12.4 Provide examples of the good relationship(s) between nursing and other departments.

Effective interdepartmental and interdisciplinary relationships are essential to nursing in the provision of excellent patient care. The following are examples of the impact of these relationships with specific departments.

Police and Security

Close working relationships between Maternal-Child Nursing and Police and Security developed initially around activities focused on minimizing the risk of infant abduction, resulting in the creation of the Infant Protection Committee. This is a multidisciplinary group that developed and initiated procedures to mitigate and call attention to infant protection throughout the MGH community (attachment 12.4.a). The committee is co-chaired by Newborn and Family Unit’s Nursing Director and Police and Security Senior Management. Examples of the strong relationship are evident in the teamwork and outcomes that have been accomplished over the past 24 months.

- Monthly meetings of the Infant Protection Committee, where “success stories” are the first thing on the agenda (examples shared of teamwork displayed, best practices, enhanced security efforts, etc.).
- Pizza parties to meet and greet each department’s staff and build relationships.
- Crime Biter Award, an award that Police and Security presented to the Newborn and Family Unit for exceptional practice; senior management from both departments were present for the presentation and celebration.
- Presentations by Police and Security during the unit based nursing orientation to discuss the role and relationship Police and Security have with nursing.
- Joint development of tools to enhance safety for patients (attachment 12.4.b).  
- Collaboratively developed “code pink” practices, drills, training and informational material (attachment 12.4.c).

Police and Security was also recognized by the nurses on the Pediatric Intensive Care Unit for their excellent response to the needs of a patient and family, as described in this article from MGH Hotline:

*Time is of the essence in medicine. Working at a fast pace to help patients is routine for most clinicians. Such timeliness was particularly important in the case of a young boy several weeks...*
ago when his care team battled the clock to reunite him with his father, who was traveling back from overseas.

According to Brenda Miller, RN, Nursing Director for the Pediatric Intensive Care Unit (PICU), the patient, who was battling cancer, quickly declined and needed to be put on a ventilator immediately to help him breathe. His father was on an international flight heading to Logan Airport in Boston and hadn’t arrived yet. Because a ventilator requires a tube in a patient’s throat that renders speech impossible, the PICU staff wanted to hold off putting the boy on the breathing machine as long as possible so that he could speak to his father. The staff tried to stave off the intubation — the process of inserting the ventilator tube — all day, but they were running out of time and wanted to investigate getting the father from Logan to the MGH as quickly as possible when he arrived. They made one phone call to MGH Police and Security, and the wheels were put in motion to reunite the family at this critical time.

Tom O’Brien and Jennifer Goba, both with MGH Police and Security, worked rapidly behind the scenes, placing numerous phone calls to local authorities and to Logan Airport to make sure the father was able to get through customs quickly and meet the MGH Police and Security escort that would drive him directly to the hospital. The plan worked flawlessly, and the father was able to hold his son’s hand and spend the last five minutes with him before he was intubated.

"When his father arrived, the child beamed," says Miller. "Police and Security’s guidance was clearly the only reason the son was able to speak with his father. Without their help, the father never would have made it to the PICU in time."

Miller and the rest of the PICU team were so grateful for O’Brien and Goba’s assistance, they nominated Police and Security for an Excellence in Action award, an honor bestowed on MGHers who go above and beyond the call of duty to help patients and colleagues. Peter L. Slavin, MD, president of the hospital, presented the award — a certificate and a catered meal from Nutrition and Food Services — March 8 to the department.

"Through your intervention, the dad was able to talk to his son for five minutes before he was put on the breathing machine," said Slavin. "As a father myself, I can relate to how priceless those five minutes must have been to him. On behalf of the hospital, the doctors and nurses caring for this patient and this family, I want to thank you for all that you did."
Materials Management

The Materials Management Task Force is an interdisciplinary taskforce that was initially created from a need to enhance communication and service coordination between Nursing and Materials Management. It was subsequently expanded to include other relevant departments such as Biomedical Engineering, Respiratory Therapy, Environmental Services and Emergency Department (attachment 12.4.d). It continues to serve a vital role in ensuring that staff receive the support and information they need to care for their patients. Suggestions and recommendations regarding various clinical support issues and improvement opportunities are discussed by the taskforce (attachment 12.4.e).

Human Resources

The relationships between Nursing and Human Resources (HR) are critical to the overall management of the Department of Nursing. Therefore, HR has a continuing presence and representation in the significant activities of the department. The HR Generalists attend the weekly leadership meetings with the Chief Nurse and the Nursing Directors, and the Director of HR for Patient Care Services is a member of the Executive Nursing Operations Committee. HR is represented on the Management Systems Advisory Committee and contributes significantly to discussions on implementation of personnel policies across the Department of Nursing. HR Generalists and the Director meet biweekly with the Director of Patient Care Services Financial Management Systems, where issues related to salaries, benefits and personnel policies are discussed and questions resolved. Collaboration on activities around recruitment, retention and market adjustments have been described in Force 4.3 and Force 4.9. Nursing Directors communicate directly with their HR Generalists regarding recruitment, retention and personnel management. Nursing Directors also works closely with HR when staff attend conferences or have other speaking engagements, with HR providing recruitment materials for staff to bring to these events. The Director and an HR Staffing Specialist attend the monthly Staff Nurse Advisory Committee, and HR has been invited to attend the OA/USA connections meetings as topics related to HR, such as changes in benefit, arise.

Effective interdepartmental relationships are also demonstrated in the successful completion of programs and projects that involve multiple departments. Three such examples are the CBED implementation, the LEAN equipment program and the Blake Elevator Pilot.
CBEDS

CBEDS stands for Coordinated Bed Efficiency Dashboard System. This system enhances patient throughput with real-time display and communication of bed and patient status. Under the auspices of the Strategic Planning Capacity Management Team, a task force of representatives from the Departments of Nursing, Admitting and Information Systems investigated available options and recommended the CBEDS system. The core project structure included Admitting Services, Patient Care Services, Perioperative Services and Emergency Services, working in close conjunction with Information Systems as the CBED system was configured, tested and implemented (attachment 12.4.f).

LEAN Equipment Program

Staff from Patient Care Services, Materials Management, and Biomedical Engineering worked to improve the systems driving the care, management, and distribution of centrallystored equipment. The multidisciplinary team concluded MGH needed a system that would address both the functionality and accessibility of equipment to ensure optimal patient care. The group evaluated identified problems with the current system and, based on these findings, presented a new design for equipment flow. The LEAN Equipment Program, as it is titled, is designed to improve the flow of high demand patient equipment on patient care units and eliminate the amount of time that the equipment is not in use on patients (attachment 12.4.g). Five identified pieces of equipment are supported in the LEAN equipment program including: Propaq Monitors, Feeding Pumps, Sigma Pumps, 3M Pumps and PCA pumps. All of these items were analyzed for demand, and minimum and maximum levels established for each item for each patient care unit. Pilot programs on several units gave the team an opportunity to look at the overall process, study staffing issues, and refine supply levels needed to support the demand for equipment on each unit. It also allowed the implementation team to spend time with staff hearing feedback and promoting best practices. The program has been successfully implemented on all inpatient units.

Blake Elevator Pilot

The Blake Elevator pilot is a cooperative effort between Nursing, Materials Management and Buildings and Grounds to address issues of delays and lack of privacy in patient transport. The multi-disciplinary task force proposed a pilot that occurred in April and May of this year. Following analysis of the pilot in July 2007, the information was presented to the Transport Systems
Committee (attachment 12.4.h). While Buildings and Grounds expressed concern about increased wait-times for the rest of the Blake elevators, the end result was that the committee supported the dedication of one elevator in the Blake bank for patient transport Mon-Fri, 11am-7pm. The group believed that the wait time increase was negligible and outweighed by the enhanced patient experience. They also suggested another 2-week pilot after Labor Day as 1) OR volume was low in week 1 of the pilot, and 2) the pilot could have been more effective with better communication/more specific instructions for staff. The next pilot will be scheduled during the fall, and data will be analyzed and presented for further consideration.

In addition to the departmental initiatives, individual units have also provided examples of effective relationships with departments outside of Nursing. These are some of their stories:

“Collaborative care is pivotal to successful ICU care. Most recently we have had increased collaboration with case management trying to meet the needs of our patients who are ready to leave the ICU before the hospital has floor beds available. This has been huge in opening up ICU beds for patients who truly need them in a time when MGH has been at full capacity and floor beds aren't as readily available. The ICU now has our own Case Manager who works with us daily on transitioning patients straight to rehab or even home from the ICU. Having our own Case Manager, dedicated to the ICU population is a new occurrence. This was initiated and implemented by our Nursing Director who acted in response to staff requests for increased help and support in the area discharging from the hospital to rehab and home instead of the floor. The change has been very successful and the Case Manager now works daily with the nursing staff to help ensure smoother and safer transitions. The other important collaborative effort worthy of mentioning is the work we do with our Social Worker, who is dedicated to our ICU patient population and helps to provide great continuity of care. This relationship has been present in the ICU for many years now but has only improved with the work we did with the Robert Wood Johnson Palliative Care Grant, Merging Palliative Care and Intensive Care. Through this grant we developed the “get to know” posters which now follow patients throughout the hospital and are great in helping staff get to know more about the patient and form a trusting relationship with the family. Our social worker worked with us diligently on this process and now it is just as much a part of our admission process as the vital signs. We also have weekly interdisciplinary rounds on patients we feel would benefit, with our Case Manager, Social Worker, Attending and Resident from the medical team caring for the patient we are discussing, a Palliative Care Representative, our Nursing Director, Nutritionist, and the Staff.
Nurse. These have been very helpful to streamline and refocus goals of care on difficult patients who have usually had very long ICU stays. Last but not least, we hold ethics rounds twice a month where all staff are welcomed. These rounds are led by a palliative care attending and a representative from the chaplaincy and are attended by members of the medical team, nursing management and nursing staff. Here we discuss cases that have been difficult to manage, difficult situations with death and dying or triumphs from some of our many difficult cases.”

Medical Intensive Care Unit

“An example of interdisciplinary relationships is the Palliative Care team’s work on Phillips House 21 and other units in educating Staff Nurses on end-of-life care and issues. Meetings are scheduled to discuss difficult ethical cases our units have experienced over the past few months. These meetings help Staff Nurses and other disciplines reflect on situations to support staff with their practice and for a better understanding of future situations. Palliative Care staff stated they talk to nurses more than any other disciplines to get all answers regarding patients and patients’ cases. Nurses will call Palliative Care when they are needed to step in when there is a conflict between disciplines relating to palliative care. Nursing consults Palliative Care for support and educational purposes on various complicated situations. Nursing works hand in hand with Palliative Care for patients who are facing the dying process.”

Phillips House 21 General Medicine

“On Bigelow 11, the relationships with our Medical teams are critical. Every day, the Resource Nurse engages in interdisciplinary rounds. Here, members of medicine, nursing, physical therapy, nutrition and case management interact to discuss goals of patient care. The relationship continues throughout the day, as members of all teams interact with nursing, discussing outcomes of interventions, suggestions for patient care, and plans for discharge. Also, as Bigelow 11 is a house medicine floor, at the start of every new medical team rotation, the team Juniors meet with our Nurse Manager or “J role” nurses to become familiar with the uniqueness of our floor. They are given a welcome packet explaining that Bigelow 11 is an all-RN floor and describing the culture and tradition on our floor.”

Bigelow 11
General Medicine
6 Steps to Keep your Baby Safe

1. Let only family and longtime friends care for your baby

Never give your baby to someone you don’t know, or only know slightly. Ask for references of anyone you plan to hire as a baby sitter.

2. Don’t leave your baby alone

When you are away from home, never leave your baby alone. Babies have been kidnapped from shopping malls, clinics, parking lots, vehicles, and other locations.

3. Ask about hospital home visits

You may have a home visit to check up on you and your baby. Find out in advance when this will be, and ask what to expect. Do not let anyone into your home until you are sure that person is official. Call your healthcare provider first if you’re not sure.

4. Keep a photo of your baby

Take at least one color picture of your baby (full front view), and put together a complete written description, including your baby’s weight and length, plus hair and eye color.

5. Don’t “Advertise” your baby

Think twice before putting up decorations outside your home, or placing birth announcement in the newspaper. It’s nice to let others know about your new arrival, but an abductor might notice too.

6. Don’t give out personal information

At home, just like in the hospital, do not give out any personal information about you or your baby over the telephone or in person unless you know the person well.
Code Pink drills

Scenario 1
“Visitors take Baby”

Set up:
- Need infant doll
- Need pts HUGS tag
- 1 RN participates in drill
- 2 mock visitors carrying one bag security will provide “visitors”
- 1 family involvement

Event:
1. 2 visitors buzz into the unit to see patient “smith”
2. Visitors go to desk for visitor badge and to find room number
3. Visitors go to pt “smiths” room (doll already in room with RN, family already aware, RN introduces mock visitors (security) to the family, security shows their ID badge. RN has already loosed the HUGS tag and now slips the tag off baby and onto the doll)
4. Visitors come back out of the room with doll and the active HUGS tag from the real baby. RN or security stays with family and baby in pts room (at this point the real baby has no HUGS tag on but is constantly supervised)
5. Visitors leave unit. One gets buzzed out while the other with the doll and active HUGS tag lags behind. The first visitor holds the door open for the second visitor with the baby to get through the door.
6. Visitors leave unit and go out of sight (security decides how far the “drill” goes from here)
7. RN comes out of room and states “BABY SMITH IS MISSING”
8. ND/CNS states I will go and support the family (goes to the family’s room and waits and asks 1 other leadership person to be gatekeeper—hopefully this will stop extra RNs from entering the room
9. Code Pink needs to be activated

Security:
1. Needs to decide who will be in on the drill
2. Will know the patient name, HUGS tag number, and room number ahead of time
3. Will have script of event and script of what to say to the unit when the unit calls P&S
4. Will provide the mock visitors
5. Will respond to protocol
MATERIALS MANAGEMENT TASK FORCE
Member List

Breed, James F. Operations Coordinator
Burns, James Materials Management
Coughlin, Henry Materials Management
Fairneny, Caitlin Biomedical Engineering
Kelly, Kathleen M Materials Management
Khan, Asadullah Biomedical Engineering
Lewis, Daniel Materials Management
Martino, Lisa Materials Management
Panzer, Joseph Biomedical Engineering
Reisman, David J Emergency Department
Washington, Carolyn L Operations Coordinator
Banchiere, Guillermo J Environmental Services
Brown, Joan C. Biomedical Engineering
Cardona, Juan Materials Management
Chef, Kimberly M PCS Systems Improvement
Ciulla, Michael Materials Management
Cohen, David Operations Coordinator
Conceicao, Amand Materials Management
Cooper, Stephanie A. Training and Development
Cross, Roberta G. Operations Coordinator
Desauguste, Sagyn Practice Support
Digiovine, Anthony D., R.N. PCS Systems Improvement
Empoliti, Joanne, R.N. Patient Transport
Galvin, Patricia Respiratory Therapy
Hally, Patricia Emergency Department
Houghton, Stacey Materials Management
Kerls, Daniel R. Orthopedics
Klincewicz, Krys Materials Management
Kratohvil, Joseph Operations Coordinator
McCarthy, James C. PCS Systems Improvement
McDonald, Ann E. Materials Management
McGah, Michael E, R.N. Practice Support
Mulrey, Gary P PCS Systems Improvement
Myrie, Oneil Patient Transport
Pines, Judith M Respiratory Therapy
Reardon, George Emergency Department
Rodolosi, Nicholas Materials Management
Rossborough, Julie Operations Coordinator
Sacchi, Judith A Operating Room Services
Sullivan, Erin MGH Main O.R. Nursing Director
Sullivan, Erin, MGH Main O.R. Materials Management
Tully, Susan M., R.N. Materials Management
Uga, Denise Materials Management
Vincent, Alexandria Biomedical Engineering
Viscomi, Alfonso Materials Management
Volpe, Patricia E. PCS Systems Improvement
Welsh, Carla
Subject: 7/19/07 Nursing/Materials Management Task Force Minutes

Hello everyone,

Here is a recap of the 7/19/07 Nursing/Materials Management Task Force Meeting

Attendees: Judy Pines, Caitlin Fairneny, Jamie Breed, Oniel Myrie, Krys Klincewicz, Carla Welsh, Dan Kerls, Gary Mulrey, David Cohen, Pat Hally, Lexi Vincent, Henry Coughlin, Julie Rossborough, Amanda Conceicao, Joanne Empoliti, RN, Kathy Kelly

Welcome/Introductions. Welcome to Amanda Conceicao, Partners MM/PNG Recall Coordinator

Partners Materials Management
Recalls/PNG. Amanda Conceicao reviewed the PNG process and her role in supporting MGH product conversions and recalls. In the event of a product failure, it is important and helpful to hold on to the product in question and associated packaging. Email, call or page Materials Management and we will come to the unit right away to get the product sample.

PCS
New pumps. Dan Kerls reviewed the Sigma pump conversion plan. Pumps are currently arriving and tested prior to the conversion planned for August 20th.

Ceiling lift installation. Ceiling lifts have been installed on White 12, Blake 7, Ellison 16, Blake 12, Bigelow 6 PICU, White 8 and are currently installing on Blake 8 and Bigelow 9.

Bio Med
Tethering ECG cables to the Propaqs in the equipment pool. After discussion, it was agreed that currently most Propaqs have tethered ECG cables; sometimes the tethering is cut. When LEAN staff maintain the equipment, they have a supply of extra cables on hand if needed. The Micro-paqs currently do not have tethered cables. They have a 5 lead EKG and a reusable pulse-ox cable. As these cables are very expensive to replace, Jamie Breed, Operations Coordinator on Ellison 7/White has offered to work with Caitlin Fairneny from Bio-Med to see if/how these can be tethered.
Receiving & Distribution

*New O2 tanks and bracket modifications for the mobile IV poles.* Gary Mulrey updated the group on the conversion to new MRI-safe (orange handled) O2 tanks and the processes for empty/fill storage. We are looking at a new sample bracket that will safely attach the new tanks to IV poles.

Supply Support

*Hospira tubing conversion.* Kathy Kelly reviewed the upcoming Hospira tubing conversion planned for August 1st. An email detailing the new product arrival and pulling of old product will follow.

*Sterling/nitrile gloves.* Email Lisa Martino or Kathy Kelly if you would like to reduce or remove your current par of the "purple" nitrile gloves in your unit with the new "Sterling" alternative. Sterling gloves have the same features and benefits of the "purple" and are more cost effective. However, the long "purple" gloves need to be held in units for chemo use.

*IV solution cart trial.* There is an ongoing trial of a "lock up" IV solution cart in the Ellison 4 SICU, Ellison 19, Bigelow 9 and White 11 clean supply rooms. Overall feedback from Nursing has been positive. There have been concerns re: having difficulty with the locks/door knobs becoming "stuck" on occasion. Based on this feedback we are obtaining a sample of a different version of the lock/key pad that has more "user friendly" buttons. Additional shelves can be added or shelves moved. Please contact Lisa Martino if any questions/concerns.

*Pedi sub-group* activity is ongoing. The group with representation from Newborn, NICU, PICU and Pedi areas meet bi-weekly to add pedi items to carts. To-date approximately 105 items have been added with more to follow.

*Ostomy supplies.* Kathy Kelly updated the group on efforts to make ostomy supplies more readily available house-wide 24/7. Kathy recently met w/Mary McDonough who is currently reviewing frequently used items for addition to appropriate unit clean supply rooms; with availability of a limited number of ostomy items in the Materials Stat Room. Once items are selected for cart adds/Stat room, a communication email will be sent to Nursing.

Customer Service

*Dispatcher role.* Kathy Kelly announced the hire of a dispatcher for Customer Service whose primary role will be to ensure accurate and timely deliveries of emergent linen, supply and central equipment items.
Patient Transport

**Weekend Supervisor role/open position.** Krys Klincewicz announced the hire of Nicholas Rodolosi (ext. 6-6910, page 3-2683) as on-site week-end supervisor. An announcement will be forthcoming re: the selection of a new evening supervisor.

Linen

**Overnight team lead role/open position.** Kathy Kelly announced that there will be on-site team leadership coverage on the overnight shift to support any linen, supply or customer service issues. This role will provide important oversight between the hours of 7pm-6am weekdays.

**Soiled linen bags/chute issue.** There was group discussion re: the importance of ensuring that only soiled linen - never trash/glass - comes down the linen chutes and that all bags are tied. At the meeting Nursing representation again expressed their strong support and efforts underway to educate and communicate the criticality of this safety issue for our linen staff.

The next quarterly meeting will be held on Thursday, **October 18th at 11:30am** in **Yawkey 2-210.** As always, lunch will be served. See you then.
Coordinated Bed Efficiency Dashboard System

Update
November 1, 2006

Agenda

- Project Background
- Objectives
- Scope
- Project Status
- View of System
- Implementation
- Questions?

Project Structure

Project Background

In 2005 The Strategic Planning Capacity Management Team led by Jeanette Ives Erickson & Rick Bringhurst charged the Enabling Technology sub-committee with:

Selecting the best available Bed Management/Bed Turnover System on the market

- A Taskforce from Nursing, Admitting Services & Information Systems investigated available systems
- PREMISE Development Corp emerged as the “right fit,” contract was signed late 2005
- The “CBeds Project” kicked off in January of 2006

Joint Commission on Accreditation of Healthcare Organizations

“The leaders develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the organization.”

Managing Patient Flow
Leadership
Standard LD.3.10.10
Benefits of CBeds

- Patient placement aided by use of one system that contains all the information about bed availability and status
- Bed turnover communication streamlining will decrease delays and help patient throughput
- On-line bed management that will allow hospital-wide monitoring of bed availability

CBeds will improve Capacity Management by providing:

- Real-time display & communication of bed & patient status:
  - Bed status: Open, closed, occupied, dirty, in process, clean, etc.
  - Patient attributes: isolation, equipment needs, etc
  - Bed attributes: neg. pressure, monitoring, etc
- Tracking and display of time to planned discharge
- Enhanced support for patient placement decision making
- Room turnover (cleaning) management support
- Real time view of unit level & MGH-wide occupancy, # of patients waiting for beds, wait time, closed beds, etc.
- Information to support ongoing decision making and process improvement

What CBeds is Not (at least at this time)

CBeds is not an:
- Electronic white board
- Patient Tracking/Locating system
- Asset Tracking system

Project Guiding Principles

Technical implementation of CBeds alone will not improve patient placement and turnover issues. Patient Placement & Bed Turnover Processes should be as efficient as possible.

- This should be achieved by doing the Right Work in the Right Place at the Right Time by the Right People.
- With staff working in only one information system whenever possible
- Appropriate process change with minimal software modification

Go-live of Premise will be Phased:
- Primary users will go first. Primary users: Patient Care Units, Admitting, Emergency Dept. and Peri-Operative Services.
- Additional users to be phased in later.

Project Status: Where We Are

- Project teams formed
- Validated current state processes
- Gained full understanding of Premise products’ capabilities
- Designed and validated future state process flows
- Configured CBeds
- Built Interfaces
- Loaded software at MGH
- Completed Unit Testing of software
- Kicked-off Implementation process on Patient Care Units
- Training: underway
- Implementation: Stage 1 = 11/07/06

CBeds Functionality-Searching for a Bed
Atta

12.4.f continued

CBeds Functionality- Unit Floorplan

Room Turnover

- When patient is discharged bed turns Brown, CBeds will page the USA assigned to clean that bed
- Before Cleaning USA dials extension on the bedside phone to access IVR
  - Press #1 to Start Cleaning - Turns Bed Yellow
- After Cleaning USA dials extension on the bedside phone to access IVR
  - Press #2 to Complete Cleaning - Turns Bed Gray

ED and PACU/SDSU Impact

Emergency Dept:
- Real time information on the bed the ED is waiting for will flow from CBEDS to EDIS. Thus the ED will know the status of the bed they are waiting for:
  - Still occupied
  - Empty, but dirty
  - Being Cleaned
  - Clean and ready for the next patient

PACU/SDSU:
- Will use CBeds to view a status list of their patients awaiting beds. Thus the PACU and SDSU will know the status of the bed they are waiting for:
  - Still occupied
  - Empty, but dirty
  - Being Cleaned
  - Clean and ready for the next patient

Inpatient Unit Implementation Timeline

- Each patient care unit will go-live by following the implementation timeline below.
- All tasks on the timeline will are further defined in an implementation toolkit.

Note: A similar timeline is being followed for the PACU/SDSU, ED, and Admitting.

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<th>Week</th>
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<td>Kick-Off Mtg Model Review</td>
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<td>2</td>
<td>Weeks 3 - 5 User Validation Go-Live Support Training Enrollment Pager Set-up</td>
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<td>3</td>
<td>Super User Training</td>
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<td>4</td>
<td>Weeks 5 - 6 Go Live Support Training</td>
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Week 2 - 1 User Training

Week 3 Super User Training Go-Live Support Training

Week 4 Weeks 5 - 6 User Validation Go-Live Support Training Enrollment Pager Set-up

Week 5 - 6 Go-Live Support Training

Week 6 Kick-Off Mtg Model Review
### CBeds Implementation Master Schedule

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### Questions

- 62
What is the Lean Equipment Program?
- The LEAN Equipment Program is a program that brings together Patient Care Services, Materials Management and Biomedical Engineering to improve the flow of high demand patient equipment on patient care units, and eliminate the amount of time that equipment is not in use on patients.

When does the Program start?
- The program will begin on Wednesday November 29th on Ellison 8, Blake 8, White 8, Ellison 7, Blake 7, White 7. Staff from all departments will be meeting and evaluating the program and feedback from all three departments. We will review all recommendations and make any modifications to the programs.

How will the Lean Equipment Program help our unit?
- The LEAN equipment will be available when needed (no waiting time)
- More time spent on patient care (ex: via the decrease in time searching for equipment, trying to fix equipment, & / or contacting customer service)
- Cleaning of equipment will be performed on unit
- A quick functionality check will be performed on the unit

Which units are already participating in the program?
- Bigelow 7, 9, 11, 13, 15; Ellison 11, 12, 14, 16, 17, 18; Blake 11, 12; Phillips 20, 21, 22

What pieces of equipment will be supported in the Program?
- 5 pieces of equipment will be supported in the LEAN equipment program including: Propaqs, Feeding Pumps, Sigma Pumps, 3M Pumps and PCA pumps.
- All of these items have undergone analysis on demand levels and min and max levels have been established for each item for each patient care unit. During the pilot, levels may be readjusted according to the floor's needs. We will be looking for feedback from all employees on the unit about the PAR levels.

Where will the equipment be located?
- Each unit will have a LEAN equipment cart that is located on the floor. Your OC will be able to tell you exactly where the cart is. Only the pieces of LEAN equipment should be on this cart to assist Materials Management in maintaining the appropriate PAR levels for each item. The cart will have photos and signage detailing which items will be on the cart.
Where will the equipment be cleaned?
- Each soiled utility room will be equipped with one cart for the Equipment Associate to use to clean the 5 pieces of equipment. After the equipment has been cleaned, it will be returned to the LEAN equipment cart. It is important that upon discharge of the patient, this equipment is quickly moved to the soiled utility room in order to facilitate this process.

Who are the Lean Equipment Associates?
- Mariana Me4ndez (day shift) and Winer Vancol (evening shift) are the Equipment Associates assigned to this program. They will carry a dedicated beeper # 33654 for LEAN Equipment 5 Associate. They will carry the same beeper during their respective shifts to minimize confusion. After 11pm and before 7am, if additional equipment is needed, the unit should call Customer Service 6-9144.
- Staff Names will be in contact on a daily basis with the Operation Coordinator, Resource nurse, and Operations Associates on each floor to discuss anticipated needs based on admissions and patient census.
- For all other equipment, the floors should continue to call Customer Service.
- We look forward to a very successful program. The OC's for the participating units will be working with the floors to provide feedback on a daily basis during this pilot. Your feedback is important, therefore, please provide all suggestions and feedback (positive or constructive) to your OC.

What can I do to contribute to the success of the Program?
- When equipment is no longer being used with a patient (either because the patient has been discharged or no longer needs the equipment), you should bring it to the Soiled Utility room ASAP. This will help the equipment get cleaned and back on the cart quickly.
- Return all cables with the equipment.
- Talk to the Equipment Associate about planned admissions/anticipated spikes in equipment demand so he can plan accordingly.
- Fully complete yellow Biomed tags so Biomed and Materials Management know exactly what the problem is.
- Keep only LEAN equipment on the LEAN equipment cart
- Provide feedback to your OC about the program.
Blake Patient Elevator Pilot

Multi-Disciplinary Taskforce

- Materials Management: Ed Raeke, Bruno Viscomi, Krys Klincewicz
- Patient Care Services: Theresa Gallivan, Chris Donahue Annese, Scott Ciesielski, Carla Welsh
- Building & Grounds: George MacNeil, Chris Longchamps, Russ Wallace, Bob Gallagher

Issue

- Proximity to the Blake units & PACU has increased the volume of patient transports in the public Blake elevators. Issues associated with this practice include the following:
  - Delays waiting for an elevator to arrive that can accommodate the patient.
  - The potential for multiple stops prior to reaching the patient’s destination.
  - And most importantly, an unacceptable compromise of patient privacy as staff and visitors frequently share the elevator with the patient.

Plan

- Conduct a pilot dedicating one elevator in the Blake bank to patient transport
- Pilot duration: 2 weeks
  - April 23- 27
  - April 30 – May 4
- Pilot hours: Monday-Friday, 11am-7pm
- To call for elevator: Upon leaving the unit, dial 5-0108 to call the Blake elevator (car 14)*

* Should the pilot prove successful, installation of house phones in the Blake elevator vestibules will move forward

Pilot Evaluation

Measures of success will include:

- Decreased wait time for patient transports
- Enhanced patient/clinician experience
- Negligible impact upon the Blake elevator banks ability to serve non-patient transport volume.

PLEASE POST

Blake Patient Elevator Pilot
Focused upon expediting safe transport & enhancing patient privacy

- Serving the Blake units & PACU
- Start date: April 23rd
- Pilot duration: 2 weeks
- Hours: M-F, 11am-7pm
- Upon leaving the unit, dial 5-0108 to call the Blake elevator (car 14)*

* Should the pilot prove successful, installation of house phones in the Blake elevator vestibules will move forward