Give examples of how nurses in nontraditional roles (e.g., informatics, group facilitation, organizational performance, staff development, resource analysis) have had a positive impact on the image of nursing within the organization.

The image of nursing may be defined as its character or reputation as generally perceived by others. Nurses in nontraditional roles influence the image of nursing by the roles and responsibilities they assume, the outcomes they achieve, and the recognition they receive. Massachusetts General hospital (MGH) has a number of nurses in nontraditional roles.

Advanced Practice Nurses

Nurse Practitioners have traditionally functioned in ambulatory care settings. At MGH, in addition to that role, Nurse Practitioners also function in the inpatient setting. In these positions, the Nurse Practitioners follow patients, coordinate and manage care, prescribe, instruct and discharge. They have demonstrated success in improving patient care, improving communication and coordination, expediting discharges and reducing overall lengths of stay. A measure of their success is the number of inpatient areas in which they practice: medicine, neuroscience, orthopaedics, obstetrics, cardiology, psychiatry, neonatology and oncology. They are also active in the inpatient dialysis and research units, in the trauma program and in the pre-admission testing area.

The role of the inpatient Nurse Practitioner is varied and diverse. As described in Force 8.6, one Nurse Practitioner works with the medical team that is responsible for longer term patients who experience complicated psychosocial as well as medical issues. In contrast, the Nurse Practitioner in Dialysis functions as the access coordinator. She has been successful in establishing positive relationships and effective communications with Interventional Radiology, where dialysis patients are frequently seen for access placement prior to dialysis treatment. Because of the success of inpatient Nurse Practitioners in other nontraditional roles, planning of the Emergency Department Observation Unit (described in Force 2.6) included Nurse Practitioner coverage. They currently provide 24/7 care and service to patients in that unit. Certified Nurse Midwives are also an important part of MGH’s Vincent Obstetrical Service. The Certified Nurse Midwives manage almost 30% of the service’s approximately 3,400 annual deliveries and was featured in the organization’s publication MGH Hotline (attachment 12.5.a).

Informatics

Several nurses are involved with informatics and in relationships with Information Systems
and related projects. The nurse Director of Patient Care Services Informatics (PCS IS) and her staff (which includes three other nurses) manage the Department of Nursing systems for scheduling and productivity, and support leadership and staff in the development, access and use of information technology and systems. In addition, they have taken the lead in the development and implementation of hospital- and system-wide changes:

- Information Systems and Patient Care Services staff have been developing a process for providing internet access to patients. The attached brochure (attachment 12.5.b) was developed as part of this program. In addition, a policy regarding the safe use of laptops was developed in concert with Information Systems, Biomedical Engineering, Safety department and Patient Care Services (attachment 12.5.c).

- There is currently an initiative underway to implement Acute Care Documentation (ACD) throughout the MGH and Brigham and Women’s Hospital (BWH). This massive project will automate flow sheets, progress notes, and assessments (attachment 12.5.d). It is multidisciplinary and includes all clinical disciplines as well as Information Systems. The Director of PCS IS and a Corporate Manager of Clinical Systems in Partners Healthcare System (PHS) Information Systems, also a nurse, are among the leaders of this project (attachment 12.5.e).

- MGH has developed, along with the BWH, a medication reconciliation application within MGH’s clinical information systems. The management and accomplishments of the project are described by the Director of PCS IS, who was one of the project leaders:

  “In 2006, the JCAHO mandated that every patient have medication reconciliation performed upon admission. A nurse, physician and pharmacist were appointed to lead the Medication Reconciliation project at the MGH. An electronic solution called the Pre-Admission Medication List (PAML) was created. This is a Partners-wide initiative that has been developed and implemented at the two Partners academic medical centers (MGH and Brigham and Women’s). Workflow processes for the physician, nurse and pharmacist role groups were articulated (attachment 12.5.f). From these, the functional requirements for the electronic solution were developed. The application had extensive review and testing by clinicians and technical staff. Education and marketing plans were developed. A staggered role-out occurred at the MGH which was completed in July 2006.”
This project is currently in the evaluation phase. All three disciplines involved in the process are receiving compliance data. Additionally, enhancements to the software have been occurring since go-live. PAML-to-orders was implemented in January 2007. A hard stop was implemented in February 2007. The hard stop makes it impossible for a physician to discharge a patient without the PAML being created. Version 1.5 of the software will be rolled out in the Spring of 2007. The Med Rec team continues to meet every other week.

In the fall of 2006, the Medication Reconciliation Team won a Partners in Excellence award for its work on this project. In addition, in November 2006, a paper was published (Poon E, et. al: “Design and Implementation of an Application and Associated Services to Support Interdisciplinary Medication Reconciliation Efforts at an Integrated Healthcare Delivery Network,” Journal of the American Medical Informatics Association, 3:6, November-December 2006). In 2007, the program was cited as one of the “Best Practices” by the Advisory Board Company in its publication Electronic Medication Reconciliation: Practices for Streamlining Information Transfer (attachment 12.5.g).”

Financial Management Systems

For all of Patient Care Services, the Department of Financial Management Systems provides support for budget preparation, implementation and evaluation; productivity and program analysis; trending, forecasting and other statistical analysis; and personnel management and issue resolution. The nurse Director and her staff (including two other nurses) communicate and collaborate with administration, finance, human resources, information services and other departments on behalf of Patient Care Services to ensure availability, accuracy and timeliness of resource utilization information to be used in planning and decision-making. The department is recognized throughout the organization for its capability and responsiveness in these areas and is frequently consulted by other department heads and managers. The Director of the Budget Office reflects on the Financial Management Systems staff:

“The collaboration and input from PCS Financial Management Systems is invaluable to the Budget process and the Finance department overall. Given the size and complexity of Patient Care Services, coordination and communication are required between our two areas. The high level of quality produced by this department is key to ensuring that our reporting and budgeting is accurate and
understandable. Their clinical perspective is indispensable in giving meaning to the data as well. I have worked with the Management Systems staff for seven years and have been consistently pleased with the level of service and knowledge they exhibit.”

Innovations

The Center for Innovations in Care Delivery (discussed in Force 7.8) is led by a nurse who is an Innovations Specialist. The Innovations Specialist is a unique position designed to support the culture of creativity and innovation throughout Patient Care Services. Utilizing a variety of tools, research, think tanks and skill development, the Innovations Specialist brings together staff from various areas within Patient Care Services to consider new practices, find solutions to practice issues and construct innovations to enhance patient care. In March, the Innovations Specialist, in partnership with Medical Nursing under the leadership of the Associate Chief Nurse, submitted a proposal in response to an RFP from the American Organization of Nurse Executives and The Robert Wood Johnson Foundation for Transforming Care at the Bedside grants (TCAB). In late April, the Center was notified that MGH had been selected for this project. The grant is a two-year effort with the goal of increasing the amount of time nurses have to provide direct patient care. Two General Medicine units have been selected, one as the participating unit and the other as the control unit. Grant implementation began in June, and the project was featured in the MGH Hotline in July (attachment 12.5.h).

Another nurse in The Center for Innovative Care Delivery is a Director Emeritus whose efforts focus on issues related to the aging nurse. As a result of his work, he received a grant from the US Department of Health and Human Services to pair older nurses precepting younger nurses in a nine-month mentored residency. The program, discussed in Force 7.8, was described in the July, 2007 issue of Caring Headlines:

**RN Residency Program at MGH**

*MGH has been awarded a grant from the US Department of Health and Human Services, Health Resources and Services Administration Division of Nursing to conduct an innovative RN Residency Program, which will provide nurses with an opportunity to improve their care to older patients.*
The RN Residency Program, a nine-month, mentored residency, will help nurses gain competence in geriatric and palliative care. The three-year grant provides a unique opportunity for nurse preceptors and nurse residents.

Nurse preceptors will be registered nurses:
- age 45 or older
- currently employed at MGH working 24 or more hours per week
- working in an acute care unit
- identified by nursing director as proficient or expert
- possessing emerging qualities of mentors:
  - effective communication skills
  - respect, patience, good listening skills
  - trustworthiness in working relationships
  - positive attitude, enthusiasm, optimism
  - belief in the value and potential of others

Nurse residents will be registered nurses:
- currently employed at MGH working 24 hours per week (but not more than 32)
- interested in geriatrics and palliative care specialties
- who have a two-year commitment to employment at MGH,
- recommended by nursing director

Information sessions are scheduled.

For more information about the RN Residency Program, contact Ed Coakley, RN, project director and coordinator, at 6-6152.

His unique position and program were also spotlighted in an article in the Boston Herald: “Nursing comes of age” (attachment 12.5.i).
At the MGH, welcoming new babies into the world is a team effort. Along with the physicians, nurses and other staff members who work together to ensure safe deliveries, there also is another vital member of the Obstetrics team — the nurse midwife. These dedicated health care practitioners provide care throughout a woman's pregnancy, labor and delivery, and first few weeks postpartum with the ultimate goal of ensuring that each mother has the birth experience she hopes for and that best meets her individual needs.

*Osborne, left, and Hernandez*
Nurse midwives have been an integral part of the Vincent Obstetrics and Gynecology Service since its inception in 1994. They see patients at both the MGH main campus and at many of the health centers. The majority of patients admitted to the Labor and Delivery Unit on Blake 14 meet with a nurse midwife at least once for triage, and nearly one-third of the babies born at the MGH each year are delivered solely by a midwife.

Susan Hernandez, CNM, and Cara Osborne, CNM, are two of the 15 nurse midwives currently on staff at the MGH. Both were initially attracted to the profession because of its emphasis on meeting the specific needs of each patient. "I worked with midwives at my first job," says Hernandez. "I liked the way they interacted with the women they cared for and was impressed by their approach to clinical situations. Their focus was on patient empowerment, teaching and wellness." Says Osborne, "I became a midwife as a way to help women learn to take charge of their own health and well-being. I enjoy supporting women as they explore their needs and celebrate the births of their babies."

Nurse midwives must undergo rigorous training to prepare for their roles — all nurse midwives are registered nurses who have completed additional midwifery programs. Like nearly all of the MGH nurse midwives, both Hernandez and Osborne have advanced degrees, and Osborne currently is enrolled in a doctoral program in Maternal and Child Health at the Harvard School of Public Health.

Both Hernandez and Osborne agree that working with women of different ethnicities and nationalities is one of the most rewarding aspects of their jobs. "I truly enjoy working with a diverse patient
population," says Osborne. Adds Hernandez, "The best part of my job is that I get to attend the deliveries of babies from women from all over the world. At the Chelsea HealthCare Center, most of my patients are from Central and South America, but I also care for women from the Middle East, Africa and Asia. It's fun, interesting and challenging to attend their births."

For more information about midwifery services at the MGH, visit www.massgeneral.org/vincent.
Inpatient Guest
Wireless Internet Access Guide
**Introduction**

MGH is pleased to provide you with free wireless internet access so you can stay connected to family and friends using your personal laptop computer while you are in the hospital.

Your laptop has passed the electrical safety test performed by a Partners HealthCare Information Systems technician. But before you get started, please take a moment to review the MGH Guest Wireless Internet Access policy...

**Background / Safety Guidelines**

Like any electronic device, the presence of a laptop in the patient vicinity raises concerns of electrical and other safety issues, e.g., overheating, fire and burns, and infection control. Typically, these devices are designed using “electrical safety” standards to prevent stray current from escaping the device. MGH requires an initial testing by PHIS technicians of all patient laptop computers to ensure they conform to MGH’s safety standards. For a laptop to be of practical value to a patient, the patient must be allowed to be use the laptop while in bed. Manufacturers typically warn against the use of laptops on a bed or any soft surface that might block air circulation for cooling. Patients should also employ proper ergonomics while using their laptops in bed. These precautions should be taken to avoid situations that would contribute to an increased risk of injury.

**Policy**

1. The patient or family must check with the patient’s nurse before using their laptop to make sure it will not interfere with the patient’s plan of care.
2. Inpatients may use a laptop at their bedside if:
   a. The patient or family’s personal laptop computer and its accessories, e.g., the power cord, are inspected by a Partners HealthCare Information Systems (PHIS) technician prior to being used in the hospital, and any restrictions on use required by PHIS are followed.
   b. The patient has no exposed conductive intracardiac leads, e.g., pacemaker wires.
   c. The laptop is only used on a solid surface such as a bedside tray table.
3. The charger may only be used either away from the bedside or on the bedside table. Under no circumstances should the charger be on the bed.
4. All audible alarms, including anti-motion alarms, reminders, and any other sound feature on the laptop must be turned off at all times for the comfort of all patients. If sound is required, such as when listening to music or watching video clips/movies, headphones must be worn.
5. The patient or family will not engage in any illegal activities while using the Wireless Guest Internet Access.
6. MGH is not responsible if the laptop is stolen, damaged or comes in contact with fluids or radioactive material during your stay at the hospital.
7. Use of the Wireless Guest Internet connection is at the patient or family’s own risk. MGH is not responsible for any computer viruses that may infect the patient or family’s laptop via the connection, or for any unintended disclosure of personal information via the connection.
8. MGH does not guarantee that the patient or family’s laptop will work with the Partners Guest wireless connection and cannot provide technical support or troubleshoot hardware, software or connection problems they may experience during their admission or after their discharge from MGH.
9. Any restriction or monitoring of a minor’s access to the Wireless Guest Internet connection is the sole responsibility of the patient’s parent or guardian.
MGH Guest Wireless Internet Access Policy

1. Overview

1.1. Massachusetts General Hospital (MGH) understands it is important for patients to keep connected with family, friends, and work while in the hospital, as well as to have access to diversional activities to help pass the time. Portable laptop computers (laptops) provide inpatients with the capability to communicate and remain connected.

1.2. Free Wireless Guest Internet Access will be available to patients and families who agree to MGH’s wireless internet access policy. This wireless internet access will be limited to the duration of the patient’s stay with us.

1.3. Partners HealthCare Information Systems (PHIS) Computer Technicians will conduct a device safety check on patient laptops Monday through Friday between 8:00 AM and 4:30 PM.

1.4. The following procedure must be used in order to ensure device safety.

2. Background / Safety Guidelines

2.1. Like any electronic device, the presence of a laptop in the patient vicinity raises concerns of electrical and other safety issues, e.g., overheating, fire, and burns, and infection control. Typically, these devices are designed using “electrical safety” standards to prevent stray current from escaping the device. MGH requires an initial testing by PHIS technicians of all patient laptop computers to ensure they conform to MGH’s safety standards. For a laptop to be of practical value to a patient, the patient must be allowed to use the laptop while in bed. Manufacturers typically warn against the use of laptops on a bed or any soft surface that might block air circulation for cooling. Patients should also employ proper ergonomics while using their laptops in bed. These precautions should be taken to avoid situations that would contribute to an increased risk of injury.

3. Policy

3.1. The patient or family must check with the patient’s nurse before using your laptop to make sure it will not interfere with the patient’s plan of care.

3.2. Inpatients may use a laptop at their bedside if:

3.2.1. The patient’s personal laptop computer and its accessories, e.g., the power cord, are inspected by a Partners HealthCare Information Systems (PHIS) technician prior to being used in the hospital, and any restrictions on use required by PHIS IS are followed.

3.2.2. The patient has no exposed conductive intracardiac leads, e.g., pacemaker wires.
3.2.3. The laptop is only used on a solid surface such as a bedside tray table.
3.2.4. The charger only may be used either away from the bedside or on the bedside table. Under no circumstances should the charger be on the bed.
3.3. All audible alarms, including anti-motion alarms, reminders, and any other sound feature on your laptop must be turned off at all times for the comfort of all patients. If sound is required, such as when listening to music or watching video clips/movies, headphones must be worn.
3.4. The patient or family will not engage in any illegal activities while using the Partners Guest wireless Internet access
3.5. MGH is not responsible if the laptop is stolen, damaged or comes in contact with fluids or radioactive material during your stay at the hospital.
3.6. Use of the Partners Guest wireless Internet connection is at your own risk. MGH is not responsible for any computer viruses that may infect your laptop via the connection, or for any unintended disclosure of personal information via the connection.
3.7. MGH does not guarantee that your laptop will work with the Partners Guest wireless connection and cannot provide technical support or troubleshoot hardware, software or connection problems you may experience during your admission or after your discharge from MGH.
3.8. Any restriction or monitoring of a minor’s access to the Partners Guest wireless connection is the sole responsibility of the parent or guardian.

4. Procedure

4.1. The patient’s nurse or the patient care unit’s operation associate will verify that the laptop is with the patient before placing a request for wireless guest Internet access.
4.2. The patient’s nurse or the patient care unit’s operation associate will contact the Partners HealthCare Information Systems Help Desk at 617-726-5085 to request the device safety check. Requests made after 4:30 PM or on the weekend will be carried out on the next business day. Information needed to complete the request:

4.2.1. Nurse or operations associate’s Partner User Name
4.2.2. Patient care unit
4.2.3. Patient’s room number with bed letter
4.3. The Partners HealthCare Information Systems Help Desk staff will enter the information and create a service request that will page the on-call computer PHIS technician at MGH.
4.4. The on-call PHIS computer technician at MGH will notify the computer technician responsible for the building where the patient is located.

4.5. The PHIS computer technician responding to the request will speak with the nurse caring for the patient upon arriving on the patient care unit to verify which patient has requested access.

4.6. The PHIS computer technician will conduct the device safety check at the patient’s bedside.

4.7. A label will be adhered to the laptop, power cord or brick to indicate that the laptop passed the safety test.

4.8. The PHIS computer technician will give the patient and/or family an MGH Guest Wireless Internet Access booklet that contains internet logon directions and a copy of the policy.

4.9. The PHIS computer technician will complete the device safety check form and return it to the lead technician. The form will remain on file in the PHIS department for six (6) months.

4.10. The PHIS computer technician will close the request ticket.

Reference:
CPSC Tips on Notebook Computer Use: Includes warnings from the Consumer Product Safety Commission against placing a portable laptop on one’s lap or bed. (http://www.cpsc.gov/cpscpub/prerel/prhtml06/06271.html)


MGH Safety Policy for Personal Communications Devices: Describes rationale and circumstances where these devices, e.g., cell phones, can be used. (http://librarypartners.org/MGH1/webserver/custom/trovedoframeset.asp?OS=11&HU=EmptyURL&P2=1&w=800&h=600&c=16)

Attachments:
Copy of the logon directions
July 26, 2007
The Acute Care Documentation Project: charting a course to a safer future

The Acute Care Documentation Project is an initiative to automate inpatient documentation (flowsheets, notes, patient assessments, and care plans) to improve safety, efficiency, and accuracy throughout the hospital. Having an automated system will facilitate communication among clinicians and streamline documentation by providing an integrated electronic system by which to enter and view patient information.

At right, Sally Milan, director, Patient Care Services Information Systems (left), and Chris Schilling, corporate manager, MGH Clinical Systems, confer. Below, members of the Acute Care Documentation Project Working Group evaluate prospective vendors.

Please join us for an informal vendor demonstration/question-and-answer session, August 1, 2007, in the Haber Conference Room, any time between 10:00am and 8:00pm. Watch for posters and e-mail communications in the coming weeks.

For more information about the Acute Care Documentation Project and how it will help improve documentation and communication, contact Michele Calden, project manager at mcullenl@partners.org.
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### Massachusetts General Hospital Medication Reconciliation Guidelines

<table>
<thead>
<tr>
<th>Physician, Nurse Practitioner, Physician’s Assistant</th>
<th>Registered Nurse</th>
<th>Pharmacist</th>
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<tbody>
<tr>
<td><strong>On Admission</strong></td>
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<tr>
<td>1. Start the Pre-Admit Medication List (PAML) Builder by opening Orders in CAS and selecting the button in the right lower row, “Pre-Admit Med List,” or PAML.</td>
<td>1. When you see the &quot;PAML&quot; flag on the Unit Census Monitor (UCM), select the patient. Then select the Pre-Admit Med List to enter the PAML.</td>
<td>1. When you see the &quot;PAML&quot; flag on the Decentralized Pharmacy Queue, select the patient. Then select Approve / Review button to enter the Pharmacy Review and Approve screen.</td>
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<tr>
<td>. Print the Meds from Electronic Sources list from the PAML Builder and review the preadmission medications, herbals and supplements with the patient, family, and/or caregiver in order to maximize accuracy. Note: if there are no electronic sources of medications, start the PAML using information obtained from other sources, e.g., patient, family.</td>
<td>2. Print the PAML to use as a worksheet when reviewing medications with the patient, family and/or caregiver.</td>
<td>2. Print the PAML to use as a worksheet to compare PAML medications with admission medication orders.</td>
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<tr>
<td>3. Re-enter the PAML Builder to create as complete a PAML as possible. If the patient, family, and/or caregiver are unable to provide information, click Unable to Obtain History button in the PAML.</td>
<td>3. Review printed PAML with the patient, family, and/or caregiver.</td>
<td>3. In the absence of any pre-admission medication information or internal inconsistencies within the PAML, the pharmacist will add to or edit the PAML, as appropriate.</td>
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<td>4. Indicate the Planned Action on Admission for each of the medications in the PAML. Note: The PAML may be saved as a draft before all the Planned Action on Admission fields have been completed.</td>
<td>4. Identify any discrepancies in medications and edit the PAML, as necessary. The ordering clinician should be informed about any edits to high risk medications.</td>
<td>4. Resolve discrepancies between the PAML and the admission medication orders with the appropriate MD/NP/PA.</td>
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<tr>
<td>5. Click on the Sign button, identify your role as the PAML Builder / Editor, and mark the PAML as Ready for Review by the nurse (Steps 1-5 should be completed within 24 hours of admission.)</td>
<td>5. If medication information cannot be confirmed with the patient, family and/or caregiver, make a notation in the Comment section of the PAML.</td>
<td>5. Once the admission medication orders have been reconciled with the PAML, click the “PAML Reconciled with Orders” button in POE.</td>
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<tr>
<td>6. Enter POE and write an order for each medication that is required for this admission.</td>
<td>6. Electronically sign the modified PAML as the PAML reviewer.</td>
<td>6. Approve the admission medication orders.</td>
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<td>7. Modify the PAML during admission, as necessary, if/when new medication information becomes available.</td>
<td>7. Discard the paper PAML in the recycle bin.</td>
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<tr>
<td><strong>ON TRANSFER</strong></td>
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<td>8. At the time of transfer between services or levels of care within the hospital, compare the PAML with the transfer medication orders and change orders in POE, as appropriate for the new level of care.</td>
<td>8. After transfer orders are written, review the medication orders for consistency with the PAML.</td>
<td>7. Compare the transfer medications orders with the PAML.</td>
</tr>
<tr>
<td><strong>ON DISCHARGE</strong></td>
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<td>9. At hospital discharge, compare the active medications in POE with the PAML in the Discharge Medications screen of the Face Sheet Discharge module and order the discharge medications.</td>
<td>9. Compare the discharge medications with the PAML, and notify the MD/NP/PA of any unexplained differences. The MD/NP/PA can adjust the discharge medications or PAML, as appropriate.</td>
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<tr>
<td>10. Incorporate the final discharge medication list and the PAML into the discharge summary that accompanies the patient.</td>
<td>10. Click the &quot;Check here if PAML has been reviewed discharge medications&quot; button in the Nursing Discharge Note section. This indicates that the PAML and discharge medications have been reconciled.</td>
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<td>11. Review the discharge medications with the patient, family, and/or caregiver, and give them a copy of the completed discharge medications which are located on the Post-Hospital Care Plan. Note: the PAML is incorporated into the Patient Care Referral form. In order to prevent confusion, the patient should NOT be given a copy of the PAML.</td>
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March 1, 2006
Practica #7: Inpatient Order Conversion

#37 For hospitals with CPOE, conversion from home med to an inpatient order is at the top of clinicians’ wish lists.

Clinicians have no incentive to enter a home medication list if they must then re-enter it into an order entry system. Home medications appear side-by-side with ordered medications in Partners’ CPOE screen, assisting the ordering process. Clinicians can click “Add” and move a medication from the home medication list into an inpatient order.

An Actionable Home Med List

Case in Brief

- A six-hospital health system, located in Boston, Massachusetts
- In 2006, created a Pre-Admission Medication List Builder (PAML Builder), a novel web-based application that pulls medications from multiple electronic sources including inpatient CPOE systems and outpatient EMRs
- To respond to clinicians’ demands and increase their use of the PAML Builder, Massachusetts General Hospital added a PAML-to-Orders feature which allows medications already entered in the PAML to be carried over to inpatient orders

#38 However, order conversion is not a one-step process—clinicians must still confirm details or enter formulary substitutions

Order details are pre-populated, but clinicians must still confirm the details to prevent hasty ordering. Partners is working on an automatic formulary substitution feature, however this requires synchronizing multiple drug dictionaries.

**Not a “One Click” Conversion**

1. Physician selects a med to add, bringing up a dialog box with more medication details

2. Details are pre-populated with data from the PAML if med is on hospital formulary and physician presses “OK” to confirm

**Ideal Future System Automatically Suggests Formulary Substitutions**

- Zantac 150 mg
- Tagamet 400 mg
- Axid 150 mg

Source: Partners HealthCare System, Boston: True North interviews and analysis.
#39 Although the PAML-to-Orders conversion was key to clinician buy-in, maximum compliance was achieved by barring discharge until a home med list is built.

To maximize compliance, Partners installed a Hard-Stop-at-Discharge: clinicians cannot complete discharge orders until a home medication list has been created. The PAML-to-Orders feature was a key incentive allowing them to impose this constraint.

**Underlying Full Compliance**

Admissions with Pre-Admission Medication List

<table>
<thead>
<tr>
<th>Time</th>
<th>Baseline</th>
<th>Introduce PAML-to-Orders</th>
<th>PAML Required for Discharge Ordering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>41%</td>
<td>47%</td>
<td>97%</td>
</tr>
<tr>
<td>6% increase over two weeks</td>
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</table>

PAML-to-Orders feature did not boost compliance as much as mandating PAML use.

**Carrot Pre-Requisite to Stick**

"Our users told us that it was critical to have the PAML-to-orders functionality and we always try to accommodate their requests. We used a 'carrot and stick' method for improving compliance. The carrot was the PAML-to-orders upgrade. Two weeks later after that went live, we implemented the 'stick'... a hard stop on discharge if a PAML had not been created."

Sally Millar, RN
Massachusetts General Hospital

Source: Partners HealthCare, Boston, MA, True North interviews and analysis.
Practice #8: House-Wide Reconciliation Tracker

A house-wide reconciliation tracker makes the reconciliation process transparent to all clinicians

Partners automatically tracks the status of patients’ pre-admission medication lists (PAMLs). Tracking is accessible to all clinicians in real-time, so different team members can initiate their reconciliation steps at the correct stage in the process. While the tool is not used to reprimand or punish individual clinicians, it can help identify problems on a unit level.

Keeping Tabs on Progress

Tracker displays status of PAML for each patient

PAML statistics can be sorted by unit and accessed by nurse managers and pharmacists

Source: Partners HealthCare, Boston, MA
MGH nurses transform care at the bedside

The MGH is among 68 U.S. hospitals and the only adult academic center in the state selected by the American Organization of Nurse Executives to participate in the second phase of a national, two-year patient care improvement project, Transforming Care at the Bedside (TCAB), sponsored by the MGH Center for Innovations in Care Delivery. Originally launched in 2003 by the Robert Johnson Wood Foundation and the Institute for Healthcare Improvement, the TCAB project aims to engage nurses as leaders in driving patient care improvements. It provides nurses with the tools and training to lead quality and safety improvements on medical and surgical units, increase the retention of nurses and improve the effectiveness of the entire care team.

General Medicine Unit White 10 will serve as the central TCAB site at the MGH, and White 9, also a General Medicine Unit, will be the project's control unit. Members of the TCAB leadership team at the MGH are: Barbara Blakeney, RN; Eileen Flaherty, RN; Theresa Gallivan, RN; Christina Graf, RN; Susan Kilroy, RN; Sara Macchiano, RN; Nancy McCarthy, RN; Sally Millar, RN; and Amanda Stefancyk, RN.
As a 64-year-old nurse administrator, Ed Coakley is using his own experience at Mass. General as a catalyst to help make the hospital workplace more accommodating for older nurses. When Coakley began rethinking his future after a 30-year-plus career, it led him to examine the problems older nurses face.

The hospital, in turn, came up with a new role for the former nursing director of the operating room, who wanted to get back into clinical medicine. He would work fewer hours and as a supplement to an RN. He would have more limited basic care tasks but much more oversight, mentoring and support responsibility.

As part of his new role, Coakley formed what's called the Aging Nurse Project at MGH, an initiative he devised to investigate issues of concern to older nurses and to find ways to keep them working longer at the hospital.

As part of the project, he has interviewed older nurses at MGH, and at hospitals in Michigan and in Florida.

"The biggest concern older nurses have is about their physical health," says Coakley, who is currently MGH's project director of the RN residency program for geriatric and palliative care. "They are worried about their backs and if they will continue to have the stamina to do their jobs."

He also found that because of retirement plan changes at many hospitals, older nurses say they will have to work longer than anticipated.

National studies, such as one done by Professor Peter Buerhaus of Vanderbilt University, back up Coakley's contention that the country's nursing force is aging. Buerhaus' 2003 study found that the number of nurses between the ages of 50 and 64 grew by 129,750 in just two years and they represented two-thirds of nurses entering or re-entering the work force.

Why are so many older nurses returning to the work force?

"There are many nurses who were out of the work force raising their children who now want or need to return," says Dr. Jean Weyman, director of continuing education at the William S. Connell School of Nursing at Boston College, who oversees the RN Refresher Certificate Program. "Some do so because of concerns about their spouse's job. Others have divorced and need to support themselves."

Older nurses now make up 28 percent of the national nursing work force.

At Mass. General, the numbers are even higher. MGH nurse recruiting specialist Michele Andrews estimates that a third of some 6,000 nurses at Mass. General are over 50.

"Many nurses express a desire to retire but they are not ready to leave both because they love the work and also because they can't afford to leave," says Andrews, adding that the nurse turnover rate at MGH is only 4 percent, one of the lowest among Bay State hospitals.

With growing numbers of older nurses planning to work longer, MGH’s Coakley saw a need for hospitals to find better ways to retain them.

Hospitals offer flexibility in terms of hours and schedules. Many hospitals, such as MGH and North Shore Medical Center, will provide benefits as long as nurses work at least 20 hours per week. Some older nurses work shorter shifts of 4-to-6 hours, some even "retire" and then come back as part of a growing pool of “per diem” nurses. Others change direction into less demanding work.

"We had one nurse who worked for 30 years in a medical surgery unit and retrained to go into day surgery," says Tim Kerrigan, the nurse recruiter at North Shore Medical Center.

Kerrigan says it isn't just physical labor that challenges older nurses, but the constantly evolving technology. With new computerized IVs, physician order entry systems and online patient documentation, nurses must be able to keep up with the latest technology.
Mass. General has begun equipping nurses with cell phones as well, and Coakley says that while multitasking with phones is second-nature for younger nurses, it takes some adjustment for older RNs.

“The good news is that in our surveys older nurses say they are not frightened by new technology,” Coakley says. “In fact, contrary to the stereotype, older nurses are able to learn quickly and keep up with changing job demands.”

But it’s the physical part of the job that is a more difficult challenge to solve.

Faith Kramer, a 74-year-old nurse who retired but works as a per diem nurse at the North Shore Medical Center’s Union Hospital in Lynn, agrees. “Nursing is a rewarding career, but it’s hard - people just get tired,” Kramer says. “There’s a lot of physical strain from lifting and moving patients.”

Working with the MGH, Coakley began a pilot program in the medical ICU unit where mechanical lifts were installed in the ceilings to help lift and move patients.

With the graying of the work force, what’s called Safe Patient Handling has become a huge issue. U.S. Bureau of Labor statistics show an increasing number of nurses with injuries blamed on lifting patients. Nurses have even higher injury rates than construction workers, with 12 nurses out of every 100 in hospitals and 17 out of 100 in nursing homes reporting muscular-skeletal injuries, including back injuries - nearly double the rate for all other industries combined.

A bill now in committee at the State House would establish policies and standards for patient lifting just as OSHA now has for workers who routinely lift heavy objects.

“OSHA has standards for the average warehouse worker lifting 40-pound boxes, but nurses are expected to lift 300-pound patients by themselves with no help,” says David Schildmeier, communications director for the Mass. Nursing Association, which is backing the Safe Patient Handling bill.

But there is more to the Aging Nurse Project than trying to ease nurses’ physical work.

Coakley applied for and has received a grant from the Department of Health & Human Services that will provide funds to pair older and younger nurses for nine months, an extension of the hospital’s usual 6-to-8 week preceptor programs.

One nurse who is planning to participate at MGH is clinical nurse specialist Lillian Ananian, who has been a nurse for 29 years, including 19 at Mass. General.

“Older nurses can help younger nurses in a lot of ways,” say Ananian. “How to comfort patients during infusions, show them ways to cope with end-of-life issues, and to learn to deal with seeing so much death.”

Coakley sees it as a way to establish deeper connections between older and younger nurses and create a better functioning multigenerational staff.

“Older nurses are a rich repository of wisdom that they can pass on to younger RNs,” Coakley says. “Valuing that wisdom is one of the most important things a hospital can do.”