitro to a more robust, resistant phenotype that may help patients dying of organ dysfunction (Tables 1 and 2). Understanding the biology of organ-specific stem cells may help to develop therapeutic avenues for rescuing endogenous, latent, regenerative activity in injured human tissues. Thus, our future should be aimed in part at refining our skill sets and refocusing (even rebranding) critical care as health engineering aimed at MORE.

ACKNOWLEDGMENTS

I thank Dr. Jayaraj Rajagopal for his thoughtful review and help in revising the manuscript (Table 2).

REFERENCES

39. da Silva ML, Caplan AI, Nardi NB: In search of the in vivo identity of mesenchymal stem cells. *Stem Cells* 2008; 26:2287–2299
47. Takahashi K, Yamanaka S: Induction of pluripotent stem cells from mouse embryonic and adult fibroblast cultures by defined factors. *Cell* 2006; 126:663–676
APPENDIX 2

Nursing staffing calculation

<table>
<thead>
<tr>
<th>Description</th>
<th>FY'11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds</td>
<td>18</td>
</tr>
<tr>
<td>Occupancy</td>
<td>85%</td>
</tr>
<tr>
<td>Midnight ADC</td>
<td>15.3</td>
</tr>
<tr>
<td>Classification ADC</td>
<td>15.3</td>
</tr>
<tr>
<td>Acuity</td>
<td>3.81</td>
</tr>
<tr>
<td>Workload Index</td>
<td>58.3</td>
</tr>
<tr>
<td>Hours / Workload Index</td>
<td>6.28</td>
</tr>
<tr>
<td>Shifts / 24 Hours</td>
<td>45.8</td>
</tr>
<tr>
<td>Indirect Time</td>
<td>4.75%</td>
</tr>
<tr>
<td>Benefit Time RN</td>
<td>14.5%</td>
</tr>
<tr>
<td>Benefit Time Non-RN</td>
<td>13.5%</td>
</tr>
<tr>
<td>Direct Care FTEs - WI</td>
<td>76.5</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>68.9</td>
</tr>
<tr>
<td>Non RN Direct</td>
<td>7.7</td>
</tr>
<tr>
<td><strong>Total Direct Care FTE</strong></td>
<td><strong>74.0</strong></td>
</tr>
<tr>
<td>Nursing Director</td>
<td>1.0</td>
</tr>
<tr>
<td>CNS</td>
<td>1.0</td>
</tr>
<tr>
<td>Op. Assoc.</td>
<td>7.3</td>
</tr>
<tr>
<td>Unit Assist/ USA</td>
<td>6.0</td>
</tr>
<tr>
<td><strong>Other FTE's</strong></td>
<td><strong>15.3</strong></td>
</tr>
<tr>
<td><strong>Total FTE's</strong></td>
<td><strong>89.3</strong></td>
</tr>
</tbody>
</table>

% RN Direct Care 90.0%

**Assumptions:**
- Acuity per FY 2011 Actual Avg. for Blake 6 transplant ICU Patients (boarders not included)
- Hours per Workload Index for MGH Adult ICUs
- RN Mix per usual MGH Adult ICU
APPENDIX 3

Massachusetts General Hospital
Institute for Patient Care
Nurse Residency Program

Introduction

The Nurse Residency Program (Program) is an innovative model for transitioning new-graduate nurses from student to staff. The Program is based on the concept of caring as the core mission of the nurse-patient relationship. The Program is designed to promote, foster and cultivate the concepts of caring in newly-graduated nurses in order that they are able to meet the unique and varied needs of our patients and their families.

The goal of the Program is to provide a supportive, caring, engaging, enriching and intellectually stimulating transition period during which time the Nurse Resident is provided with exposure to the complex needs of patients, and the multiple situations patients and families experience, while under the direct guidance and supervision of our expert CNS Faculty.

Objectives

The objectives of the Program include preparing the Nurse Resident to:

- Develop general- and specialty-specific nursing knowledge necessary for the safe, effective care of complex patients in a high-tech, face-paced, and dynamic environment;
- Understand the uniqueness of the patient- and family-centered care model;
- Embody professional behaviors built on ethical principles through the art of caring;
- Acquire leadership principles as tools for managing the patient care experience, self and others;
- Demonstrate an understanding of healthcare organization and systems and their effect on the patient-nurse relationship;
- Successfully master use of select technology and informatics modalities;
- Effectively communicate;
- Function as a member of a team;
- Recognize safety and quality as the hallmarks of effective patient care;
• Engage in quality improvement; and
• Incorporate evidence into nursing practice.


Program Description

The Program is a faculty-guided, 960-hour curriculum designed to transition the new graduate from academia to practice. The Program recruits newly-graduated and recently-licensed Registered Nurses who under the careful tutelage of the CNS faculty are provided with a three-phase transition plan in becoming caring, thoughtful and competent clinical nurses.

Each phase of the transition plan is designed with the unique needs of the Nurse Resident in mind. Through close interface with CNS faculty and other peers, the Nurse Resident begins to assemble the beginning knowledge, skills, abilities, attitudes and competencies required for safe, effective patient care in both the general context of patient care, and in the unique needs of the patient. Each Nurse Resident is provided with an orientation to the hospital, Patient Care Services and the policies and procedures for safe, effective, and quality patient care. The practicum portion includes mentoring and coaching as two of the strongest pillars to insure success. The Program is built around the principles of Patricia Benner’s Novice to Expert skill-acquisition model and focuses on progressive mastery of nurse competency of assimilating to a fully-functional nurse. The curriculum incorporates the components of the Nurse of the Future competencies as the bridge to a seamless transition from the academic experience as a student nurse to role assimilation of the staff nurse in clinical practice.

The most innovative distinction of the Program is the use of our Clinical Nurse Specialists as Faculty. The role of the CNS Faculty is to:

• Create an environment where learning is accomplished through a series of integrated learning modalities that provides the Nurse Resident with the opportunity to learn key and essential critical elements of patient care.
• Offer clinical experiences in which there is supervised practice of newly-acquired knowledge.
• Coach and mentor from experienced master-class clinicians.
• Develop a sense of salience.
• Become self-reflective as a method of evaluating one’s performance and using the information to seek/create additional learning.

Nurse Residency Evaluation
The design of the Program is centered on the core principles of the nurse-patient relationship. This unique relationship is created when the nurse instinctively knows how to respond to the individual needs of the patient. The Program will be evaluated using the concept of a progressive mastery-developmental pathway. Many professions, but in particular nursing, ground themselves in the field of skill acquisition for role development. Dr. Patricia Benner, a nursing theorist shows that the development and the integration of nursing competency occurs in five distinct stages. These stages include: novice, advanced beginner, competent, proficient and expert. Each has developmental milestones that can be assessed as the nurse gains expertise. Three themes of nursing practice will be used to evaluate the residents. They are:

1. Clinician/Patient Relationship: the interpersonal engagement or relational connection between the clinician and the patient and/or family.
2. Clinical Knowledge and Decision Making: understanding attained through formal and experiential learning.
3. Collaboration and Teamwork: through the development of effective relationships with colleagues and other members of the healthcare team, the best possible outcome is achieved for the patient and family.

A variety of methods will be used to assess the residents such as nationally recognized survey tools, focus group feedback from faculty and staff, individual performance appraisals, self reports and the analysis of clinical events. The hallmark of truly evaluating a successful journey through the novice to expert trajectory will be through the clinical narrative. The clinical narrative is a powerful tool in which the nurse uses the process of self-reflection to investigate the meaning of his/her relationship to the patient and family. This evaluation will take place throughout the residency and after completion to ensure that residents have the skills to practice safely in the clinical environment and to continue to support their learning needs.
**Blake 12 ICU**  
**Planning Group**  
*Tuesday, October 11, 2011*  
*8:00-9:00 AM*  
*Founders 343 Conference Room*

**Members:**

<table>
<thead>
<tr>
<th></th>
<th>Present</th>
<th>Excused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alam, Hasan, MD</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Cobb, Perren, MD</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Schmidt, Ulrich, MD</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Banister, Gaurdia, RN</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Gallivan, Theresa, RN</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Tully, Susan, RN</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Chang, Lin-Ti, RN</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>McAuley, Mary, RN</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Whitney, Kevin, RN</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Chisari, Gino, RN</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>O’Donnell, Walter, MD</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Justin Verge</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion/ Actions</th>
<th>Responsible Individual/ Time frame</th>
</tr>
</thead>
</table>
| Blake 12 Patient Population       | • Discussed the value of using mock admission data to gauge staffing patterns; challenged by patient outflow and Routine Post Procedure Recovery (RPPR) data.  
• Discussed need to create close relationship with the transplant & medicine team: patient handoff post surgery/transplant, emergency and follow-up care.  
Designated members will meet to discuss triage criteria.                                                                                  | Kevin, Mary, Susan, Uli, Hasan & Walter                                                             |
| Staff Educational Requirements    | • Gino Chisari from the Knight Center is collaborating with Brian French (Simulation Team) on planning of 2-week immersion education/training for staff on Blake 12 scheduled for mid-November:  
  ▪ Scavenger hunt  
  ▪ New nurse call system  
  ▪ Equipment skills stations  
    ▪ Belmont rapid fluid infusion  
    ▪ Blood warmer  
    ▪ PVR  
    ▪ Doppler etc.  
  ▪ Scenario based simulation practicum  
  ▪ Orientation for RN with ICU experience (4-weeks):  
    ▪ Hospital orientation  
    ▪ Department of Nursing orientation  
    ▪ Validation of competencies  
  ▪ Orientation for Internal RN transfer (6-weeks):  
  ▪ Mary and Susan will select 30 RNs with mix-level experience to start, while other staff will remain in host units  
  ▪ Lin-Ti will crosswalk three ICU (SICU, MICU & transplant) SharePoint education resources                                                                 | Mary & Susan                                                                                         |
| Pre & Liver transplant workup & admission process | • Hasan shared staff can participate liver transplant lecture series scheduled every other Wednesday on Ellison 4  
• Discussion with transplant services re triage criteria, patient needs, acceptance services and receiving units  
• Triage decisions will include representatives from nursing supervisor, medical senior, CICU/ MICU Attendants                                                                 | Hasan, Walter, Kevin and Transplant Team                                                             |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion/ Actions</th>
<th>Responsible Individual/ Time frame</th>
</tr>
</thead>
</table>
| **Construction Plans, Phasing and Timelines** | - **Capital Equipment**  
  - **Construction:** Building & Grounds  
  - **Phasing & Timelines**  
  - **MESAC Approval: Airway Cart** | **Blake 12 capital**  
  - Request Oct 5...  
  **Blake 12 Upgrade**  
  - Oct 5.pdf (9...  
  **Kevin announced approval of Blake 12 budget submission**  
  **Members reviewed approved construction & capital budget**  
  **Kevin updated pre-post occupancy construction priorities, phasing & timelines**  
  - The past weekend Kathy Johansen (AOM) & Scott Parsons (EOM) began sorting reactivation equipment/supplies in the utility rooms to prep for construction  
  - Building & Grounds will start remove/replace flooring on Oct 11  
  - Phase 1  
  - Create an alcove next the old CNS space to house 2nd Omnicell unit  
  - New coat of paints  
  - Physiologic monitoring upgrades  
  - Any upgrades/renovations in patient rooms & visitor lounge  
  - Upgrades for ADA requirements  
  - Electronic whiteboard similar to Lunder  
  - Phase 2  
  - Office area and conference room  
  **Procurement of capital and non-capital equipment by end of week**  
  **Current redeployment equipment are stored on PH 20 and in material management storage**  
  **New equipment will be deliver to Blake 12 library**  
  **Lin-Ti resubmitted MESAC application including detail medications list for the airway cart to be reviewed by MESAC committee today, 10/11** | **Mary** |

| **Leadership/ Staff Recruitment** | **CCNP**  
  - Hasan & Mary provided HR with revised/clarified CCNP job advertisement per feedback from NP candidates (e.g., deleted overflow, living laboratory etc.)  
  - Expand advertisement to all regions.  
  - Cory begins orientation with observation and team building while her credentialing application is in progress  
  - Lori’s (from Georgia) application is in progress  
  - 2 candidates are being screened by HR | **Mary** |

| **CNS** | No offer to the internal ICU candidate  
  - External candidate is in progress  
  Third candidate is scheduled to meet with NDS | **Mary** |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion/ Actions</th>
<th>Responsible Individual/ Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Con’t Leadership/ Staff Recruitment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCNP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>8 ICU experienced candidates</td>
<td></td>
</tr>
<tr>
<td>PCA</td>
<td>6 candidates completed interview &amp; 2 no shows</td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>4 potential candidates: 2 from BWH, 1 from Bay State &amp; 1 from Portsmouth General</td>
<td></td>
</tr>
<tr>
<td>PCA</td>
<td>Deferred till next meeting</td>
<td></td>
</tr>
</tbody>
</table>

**Next Meeting (2nd and 4th Tues of each month):**

DATE: Oct 25th
TIME: 8:00 – 9:00 AM
VENUE: FND 343 Conference Room
## Blake 12: Capital Request Existing Funding

### Pre Occupancy Priorities:

<table>
<thead>
<tr>
<th>Description</th>
<th>Capital Request</th>
<th>Existing Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infrastructure upgrades, maintenance &amp; construction:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Install Rubber Flooring in patient rooms &amp; throughout unit</td>
<td>$204,000</td>
<td></td>
</tr>
<tr>
<td>Replace central monitors (5)</td>
<td></td>
<td><strong>Y</strong></td>
</tr>
<tr>
<td>Prep and paint unit</td>
<td>$22,000</td>
<td></td>
</tr>
<tr>
<td>Maintenance &amp; repair</td>
<td></td>
<td><strong>Y</strong></td>
</tr>
<tr>
<td>ADA: Toilet rooms: Replace/relocate TP dispenser; replace/relocate PT</td>
<td></td>
<td><strong>ADA</strong></td>
</tr>
<tr>
<td>dispenser; replace soap dispenser; install wall hung waste</td>
<td></td>
<td></td>
</tr>
<tr>
<td>receptacle &lt;6&quot; off wall; add new coat hook below existing on door at 48&quot;;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>provide new insulation at sink pipes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Med room. Scope decreased to creating alcove OmniCell alcove</td>
<td>$30,000</td>
<td></td>
</tr>
<tr>
<td>space by modifying existing office.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Omni cell equipment for new alcove (will utilize existing EL</td>
<td></td>
<td><strong>NA</strong></td>
</tr>
<tr>
<td>14 equipment vs. purchasing new)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add dialysis boxes to patient rooms (previously installed in SICU &amp; CCU)</td>
<td>$54,000</td>
<td></td>
</tr>
<tr>
<td>Install new nurse call</td>
<td>$200,000</td>
<td></td>
</tr>
<tr>
<td>Patient room cabling for TV upgrade</td>
<td><strong>Y</strong></td>
<td></td>
</tr>
<tr>
<td>Retrofit panel within electrical closet: Will require electrical shut down</td>
<td>$40,000</td>
<td></td>
</tr>
<tr>
<td>if complete post occupancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional power and data outlets in Hub to eliminate lead cords</td>
<td>$7,500</td>
<td></td>
</tr>
<tr>
<td>Additional power &amp; data in Equip Storage</td>
<td>$2,500</td>
<td></td>
</tr>
<tr>
<td>Recalibrate sliding doors</td>
<td><strong>Y</strong></td>
<td></td>
</tr>
<tr>
<td>ADA: Provide FA strobe in waiting room 1269.</td>
<td><strong>ADA</strong></td>
<td></td>
</tr>
<tr>
<td>ADA: Reception station: remove high counter on right side to extend length</td>
<td><strong>ADA</strong></td>
<td></td>
</tr>
<tr>
<td>of accessible height counter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADA replace Calstat with 4&quot; deep model</td>
<td><strong>ADA</strong></td>
<td></td>
</tr>
<tr>
<td>ADA Move / add various Visual Alarms</td>
<td><strong>ADA</strong></td>
<td></td>
</tr>
<tr>
<td>Cbeds Electronic Whiteboards to support capacity management</td>
<td><strong>Y</strong></td>
<td></td>
</tr>
<tr>
<td>Replace table in center of nurse station with modular furniture for PC</td>
<td>$5,000</td>
<td></td>
</tr>
<tr>
<td>works stations: Pre occupancy = tel data wiring</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td><strong>$565,000</strong></td>
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### Clinical equipment and furniture:

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<tr>
<th>Description</th>
<th>Capital Request</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical equipment (see attached list)</td>
<td>$394,784</td>
<td></td>
</tr>
<tr>
<td>Replace ripped and broken furniture staff furniture</td>
<td>$13,956</td>
<td></td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td><strong>$408,740</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Pre Occupancy Priorities Sub Total:** **$973,740**

### Post Occupancy Priorities:

<table>
<thead>
<tr>
<th>Description</th>
<th>Capital Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>replace table in center of nurse station with modular furniture for PC</td>
<td>$15,000</td>
</tr>
<tr>
<td>works stations: Post go live = installation of modular work stations</td>
<td></td>
</tr>
<tr>
<td>Remove X-ray module &amp; replace w/ workstation countertop</td>
<td>$7,500</td>
</tr>
<tr>
<td>Signage / way finding at unit</td>
<td>$6,000</td>
</tr>
<tr>
<td>ADA Replace double water fountain with single at accessible height</td>
<td><strong>ADA</strong></td>
</tr>
<tr>
<td>Replace furniture in Waiting and Consult rooms</td>
<td>$14,338</td>
</tr>
<tr>
<td>Renovate library/conf room to create more space for meetings and staff</td>
<td>$20,000</td>
</tr>
<tr>
<td>education</td>
<td></td>
</tr>
<tr>
<td>Replace lockers in 2 locker rooms</td>
<td>$12,000</td>
</tr>
<tr>
<td>Renovate 1291B attending space to provide 3rd on call room.</td>
<td>$75,000</td>
</tr>
<tr>
<td>Separate office suite, can be done post go live</td>
<td></td>
</tr>
<tr>
<td><strong>Post Occupancy Priorities Sub Total:</strong></td>
<td><strong>$149,838</strong></td>
</tr>
</tbody>
</table>

**Total Blake 12 Capital Request:** **$1,123,578**
<table>
<thead>
<tr>
<th>Capital Budget: Equipment</th>
<th>Quantity</th>
<th>Capital equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>GE Solar 8000 remote/cable</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CO2 module</td>
<td>3</td>
<td>$31,500.00</td>
</tr>
<tr>
<td>Cable: Limb leads</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Cable: precordial leads</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Cable: invasive line</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Cable: cardiac output (brown)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>O2 sat cable</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>O2 sat reusable finger probe</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Noninvasive BP cable</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Medifusion IV Pump</td>
<td>10</td>
<td>$24,200.00</td>
</tr>
<tr>
<td>HT70 transport ventilator + accessories</td>
<td>2</td>
<td>$19,754.00</td>
</tr>
<tr>
<td>V60 ventilator (CPAP) with O2 stand/plate/bracket</td>
<td>1</td>
<td>$12,641.50</td>
</tr>
<tr>
<td>NICO Novametrics CO2 Monitor</td>
<td>1</td>
<td>$6,995.00</td>
</tr>
<tr>
<td>Blanket warmer</td>
<td>1</td>
<td>$5,500.00</td>
</tr>
<tr>
<td>Emergency airway cart</td>
<td>1</td>
<td>$20,000.00</td>
</tr>
<tr>
<td>Emergency supply equipment cart</td>
<td>1</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>Bronchoscopy cart</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Bronchoscopes + light source + videoscope</td>
<td>2</td>
<td>$49,948.00</td>
</tr>
<tr>
<td>Glidescope Cobalt device include pole &amp; accessories</td>
<td>1</td>
<td>$13,545.76</td>
</tr>
<tr>
<td>NxStage CVVH machine</td>
<td>2</td>
<td>$42,000.00</td>
</tr>
<tr>
<td>Exergen temporal thermometer + holder</td>
<td>18</td>
<td>$7,200.00</td>
</tr>
<tr>
<td>Flo Lab PVR machine (model 2100-SX)</td>
<td>1</td>
<td>$32,000.00</td>
</tr>
<tr>
<td>Artic Sun 5000 (hypothermia)</td>
<td>1</td>
<td>$38,500.00</td>
</tr>
<tr>
<td>Belmont FMS 2000 Rapid Infuser + IV pole, reservoir holder</td>
<td>1</td>
<td>$23,000.00</td>
</tr>
<tr>
<td>Blood warmer device + IV pole (FW600)</td>
<td>4</td>
<td>$8,000.00</td>
</tr>
<tr>
<td>Ultrasound machine w/3 sized probes (LOGIQ E)</td>
<td>1</td>
<td>$50,000.00</td>
</tr>
<tr>
<td>Portable suction device</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Line cart</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Doppler (small)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>TOF-Watch SX Monitor (pain management)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Bis Monitor (sedation assessment)</td>
<td>1</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>Mayo stands (Record Scott Company)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Glucometers + accessories</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>IV poles with wheels</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

$394,784.26
Hi Jeanette

Attached please find the updated Phillips 21 Gyne Oncology and Blake 12 ICU budgets. Debbie Burke, Kevin Whitney and I worked on. I've sent them out for a final check by Planning, Engineering and Buildings & Grounds but am quite confident that there will be only minor, if any, edits as we've been working with them this week. I've asked for all feedback by mid morning tomorrow so I can send final versions off to you and Jean Elrick in Hospital Operations.

Please note that the Blake 12 ICU spreadsheet contains a second tab which details the clinical equipment items. Per your direction last Friday we are in the process of ordering this equipment on an existing PCS capital project # so as not to delay Blake 12 ICU occupancy. We will transfer the funding into this account once we get approval.

George

---

From: Ives Erickson, Jeanette, R.N., D.N.P.
Sent: Thursday, October 06, 2011 9:33 AM
To: Reardon, George
Cc: Burke, Debra, MGH R.N.; Whitney, Kevin B.,R.N.
Subject: RE: Updated Phillips 21 and Blake 12 capital requests

Thank you all for your work. Have reviewed requests with Sally Mason Boemer in Finance and all of these requests have been approved.

From: Reardon, George
Sent: Thursday, October 06, 2011 11:39 AM
To: Ives Erickson, Jeanette, R.N., D.N.P.
Cc: Burke, Debra, MGH R.N.; Whitney, Kevin B.,R.N.
Subject: RE: Updated Phillips 21 and Blake 12 capital requests

Attachments: PH21 Capital Request Oct 6; Blake 12 Capital Request Oct 6

Fantastic!! Thanks!!
For your records the two attached spreadsheets have slight updates based on last minute input from Planning and Engineering. Bottom line is the same for Phillips 21 = $728,000. And for Blake 12 = $1,104,578 which is $1,000 more than what I sent out last night. But I'm certain we can make it work without the $1K.

At this point can I reach out to Finance for the capital numbers for the two projects?

George

[Images of attached spreadsheets]
### Lunder 9 Scenarios

<table>
<thead>
<tr>
<th>Description</th>
<th>FY'12 Budget Census</th>
<th>FY'12 Actual Census</th>
<th>FY'12 Actual Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds</td>
<td>32</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Occupancy</td>
<td>88.2%</td>
<td>93.3%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Midnight ADC</td>
<td>28.2</td>
<td>29.9</td>
<td>29.9</td>
</tr>
<tr>
<td>Classification ADC</td>
<td>28.2</td>
<td>29.5</td>
<td>29.5</td>
</tr>
<tr>
<td>Classification Acuity</td>
<td>1.768</td>
<td>1.756</td>
<td>1.756</td>
</tr>
<tr>
<td>Total Acuity</td>
<td>1.934</td>
<td>1.926</td>
<td>1.926</td>
</tr>
<tr>
<td>Classification Workload Index</td>
<td>49.9</td>
<td>51.9</td>
<td>51.9</td>
</tr>
<tr>
<td>Total Workload Index</td>
<td>54.6</td>
<td>56.9</td>
<td>56.9</td>
</tr>
<tr>
<td>Hours / Workload Index</td>
<td>5.63</td>
<td>5.63</td>
<td>5.96</td>
</tr>
<tr>
<td>Shifts / 24 Hours</td>
<td>38.4</td>
<td>40.1</td>
<td>42.4 + 4 SH/24</td>
</tr>
<tr>
<td>Indirect Time</td>
<td>4.75%</td>
<td>4.75%</td>
<td>4.75%</td>
</tr>
<tr>
<td>Benefit Time RN</td>
<td>11.1%</td>
<td>11.1%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Benefit Time Non-RN</td>
<td>8.1%</td>
<td>8.1%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Direct Care FTEs - WI</td>
<td>62.3</td>
<td>65.0</td>
<td>68.8</td>
</tr>
</tbody>
</table>

| Staff Nurse                          | 52.3                | 54.6                | 57.8                |
| Non RN Direct                        | 19.0                | 10.4                | 11.0                |
| Total Direct Care FTE                | 62.3                | 65.0                | 68.8                |
| % RN Direct Care                     | 84.0%               | 84.0%               | 84.0%               |
| RN Variance                          | 2.2                 | 5.4                 |                     |
| PCA Variance                         | 0.4                 | 1.0                 |                     |

**Estimated Salary $**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Salary &amp; Fringe</td>
<td>$245,747</td>
<td>$598,440</td>
</tr>
<tr>
<td>$18,730</td>
<td></td>
<td>$45,611</td>
</tr>
</tbody>
</table>

**Notes:**
- Actual census from 1/8/12 to 2/4/12 (after holidays).
- Actual acuity and workload from 10/2/12 to 2/4/12.
MASSACHUSETTS GENERAL HOSPITAL  
Patient Care Services  
Anticoagulation Management Service  
Budget Request  
April 5, 2012  

Goals:
- To maintain and continue program development while providing anticoagulation management to patients enrolled at MGH main campus and Mass General/North Shore Center for Outpatient Care.
- To maintain continuity of care standards and quality of anticoagulation practice across MGH care facilities.
- Improve staff satisfaction while remaining responsive to demands for service.
- Assure AMS staff attain new core competencies related to a rapidly changing anticoagulation landscape.

Current Status:
- Same day anticoagulation service for warfarin induction at hospital discharge is available to all inpatient units and has been expanded to outpatient areas for acute VTE diagnosis avoiding ED visits.
- Post procedure bridging management is available to all established AMS patients.
- AMS provides warfarin management for residents at the Spaulding North End Nursing Center, Don Orione NH, Lighthouse NH, Chelsea Jewish NH, Foxhill Assisted Living and others.
- State-of-the-art technology is guiding AMS practice and helping to shape the operating model to maximize efficiencies and allows monitoring of countless quality and safety metrics.
- A patient classification system in place for more than one year is benchmarking workload and productivity measures. YTD workload is above budget.
- Space at 275 Cambridge Street, Suite 101 is being used to its full advantage at current program size. Telework has proven a successful model for dealing with space limitations without any negative consequence for patients or other staff.
- JC National Patient Safety Goal to; “reduce the likelihood of patient harm associated with the use of anticoagulant therapy” has increased the demand for the optimized, evidence-based anticoagulant therapy provided by AMS.
- Staff nurses are directly involved as participants and consultants during required meetings and development opportunities; AMS Quality and Safety Committee, AMS Practice Committee, monthly Patient Care Presentations, Pharmacy Updates, AC Forum webinars, staff meetings and most recently formal collaboration with staff of the new Thrombosis, Hemostasis and Hematology Service.

Issues:
- New oral anticoagulants and the fine distinctions related to drug selection and management represent a new paradigm for anticoagulation management. The role of these new drugs is not yet clear with numerous challenges and questions to be answered.
- Policies and procedures need review and updating to incorporate new evidence-based standards that have recently been published.

CONFIDENTIAL
• 72% of AMS patients are 65 years or older. Atrial fibrillation (AF) is the most common indication for anticoagulant therapy. AF is strongly associated with advancing age and accordingly, the numbers of AF patients are increasing significantly as baby boomers age.

• Demand for enhancements or new service
  o Program for AMS on-site patient education to teach self-injection of anticoagulants
  o Implementation and management of pre-procedure bridging protocols
  o Coordination of seamless referral and handoff for patients discharged from MGH to Partners LTC facilities avoiding the need for interim management by MGH physicians.
  o Development of North Shore referral network to include additional MGH credentialed physician practices; currently accepting referrals from cardiology, oncology, surgery and one dual credentialed NSPO practice. In the first year at Danvers AMS has enrolled 57 patients.
  o The volume of patient self-testers (PST) is growing. This involves identifying eligible patients, coordinating physician orders and working with independent diagnostic testing facilities who determine insurance coverage, educate patients and provide supplies. AMS now has 7.2% of patients who self-test.

• The AMS patient classification system for monitoring workload and productivity requires modification to respond to changing care demands and patient needs. As a result distribution of patients to classification categories is disproportionate and workload is reported low.
  o Through ongoing evaluation of AMS critical indicators of care intensity and an intense review of evidence-based literature significant revisions to our patient classification system are underway to more accurately reflect the resources required to meet patient needs.
  o The first generation of our classification system assesses the presence or absence of indicators of care intensity. The second generation will be dynamic allowing for gradation of care intensity based on new definitions or risk.
  o AMS nurse panel size for 1.0 FTE is 431 patients. It is estimated that 400 patients per FTE is needed to conduct assessment, decision making, scheduling and communication to patients per INR.

• Staff satisfaction is low. Competing demands for time to care for patients and participate in professional activities to develop themselves, practice and systems creates added pressure.
  o Non-productive time is pulled from direct care hours
### AMS RNs

<table>
<thead>
<tr>
<th>DAY</th>
<th>TIME</th>
<th>HOURS</th>
<th>DAYS</th>
<th>TOTAL HOURS</th>
<th>RN / HOURS</th>
<th>RN HOURS</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MON-FRI</td>
<td>8:00-4:30</td>
<td>8.0</td>
<td>251</td>
<td>2,008.0</td>
<td>8</td>
<td>16,064.0</td>
<td>7.7</td>
</tr>
<tr>
<td>MON-FRI</td>
<td>Varied</td>
<td>4.0</td>
<td>251</td>
<td>1,004.0</td>
<td>1</td>
<td>1,004.0</td>
<td>0.5</td>
</tr>
<tr>
<td>SAT</td>
<td>8:00-4:30</td>
<td>8.0</td>
<td>113</td>
<td>904.0</td>
<td>2</td>
<td>1,808.0</td>
<td>0.9</td>
</tr>
<tr>
<td>SUN, HOL</td>
<td>8:00-4:30</td>
<td>8.0</td>
<td>113</td>
<td>904.0</td>
<td>1</td>
<td>904.0</td>
<td>0.4</td>
</tr>
<tr>
<td>RN TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>4,820.0</td>
<td></td>
<td></td>
<td>9.5</td>
</tr>
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</table>

#### SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUBTOTAL (1)</td>
<td>9.5</td>
</tr>
<tr>
<td>BENEFIT</td>
<td>12.5%</td>
</tr>
<tr>
<td>INDIRECT</td>
<td>4.8%</td>
</tr>
<tr>
<td>FY’13 Projections</td>
<td>11.2</td>
</tr>
<tr>
<td>FY’12 Budget</td>
<td>9.5</td>
</tr>
<tr>
<td>VARIANCE</td>
<td>(1.7)</td>
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</table>

### AMS Clerical

<table>
<thead>
<tr>
<th>DAY</th>
<th>TIME</th>
<th>HOURS</th>
<th>DAYS</th>
<th>TOTAL HOURS</th>
<th>PSC / HOURS</th>
<th>PSC HOURS</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MON-FRI</td>
<td>8:00-4:30</td>
<td>8.0</td>
<td>251</td>
<td>2,008.0</td>
<td>3</td>
<td>6,024.0</td>
<td>2.9</td>
</tr>
<tr>
<td>SAT, SUN, HOL</td>
<td>8:00-4:30</td>
<td>0.0</td>
<td>113</td>
<td>-</td>
<td>0</td>
<td>-</td>
<td>0.0</td>
</tr>
<tr>
<td>RN TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>2,008.0</td>
<td></td>
<td>2.9</td>
<td></td>
</tr>
</tbody>
</table>

#### SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>PSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUBTOTAL (1)</td>
<td>2.9</td>
</tr>
<tr>
<td>BENEFIT</td>
<td>10.0%</td>
</tr>
<tr>
<td>INDIRECT</td>
<td>4.8%</td>
</tr>
<tr>
<td>FY’13 Projections</td>
<td>3.3</td>
</tr>
<tr>
<td>FY’12 Budget</td>
<td>2.0</td>
</tr>
<tr>
<td>VARIANCE</td>
<td>(1.3)</td>
</tr>
</tbody>
</table>

Note: Does not include Leadership (1.0 Nursing Director, 0.8 CNS, 1.0 Program Manager) and other support (1.0 Systems Analyst).
MGH AMS
Continuously Improving

Consults
Education Training

Technology
Interfaces; ADT, Results, Icon

Research Committee Work
Protocols Quality & Safety Practice

AMS Quality & Safety Committee
AMS Practice Committee

AL/LTC/Rehab Affiliates/VNA

Annex Locations (Danvers)

Patient Care

MGH Credentialed NSPO PC

Spaulding NENC SRH Network

Partners Home Care International Program

Practices Cardiology Oncology Surgery

Referral/Order Management
Processing Referrals – OP/POE Create Electronic Records Track/Update MD Orders

Assessment Education Growth Acuity/Complexity Staffing Staff Mix Workload Remote Work Patient Population Regulations Documentation

Service Coordination
Patients Patient Families Pharmacies Home Care Agencies Physician Practices Hospitals IDTFs Laboratories Case Managers Police Short Term Travel Lab Changes

Interface Fax Telephone Pager

Standing Orders VNA Orders Home Draw Orders POC

MGH Billing Create PACE Account Numbers

MGH MESAC

Partners HPM

External Assisted Living Dose Pack Pharmacy Services

New Demands Scope Creep

System Upgrades

Education and Training

Internal/External Physicians Nurses NPs Pas CMs

MGH AMS_Work
MGH - Patient Care Services  
Anticoagulation Services Nursing  
FY'12 Workload - Productivity Report

### YTD Performance

<table>
<thead>
<tr>
<th>Category</th>
<th>Mgmt.</th>
<th>Support</th>
<th>RN</th>
<th>Non-RN</th>
<th>Total</th>
<th>Paid FTE</th>
<th>Brnt FTE</th>
<th>%Brnt Worked FTE</th>
<th>RVU</th>
<th>Direct FTE</th>
<th>Worked FTE</th>
<th>%Direct</th>
<th>Per RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>2.8</td>
<td>3.5</td>
<td>9.7</td>
<td>-</td>
<td>16.0</td>
<td>9.7</td>
<td>1.0</td>
<td>11.9%</td>
<td>8.7</td>
<td>5,952</td>
<td>6.9</td>
<td>1.9</td>
<td>78.7%</td>
</tr>
<tr>
<td>Budget</td>
<td>2.8</td>
<td>3.0</td>
<td>9.5</td>
<td>-</td>
<td>15.3</td>
<td>9.5</td>
<td>1.1</td>
<td>13.7%</td>
<td>8.4</td>
<td>5,833</td>
<td>6.7</td>
<td>1.6</td>
<td>80.6%</td>
</tr>
<tr>
<td>Variance</td>
<td>-</td>
<td>(0.5)</td>
<td>(0.2)</td>
<td>0.0</td>
<td>(0.7)</td>
<td>(0.2)</td>
<td>0.1</td>
<td>-1.8%</td>
<td>(0.9)</td>
<td>119</td>
<td>(0.1)</td>
<td>(0.2)</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

### Current Month Performance

<table>
<thead>
<tr>
<th>Category</th>
<th>Mgmt.</th>
<th>Support</th>
<th>RN</th>
<th>Non-RN</th>
<th>Total</th>
<th>Paid FTE</th>
<th>Brnt FTE</th>
<th>%Brnt Worked FTE</th>
<th>RVU</th>
<th>Direct FTE</th>
<th>Worked FTE</th>
<th>%Direct</th>
<th>Per RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>2.8</td>
<td>3.1</td>
<td>9.8</td>
<td>-</td>
<td>15.7</td>
<td>9.8</td>
<td>0.9</td>
<td>10.4%</td>
<td>8.9</td>
<td>1,354</td>
<td>8.1</td>
<td>0.9</td>
<td>90.5%</td>
</tr>
<tr>
<td>Budget</td>
<td>2.8</td>
<td>3.0</td>
<td>9.5</td>
<td>-</td>
<td>15.3</td>
<td>9.5</td>
<td>1.1</td>
<td>13.7%</td>
<td>8.4</td>
<td>1,167</td>
<td>6.7</td>
<td>1.6</td>
<td>80.6%</td>
</tr>
<tr>
<td>Variance</td>
<td>-</td>
<td>(0.1)</td>
<td>(0.3)</td>
<td>0.0</td>
<td>(0.4)</td>
<td>(0.3)</td>
<td>0.2</td>
<td>-3.3%</td>
<td>(0.6)</td>
<td>187</td>
<td>(1.3)</td>
<td>0.8</td>
<td>-9.9%</td>
</tr>
</tbody>
</table>

### Monthly Actuals

<table>
<thead>
<tr>
<th>Month</th>
<th>Mgmt.</th>
<th>Support</th>
<th>RN</th>
<th>Non-RN</th>
<th>Total</th>
<th>Paid FTE</th>
<th>Brnt FTE</th>
<th>%Brnt Worked FTE</th>
<th>RVU</th>
<th>Direct FTE</th>
<th>Worked FTE</th>
<th>%Direct</th>
<th>Per RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>March-11</td>
<td>2.8</td>
<td>3.4</td>
<td>10.3</td>
<td>0.0</td>
<td>16.4</td>
<td>10.3</td>
<td>1.2</td>
<td>13.7%</td>
<td>9.0</td>
<td>1,290</td>
<td>7.3</td>
<td>1.7</td>
<td>80.8%</td>
</tr>
<tr>
<td>April-11</td>
<td>2.8</td>
<td>3.1</td>
<td>10.5</td>
<td>0.0</td>
<td>16.4</td>
<td>10.5</td>
<td>1.6</td>
<td>18.0%</td>
<td>8.9</td>
<td>1,072</td>
<td>6.3</td>
<td>2.6</td>
<td>70.6%</td>
</tr>
<tr>
<td>May-11</td>
<td>2.8</td>
<td>3.1</td>
<td>10.5</td>
<td>0.0</td>
<td>16.4</td>
<td>10.5</td>
<td>1.5</td>
<td>16.1%</td>
<td>9.0</td>
<td>1,047</td>
<td>5.9</td>
<td>3.1</td>
<td>65.6%</td>
</tr>
<tr>
<td>June-11</td>
<td>2.8</td>
<td>3.1</td>
<td>10.2</td>
<td>0.0</td>
<td>16.1</td>
<td>10.2</td>
<td>1.7</td>
<td>19.6%</td>
<td>8.6</td>
<td>1,320</td>
<td>7.7</td>
<td>0.8</td>
<td>90.2%</td>
</tr>
<tr>
<td>July-11</td>
<td>2.8</td>
<td>2.9</td>
<td>10.2</td>
<td>0.0</td>
<td>15.9</td>
<td>10.2</td>
<td>2.7</td>
<td>36.2%</td>
<td>7.5</td>
<td>1,015</td>
<td>5.7</td>
<td>1.8</td>
<td>76.5%</td>
</tr>
<tr>
<td>August-11</td>
<td>2.8</td>
<td>3.1</td>
<td>10.3</td>
<td>0.0</td>
<td>16.1</td>
<td>10.3</td>
<td>1.3</td>
<td>14.7%</td>
<td>9.0</td>
<td>1,107</td>
<td>6.3</td>
<td>2.7</td>
<td>69.9%</td>
</tr>
<tr>
<td>September-11</td>
<td>2.8</td>
<td>3.2</td>
<td>9.5</td>
<td>0.0</td>
<td>15.5</td>
<td>9.5</td>
<td>1.4</td>
<td>17.5%</td>
<td>8.1</td>
<td>1,326</td>
<td>7.8</td>
<td>0.4</td>
<td>95.6%</td>
</tr>
<tr>
<td>October-11</td>
<td>2.8</td>
<td>5.2</td>
<td>9.7</td>
<td>0.0</td>
<td>17.7</td>
<td>9.7</td>
<td>1.4</td>
<td>17.2%</td>
<td>8.3</td>
<td>1,083</td>
<td>6.1</td>
<td>2.2</td>
<td>73.9%</td>
</tr>
<tr>
<td>November-11</td>
<td>2.8</td>
<td>3.0</td>
<td>9.8</td>
<td>0.0</td>
<td>15.6</td>
<td>9.8</td>
<td>0.5</td>
<td>5.6%</td>
<td>9.3</td>
<td>1,092</td>
<td>6.4</td>
<td>2.9</td>
<td>68.8%</td>
</tr>
<tr>
<td>December-11</td>
<td>2.8</td>
<td>3.0</td>
<td>9.6</td>
<td>0.0</td>
<td>15.4</td>
<td>9.6</td>
<td>1.2</td>
<td>14.5%</td>
<td>8.4</td>
<td>1,385</td>
<td>7.8</td>
<td>0.6</td>
<td>93.4%</td>
</tr>
<tr>
<td>January-12</td>
<td>2.8</td>
<td>3.0</td>
<td>9.7</td>
<td>0.0</td>
<td>15.5</td>
<td>9.7</td>
<td>1.1</td>
<td>12.2%</td>
<td>8.7</td>
<td>1,038</td>
<td>5.9</td>
<td>2.8</td>
<td>67.9%</td>
</tr>
<tr>
<td>February-12</td>
<td>2.8</td>
<td>3.1</td>
<td>9.8</td>
<td>0.0</td>
<td>15.7</td>
<td>9.8</td>
<td>0.9</td>
<td>10.4%</td>
<td>8.9</td>
<td>1,354</td>
<td>8.5</td>
<td>0.4</td>
<td>95.0%</td>
</tr>
</tbody>
</table>

### Average Hours per RVU

![Average Hours per RVU](chart)

### RVU

![RVU](chart)
MGH North Ambulatory Surgery

Block RN Staffing - 24 Hour Position Justification

Can this position be eliminated? Why or why not?

- No this position cannot be eliminated for Day Surgery. Staffing for Day Surgery was established for 5.5 OR Rooms but on Monday and Tuesdays 7 Rooms; Wednesday and Thursday 5.5 Rooms and on Fridays 6 plus Rooms are being utilized. OR – RNs are staffing GI Rooms and unavailable for surgical cases. The concept that nurses in the Pre/Post units with GI experience would man the GI cases is not being done due to the increased surgical and GI volume into the Pre/Post areas requiring theses RNs to do prep/recovery of the cases. Block Area staffing was not a consideration for the original staffing of nurses in Day Surgery. At the main campus the Block Area has dedicated staffing by residents. Having dedicated nurses who are trained and competent in the Block Area will provide continuity and consistency for both the anesthesiologist and orthopedic surgeons. It will allow for standardization; communication enhancement; and confidence in nursing staff by orthopedic surgeons. Nurses will become more insightful to the steps in safe patient flow process allowing for proficiency; faster turn around which will lead to increase volume and physician satisfaction. Dr. A could increase his volume if dedicated teams of nursing were available. Out of six orthopedic surgeons, four have increased their surgical block hours.

Can the hiring process for this position be delayed? If so, for how long? If not, why?

- The position can be delayed with the understanding that orthopedic surgeons will need to be waitlisted to do cases or expect increased delays due to limitations in providing nurses for the Block Area. The production of cases will be limited without staffing to provide throughput of cases.

Will filling this position result in a net reduction of expenses? Explain.

- No, but it will impact volume and revenue for the department if not filled, along with surgeon, patient, family and staff satisfaction.
**MGH North Ambulatory Surgery Center Justification Template**

<table>
<thead>
<tr>
<th>Job Title</th>
<th>PSC II Perianesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division/Center</td>
<td>MG/NS Day Surgery</td>
</tr>
<tr>
<td>Hiring Manager</td>
<td>Robin Gallant, RN</td>
</tr>
<tr>
<td>Workstation Location</td>
<td>Perianesthesia Dept</td>
</tr>
<tr>
<td>Associated Resources/Expenses (e.g. license fees, IS, etc.)</td>
<td>none</td>
</tr>
<tr>
<td>Will filling this position result in a net reduction of expenses and/or increase in revenue? Explain.</td>
<td>Yes <em>This position will increase RN efficiency and improve patient discharge and length of stay in PACU by freeing RNs from clerical/phone responsibilities in the PACU and Pre-op areas which interrupt patient care continuity.</em></td>
</tr>
<tr>
<td>Status (Temp/Perm)</td>
<td>Permanent</td>
</tr>
<tr>
<td>Completed Job Description</td>
<td>Yes</td>
</tr>
<tr>
<td>New position? If a replacement, who is being replaced?</td>
<td>New</td>
</tr>
<tr>
<td>Can this position be eliminated? Why or why not?</td>
<td>No, This has been an identified need since 2009.</td>
</tr>
<tr>
<td>Can the hiring process for this position be delayed? If so, for how long? If not, why?</td>
<td>No, see above</td>
</tr>
<tr>
<td>Estimated Salary</td>
<td>Annualized 27,000.</td>
</tr>
<tr>
<td>Funding Source for position and associated expenses (cost center and description)</td>
<td>MG5258; convert 16 vacant RN (823031) hours to 32 PSC II (863031) hours</td>
</tr>
<tr>
<td>Purpose for hire</td>
<td>See above* Duties include:</td>
</tr>
<tr>
<td></td>
<td>All phone triage/calls to family for discharge arrangement</td>
</tr>
<tr>
<td></td>
<td>Prism management</td>
</tr>
<tr>
<td></td>
<td>Walking in Family Members from the Waiting Room Nursing Assignments sheets</td>
</tr>
<tr>
<td></td>
<td>Print Daily Schedules</td>
</tr>
<tr>
<td></td>
<td>Print Discharge Instructions from Schedules</td>
</tr>
<tr>
<td></td>
<td>Collate Nursing Documentation Forms with Discharge instructions</td>
</tr>
<tr>
<td></td>
<td>Hand Hygiene Study Excel Spreadsheet/Data Entry</td>
</tr>
<tr>
<td></td>
<td>GI Monitor Audit ToolExcel Spreadsheet/Data Entry</td>
</tr>
<tr>
<td></td>
<td>Time Satisfaction Survey Excel Spreadsheet/Data Entry</td>
</tr>
<tr>
<td></td>
<td>Daily Chart Check Tool Excel Spreadsheet/Data Entry</td>
</tr>
<tr>
<td></td>
<td>Pedi Awards</td>
</tr>
<tr>
<td></td>
<td>Equipment Log Book</td>
</tr>
<tr>
<td></td>
<td>Obtain any missing chart documentation in LMR and OMP as noted after 2 pm</td>
</tr>
<tr>
<td></td>
<td>Any secretarial duties as assigned</td>
</tr>
<tr>
<td>Project Name</td>
<td>BU</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Tram Brick monitoring modules</td>
<td>1200</td>
</tr>
<tr>
<td>Blake 12 new ICU</td>
<td>1200</td>
</tr>
<tr>
<td>Phillips 21 Gyn</td>
<td>1200</td>
</tr>
<tr>
<td>Electronic WhiteBoards</td>
<td>1200</td>
</tr>
<tr>
<td>ICU Ventilators/Respiratory</td>
<td>1200</td>
</tr>
<tr>
<td>WACC 1 Renovation B/PT</td>
<td>1200</td>
</tr>
<tr>
<td>Giraffe Omni-beds BL10, El13</td>
<td>1200</td>
</tr>
<tr>
<td>VPOP/Interpreter</td>
<td>1200</td>
</tr>
<tr>
<td>Clinical Equipment Replacement</td>
<td>1200</td>
</tr>
<tr>
<td>Patient &amp; Visitor Lounges</td>
<td>1200</td>
</tr>
<tr>
<td>Dolphin pressure mattresses</td>
<td>1200</td>
</tr>
<tr>
<td>Infant warmers: B1 10, 13 &amp; 14</td>
<td>1200</td>
</tr>
<tr>
<td>VSC/Yawkey 8</td>
<td>1200</td>
</tr>
<tr>
<td>Ultrasound Machine/IV Therapy</td>
<td>1200</td>
</tr>
<tr>
<td>Clinitk Status Connect Plus</td>
<td>1200</td>
</tr>
<tr>
<td>Stairway Alarms White &amp; Lunder</td>
<td>1200</td>
</tr>
<tr>
<td>Sigma Pump Servers</td>
<td>1200</td>
</tr>
<tr>
<td>Artic Sun/Blake 8</td>
<td>1200</td>
</tr>
<tr>
<td>Portable Probe/Blake 14</td>
<td>1200</td>
</tr>
<tr>
<td>Video FFES/SLP</td>
<td>1200</td>
</tr>
<tr>
<td>Blood Infuser/Blake 8</td>
<td>1200</td>
</tr>
<tr>
<td>Shower Room/White 7</td>
<td>1200</td>
</tr>
<tr>
<td>Painting/PATA</td>
<td>1200</td>
</tr>
<tr>
<td>PiCCO2 Monitor/Bigelow 13</td>
<td>1200</td>
</tr>
<tr>
<td>Staff Lounge Lockers/Ellison 6</td>
<td>1200</td>
</tr>
<tr>
<td>Gym Renovation/PT</td>
<td>1200</td>
</tr>
<tr>
<td>Lite Gait/PT</td>
<td>1200</td>
</tr>
<tr>
<td>Dolphin Mat/Blake 7</td>
<td></td>
</tr>
<tr>
<td>Educational Equipment (IS)</td>
<td>1200</td>
</tr>
<tr>
<td>Cardiac Output Monitor/Blake 7</td>
<td>1200</td>
</tr>
<tr>
<td>EKG/White 13</td>
<td>1200</td>
</tr>
<tr>
<td>Defibrillator/Ellison 9</td>
<td>1200</td>
</tr>
<tr>
<td>Bladder Scanner/Blake 8</td>
<td>1200</td>
</tr>
<tr>
<td>Bladder Scanner/Blake 7</td>
<td>1200</td>
</tr>
<tr>
<td>Staff Lounge Lockers/Ellison 19</td>
<td></td>
</tr>
<tr>
<td>Staff Lockers/Ellison 11</td>
<td></td>
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<tr>
<td>GlideScope/Ellison 4</td>
<td>1200</td>
</tr>
<tr>
<td>Nursing Space Optimization</td>
<td>1200</td>
</tr>
<tr>
<td>IS Equipment/ Social Services</td>
<td>1200</td>
</tr>
<tr>
<td>Medication Refrigerator/Yawk 8</td>
<td>1200</td>
</tr>
<tr>
<td>Window Enclosure/SLP</td>
<td>1200</td>
</tr>
<tr>
<td>Educational Equipment</td>
<td>1200</td>
</tr>
<tr>
<td>Video Observation/SLP</td>
<td>1200</td>
</tr>
<tr>
<td>Card Reader/Blake 14</td>
<td>1200</td>
</tr>
<tr>
<td>Staff Lockers/Ellison 9</td>
<td>1200</td>
</tr>
</tbody>
</table>

Total Funding: 6,793,335
## Blake 8 Staff Meeting Minutes

**Date:** March 15, 2012  6:00 am & 10:00 am

**Attendance:** Vivian Donahue, RN; Christine Gryglik, RN; Shannon Avery-Desmarais, RN; Alyssa Berrian, RN; Shannon Brady, RN; Phil Cole, RN; Karen Doremus, RN; Cyndy Finn, RN; Kathy Flynn, RN; Donna Ineson, RN; Mallia MacDonald, RN; Ann Magee, RN; Alysa Monaco, RN; Kim O’Leary, RN; Lindsay Panzek, RN; Annmarie Patten, RN; Melanie Piotrowicz, RN; Maureen Piper, RN; Diana Pollini, RN; Jamie Ronin, RN; Kate Seaman, RN; Jeff Silva, RN; Cate Slomkowski, RN; Katje Stapler, RN; Alyssa Vecchione, RN; Maryssa Bradley, CCT

<table>
<thead>
<tr>
<th>Subject</th>
<th>Discussion/Action</th>
<th>Follow Up/Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cardiac Visiting Scholar</td>
<td>This year, we welcome Dr. Cynthia Dougherty April 12 &amp; 13 as our Cardiac Visiting Scholar. Dr. Dougherty’s work is mainly in heart failure patients’ experience of living with HF, their partner’s experience, withdrawal of devices and end of life. Schedule will be posted as soon as it is finalized. Highlights include: “Living Well With an ICD in 2012” Panel Discussion: Heart Failure: One Patient’s Experience Across the Continuum” “End of Life for OCD Recipients with HF”</td>
<td>Dr. Dougherty will also be rounding with us and Ellison 8 staff early Friday morning in Buckley so we hope many of you will participate.</td>
</tr>
<tr>
<td>2. Levophed Concentration</td>
<td>There was another safety report generated from a miscommunication re: Levophed concentration. An order was placed for .5-100 mcg/min for a 1:1 mix. The 64 mg/1000ml gives a 1 mcg/1 gtt. Pharmacy interprets a 1:1 mix as 50 mg in 50 ml syringe. This is all too confusing.</td>
<td>Please be specific with Pharmacy when ordering medications for infusion. Please do not order 1:1 concentrations as this is easily misinterpreted.</td>
</tr>
<tr>
<td>3. Long-Term Care Rounds Sheets</td>
<td>Every Friday, LTC Rounds sheets are placed in the blue books. We encourage all staff to add to the problems and issues list so we can have a pertinent discussion about what the patient needs. If you are the nurse assigned to a patient on the list, please bring the sheet to rounds on Monday &amp; update it after our discussion. Sheets may be getting lost in Blue Books due to lack of space in binders. Could we consider tabs to identify areas of interest?</td>
<td>This sheet is a communication tool and other disciplines may use it to get an update on what the current plan of care is, especially if they miss the meeting. We will look at blue books to see if they may be streamlined.</td>
</tr>
<tr>
<td>4. Critical Lab Values</td>
<td>As per hospital policy, all critical lab results must be received by a licensed clinician (RN, NP, MD) and recorded in the Critical</td>
<td>If the nurse caring for patient with critical lab results is too busy, Resource Nurse may take the</td>
</tr>
</tbody>
</table>
Lab Results Binder at the front desk. OA’s are not allowed to accept critical lab results. If 2 OA’s are on, one may bring the binder to the room of the RN caring for the patient to facilitate documentation.

5. ECMO Response Team

We will send the Algorithm for ECMO Response Team to everyone electronically. When a decision is made to cannulate a patient outside the OR, the cardiac surgeon will call the Gray OR desk to activate the team. The team includes the Respiratory Charge Therapist, the Respiratory ECMO Therapist, CSICU Resource RN, Critical Care Triage Nursing Supervisor and Pharmacist. The receiving ICU will be notified of the admission.

Our Resource RN will decide who the best available RN is to respond when ECMO is initiated outside the OR. This is a learning experience for all and we should expect to adjust our process as necessary each time we deploy the team.

6. Report From OR

Effectively today, all reports from the OR will be taken by the RN who is assigned to accept that patient. If s/he cannot accept report when the OR calls, s/he should ask the Resource RN or another RN colleague to take the short report. The report sheet may then be given to the OA & Resource RN so information may be placed on the white board.

OA’s will no longer accept report. The report is very short & quick and must be taken by an RN. We will look at OR Report Sheet to see if any information is redundant or could be eliminated.

7. CLABSI Safety Team Work

As our Blake 8 Safety Team begins its work, the first item we are addressing is decreasing/eliminating Central Line Associated Bacterial Infections (CLABSI). We will begin using the Central Line Infection Prevention Checklist immediately on all lines inserted. RNs will need to be present in the room before the procedure begins in order to ensure the inserter washes his/her hands prior to procedure. Chris has summarized the key points in the Checklist and Central Line Policy into a page and a half summary which all RNs need to review.

Summary will be sent out to all RNs electronically and it will be posted at the Resource Desk. When the Checklist is completed, please put it in the Medical Record as we will be auditing the charts of patients with lines inserted stating on Monday, March 19. Please let the Resource RN know if you have any central lines inserted on your shift and don’t forget to include that 1:1 time in acuity system.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Discussion/Action</th>
<th>Follow Up/Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Open House</td>
<td>Ellison 10 is hosting an Open House for Cardiac Nursing Practice on Friday, March 23.</td>
<td>Times to be announced. All are welcomed to attend.</td>
</tr>
<tr>
<td>9. Safety Reports</td>
<td>We had only 1 fall in February, our first</td>
<td>Vivian &amp; Chris review &amp; follow</td>
</tr>
</tbody>
</table>
since July 2011, thanks to the vigilance of the nursing staff on Blake 8. There were 29 Safety Reports filed in February: 4 related to Blood; 5 to equipment; 5 to medication/IV safety; 4 to surgical procedure; 3 to skin issues.

up on issues related to safety reports so please continue to use this avenue of communication in order to improve care and safety for our patients and staff.

| 10. New PDMs | The Biomed Department & the Anesthesia group have been preparing to replace the main GE acquisition bricks with GE's new patient data module (PDM) in the Cardiac Loop. Our goal is to changeover March 29. The major differences will be:
- How to remove it from the sliding dock
- Reduction to 2 invasive ports on the PDM. Cable splitters will need to be used to allow for 4 invasive lines.
- Staff will need to connect the balloon-pump cable to the front of the PDM when using the balloon-pump in addition to connecting the balloon-pump to the ports on the boom. Right now the cable is connected to the back of the Tram rack and staff do not need to connect it before using the balloon-pump.

| 11. New Equipment | We are in process of coordinating inservices for the new Bladder Scanner, Arctic Sun and Belmont Rapid Infuser. Meanwhile, there are online tutorials to familiarize yourself with each piece of equipment. Links have been sent out electronically. Watch for signs as inservices are scheduled.

| 12. Moderate Sedation | The Moderate Sedation/Analgesia (Conscious Sedation) module in Healthstream is due every 2 years. It is not assigned directly to you so you need to go into the course list & select it yourself.

We will ask the Healthstream Administrator to assign it to all Blake 8 RNs every 2 years starting in October when your annual requirements are assigned.

Respectfully submitted,
//signed//
Christine A. Gryglik, RN, CNS
All central lines will be placed under aseptic technique using the CENTRAL LINE INFECTION PREVENTION CHECKLIST included in central line kits. This includes PA lines, TRIC lines, Introducers, Hemodialysis/CRRT catheters, PICC lines which all terminate in the central circulation.

The checklist may be completed by the MD, NP or PA inserting the line or by the RN assisting with and facilitating insertion. Both the inserter/operator (MD, NP, PA) and the RN/monitor must sign the bottom of the checklist when the procedure is complete. This form is a permanent part of the patient’s medical record.

The RN/Monitor will remain present for the entire procedure and will monitor for any breaks in sterile technique.

Any member of the healthcare team may interrupt the insertion process if the inserter/operator does not follow the critical steps in the checklist or if sterile technique is broken at any time during the procedure.

The patient should be medicated as appropriate to facilitate cooperation with the procedure.

Take steps to minimize traffic in the area.

Insertion site of all catheters must be inspected at least once a shift for cutaneous maceration, erythema or purulence. Documentation of the site should be noted on the flowsheet/progress note and any abnormalities should be reported to MD/NP/PA.

For central line insertion or guidewire exchange, mask, cap, sterile gown and gloves are worn by the MD/NP/PA/RN and by persons assisting with the procedure. Double-gloving will be used for PA line insertion.

Use a sterile sleeve to protect PA catheters during insertion.

Central line sites are prepped with Chloraprep using a back and forth friction scrub for 30 seconds. If patient is allergic to chlorhexidine, a wide prep with isopropyl alcohol followed by a narrow prep with povidone/iodine will be used. If povidone/iodine is used, it must remain on the skin for at least two minutes to dry.

Insertion sites are covered with an occlusive dressing. Do not apply povidone/iodine ointment to the site. Catheter must be secured to prevent motion at the exit site.

A chest x-ray should be obtained to confirm appropriate placement of all central venous and pulmonary artery catheters.

Date, time, type and site of catheter placement should be documented in the medical record. If all items on the checklist are completed, a green sticker will be placed on the catheter tubing above the port. If one or more items, except the time out or consent, are not checked, a red sticker will be placed on the catheter tubing above the port.

If a catheter lumen is reserved for TPN or blood sampling, that lumen should not be used for any other purpose without a specific MD/NP/PA order.

Prior to accessing any port, “Scrub the Hub” with alcohol for a minimum of 20 seconds.

Change central line dressings when the device is replaced, when the dressing is soiled, damp or loosened. Gauze dressings should be changed every 48 hours; transparent dressings every 7 days. Avoid touch contamination of the catheter insertion site when changing dressing.
• Biopatch CHG-impregnated disk dressings may stay in place for up to 7 days. They may be changed sooner if saturated or soiled.
• Hemodialysis catheters should be used only for dialysis except in an emergency.
• For PA and CVP lines, replace disposable transducers every 96 hours. Replace other system components including tubing, continuous-flush device and flush solution when the transducer is replaced.
• Minimize the number of manipulations & entries into the pressure monitor system. Use a closed-flush system (continuous flush) rather than an open system (one that requires a syringe & stopcock) to maintain patency. If stopcocks are used, maintain their sterility and cover them with a cap or syringe when not in use.
• Do not administer dextrose-containing solutions or TPN through the pressure monitoring circuit.
Jeanette, Jen Lassonde and I met with Information Systems (IS) leadership (Keith Jennings, Tim White, and Jack Brown) last week to review the Voalte project status and next steps. IS will be spending the balance of the summer addressing several technical security and connectivity issues. Additionally we are hopeful that IS will receive budget approval for a system's manager position. And on July 24th, Voalte's CEO will be coming to MGH to review their product development road map and company resources.

In the meantime, we will be coordinating the replacement and enhancement of wireless access points so that the infrastructure will be in place when we resume the Voalte roll-out. IS has asked us to identify the next group of 6 floors so that they can conduct a wireless coverage survey and kick off the upgrades. Jen and my recommendations for the next group of inpatient units for Voalte Go-Live:

**Complete OB service**
- Ellison 13 Mother/Newborn
- Blake 14 Obstetrics

**The following 3 floors participated in communication PI work earlier this spring and are very ready for Voalte technology support**
- Ellison 10 Cardiac Telemetry
- Ellison 11 Cardiac Intervention Unit
- Blake 7 Medical ICU

**Complete Ortho:**
- Ellison 6 Orthopaedics: White 6 Orthopaedics will go-live on Voalte at the end of Summer once their Welsh Alyn to GE monitoring system conversion is complete.

**Moving beyond these 6 floors:**
- Will there be another round of Innovation Units and when do we think these will be identified?
- We could consider either geographic or service clusters?
- We could coordinate with other room closure projects. E.g., Phillips 22 Surgery and Ellison 7 Surgery GE monitoring system conversion this Fall?

If you all are OK with the first 6 floors we have identified above, we will instruct IS to schedule their WiFi coverage surveys and we will reach out to local leadership.

George
Policy, Procedure & Products Committee Meeting

Date: May 10, 2011 Abbreviated Minutes
Time: 12:00pm – 1:00pm
Location: Yawkey 2210
Co-chairs Maureen Beaulieu RN (ED); Thomas Lynch RN (Big 11)
Call to Order: 1:05pm

Present: Neila Altobelli RT (Resp Therapy); Mimi Bartholomay RN (Infusion); Maureen Beaulieu RN (ED); Waveney Cole (IPC); Joanne Empoliti RN (WHT 6); Patricia A Fitzgerald RN (Big11); Marsha Sherman RN (White 12); Hilary Levinson (ED); Anne Marie Thompson RN (Ell 10); Cynthia Bowes RN (Yaw 8) Richard Soria RN(BLK 7); Stephen Joyce RN (PCSIS); Earl Rona RN ( Ell 14 BMT); Sheila Burke RN (KNC); Kaye Susan RN (Ell 16); Mary Ann Killackey RN ( IV Therapy); Susan Mills (SICU); Kate Roche RN (WH 8); Jean Stewart RN ( WH 6); Erin Sinclair RN (Ell9-CICU); Michelle Howard RN (Big 7); Jannine Tipping RN (BLK 12); Susan Gavaghan RN; Cheryl Ryan RN (Ell 4); Holly Milotte RN (ELL 6); Patricia M. Olsen NP (Nutrition); James Bradley RN (Ell7); Deborah Jameson RN (Treadwell); (Big 9); Kathleen Myers RN (ELL6); Erika Ehnstrom RN (ELL 11); Nancy Swanson RN (Infec.Control); Susan Stengrevics RN (Ell 10&9) Marsha Sherman RN (WH12);

Excused: Kendra Browne RN (WH 10); Amanda Connors RN (PACU); Laurie Eiermann RN (BIG 13); Melnie Gaucher RN (WH 9); Kristen Hylan RN (WH 8); Sarah LaPerle RN (BMT); Kristen Desrosiers RN (WH 9); Laurie Eiermann RN (Big 13); Amy Israeli NP (Gen.Surg.); Claire Namkoong RN ( BIG 9); Paula Wright ICP (Infec. Control); Ellen Walsh RN (PACU); Thomas Lynch RN (Big 11); Heidi Schleicher RN (Infec. Control) Karen Waak RN (PT); Gerald Browne RN (PH21); Kristen Marie Brescia RN (Big 9); Tammy Carnevale RN (WH 13); Theresa Vaction RN (BLK12); Barbara Cashesvelly RN (PH22); Patrick Birkemose RN (BLK 6); Kisten Browne RN ( PH 22); Joyce McIntyre RN (ED); Michelle Lander RN (SICU)

Guest: Mary Ellin Smith RN (IPC); Julie, RN (Visitor from China) Samantha, RN (visitor from China) Helen, RN (Visitor from China); Ed Raeke, Director, Materials Management

Recorder: Waveney Small Cole, Recorder (IPC)

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<tr>
<td>Old business</td>
<td>Review the 04/12 Minutes</td>
<td>Reviewed Meeting Minutes</td>
<td>Meeting Minutes Approved</td>
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<td>Aqua Gard</td>
<td>The committee was asked to consider AquaGard as product they would be interested in using, given that it is working on a few units. AquaGaurd is a single-use impermeable moisture barrier that allows the clinician to cover PICCs, ports, etc. and keep them dry while a patient is showering. It is only used to cover an existing dressing while the patient showers.</td>
<td>It protects the existing dressing from getting wet and can save money by protecting dressings from moisture that would need to be changed if they became wet.</td>
<td>The committee will reflect upon the implications for the change and give their feedback to Ed Raeke.</td>
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<td>Ed Raeke</td>
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<td>Wound Cart Care</td>
<td>Group met and looked at current products on the carts, the cost of items and the use. In the past there were several different products utilized for same purpose. Several sizes of same products. The group was able to:</td>
<td>To standardize wound care products on all inpatient adult units. To look at cost of products utilized</td>
<td>Continue rollout. Will reevaluate products and need for necessary changes in 6 months. We will track calls to customer service for wound care products that staff are requesting.</td>
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| Susan Gavaghan            | • Designed a trial cart  
• Trialed the cart on a medical, surgical floor and an ICU floor  
The feedback from trial allowed changes of products kept on cart and process for rollout. Unit leadership notified of date of rollout. We ask that a nursing representative be present when cart being done on your unit. Leadership emailed after rollout for feedback and suggestions for change in process or products needed. Process still allows for individualized unit needs | • 11 units have been complete  
• Rollout will be complete by the end of July  
• Feedback has been positive  
• Importance of nursing presence during rollout has been very important |                                                                           |
Practice, Policy & Procedure
Meeting Minutes

Date: January 10, 2012 (Abbreviated minutes)
Time: 1:00-3:00 pm
Location: Sweet CR
Call to Order: 1:10 pm

Present: Neila Altobelli RT (Resp Therapy); Maureen Beaulieu RN (ED); Thomas Lynch RN (Big 11); Theresa Vachon RN (Lunder 6); Judy Curran Judith (Ell14); Erin Joanne Empoliti RN (WHT 6); Kathleen Myers RN (ELL6); Jean Stewart RN (WH 6); Cynthia Bowes CNS (Yaw 8); Karen Waak RN (PT); Susan Stengrevics RN (Ell 10& 9); Susan Kaye RN (ELL16); Patricia Fitzgerald CNS (Big 11); Kate Roche RN (WH 8); Kathryn Beauchamp (PICU); Barbara Cashavelly RN(Lunder 9); Susan Gavaghan RN; (Big 9); Tammy Carnevale RN (WHT 13) James Bradley RN (Ell7); Kristen Marie Brescia RN (Big 9); Mary Ellen Smith (KNC); Kisten Browne RN (PH 22); Mary Ann Killackey RN (IV Therapy); Richard Soria RN(BLK 7); Holly Milotte RN (ELL 6); Heidi Schleicher RN (Infec.Control); Janice Desmarais RN (PACU) Rona Earl RN (Lunder 10) Nicholas Macarelli RN (Informatics); Anne Marie Thompson RN (Ell 10)

Excused: Kendra Browne RN (WH 10); Laurie Eiermann RN (BIG 13); Kristen Hylan RN (WH 8); Sarah LaPerle RN (BMT); Laurie Eiermann RN (Big 13); Michelle Lander RN (SICU); Ellen Walsh RN (PACU); Deborah Jameson RN (Treadwell); Sheila Burke RN (KNC); Sinclair RN (Ell9-CICU); Marsha Sherman RN (WH12); Michelle Connelly RN (Big 7); Mimi Bartholomay RN (Infusion); Waveney Cole (IPC); Amanda Connors RN (MICU); Hilary Levinson RN (ED); Joyce McIntyre RN (ED); Deliris Arroyo RN (Cardiac); June Guarente RN (Endoscopy); Stephen Joyce RN (PSCSIS); Carolyn Rebolz RN (BLK8) Donna Sweeney RN (BLK )

Guest: Ed Raeke, Director, Materials Management
Recorder: Mary Ellin Smith, RN

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<td>Minutes</td>
<td>Minutes from the December 13, 2011 meeting were reviewed.</td>
<td>December 13’ 2011 minutes were approved.</td>
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<td><strong>Product update</strong></td>
<td>Ed brought the following products and information to the committee:</td>
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<td>Ed Raeke, Director, Materials Management</td>
<td>IV catheter- the new catheter was requested by the ED ad other nurses as a way to</td>
<td>The champions felt that the catheter should be piloted.</td>
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### Practice, Policy & Procedure
#### Meeting Minutes

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<td>prevent blood splash. The catheter has a valve which prevents splash but does allow pull back. There should be no change in the ease of insertion.</td>
<td></td>
<td>The champions supported the use of the kit.</td>
<td>It will take 45 days to get the kit into the system.</td>
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<td>Phlebotomy kit- the new pack eliminates the tegaderm, keeps the alcohol pad, bandage. This kit will prevent the use of the IV kit for phlebotomy. ID has reviewed the changes and approved.</td>
<td></td>
<td>Paula Restrepo, RN from the SICU has done research on this and will be invited to our next meeting.</td>
<td>The committee leadership will contact Paula about attending.</td>
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<td>Pneumo boots- patients complain about how hot and sweaty their legs get with the sleeves. The new sleeves have a cloth interior and keep the patient more comfortable. The champions noted that patients are also wearing TEDS and stated that wanted more information on what the evidence is on the use of TEDS, and pneumo boots.</td>
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<td>The new gloves will be brought in but on surgical units, ICU the current gloves will still be available on the units.</td>
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<td>Gloves- Ed presented a new sterile glove that costs .53 cents versus $1.39 for our current sterile gloves. The champions approved the gloves and felt it was a great alternative. It was noted that surgeons do not want a S, M, L glove they want and need a specific size.</td>
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<td>Re-usable cables- Several units- SICU, CICU, Ellison 10- have been trialing</td>
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**Massachusetts General Hospital**  
**Patient Care Services Collaborative Governance**  
**Practice, Policy & Procedure**  
**Meeting Minutes**

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<td>reused cables. The trials have reported good signal, good adherence to the electrodes. The cables are being used in two ICUs at BWH- who advocated for the change.</td>
<td></td>
<td>Ed is working with Jeanette Ives Erickson, RN and others on this issue.</td>
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<td>IV pumps- Ed informed the champions that as part of Partners patient affordability initiative, we are looking at IV pumps and whether we can generate a cost savings by moving from Sigma to Baxter.</td>
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