5.5 Describe the role of the direct care nurse in the development, implementation, and evaluation of care delivery models.

Professional Practice Model

In Peter Senge’s hallmark book, *The Fifth Discipline* (1995), he spoke of the importance of team alignment and said, “When a team becomes aligned, a commonality of direction emerges, and individual’s energies harmonize. There is a shared purpose and understanding of how to complement one another’s efforts.” One of the most effective strategies for aligning nurses, and clinicians across the disciplines, is the articulation of a professional practice model.

In the White Paper: Hallmarks of the Professional Nurse Practice Environment, The American Association of Colleges of Nursing, (2002), cite the following as characteristics of the practice setting that best support professional nursing practice:

- Manifest a philosophy of clinical care emphasizing quality, safety, interdisciplinary collaboration, continuity of care, and professional accountability.
- Recognize contributions of nurses’ knowledge and expertise to clinical care quality and patient outcomes.
- Promote executive level nursing leadership.
- Empower nurses’ participating in clinical decision-making and organization of clinical care systems.
- Maintain clinical advance programs based on education, certification and advanced preparation.
- Demonstrate professional development support for nurses.
- Create collaborative relationships among members of the health care provider team.
- Utilize technological advances in clinical care and information systems.

The operational challenge in articulating a professional practice model is in defining concepts in such a way that brings significance to daily practice. Each component is critical to practice and care delivery. If model is to work, each clinician needs to understand, embrace and master the skills involved and be willing to learn — continuously learn — because the environment in which care is delivered is rapidly changing. This is a journey that the healthcare team takes together.

As noted in Force 1.1, the MGH Professional Practice Model (PPM) was developed to provide a comprehensive view of professional practice and the discipline-specific contributions of
providers engaged in patient care. It was originally developed around nine essential elements including: values; philosophy; standards of practice; professional development; patient care delivery models; authorization, credentialing and peer review; research; and descriptive theory models. Ten years later, after undergoing significant review by the PCS Executive team, nursing leadership and staff throughout PCS, the nine components of the PCS PPM were revised to include: vision and values; standards of practice; narrative culture; professional development; patient-centeredness; clinical recognition and advancement; collaborative decision-making; research; and innovation and entrepreneurial teamwork (see Figure below). The revised PPM is showcased in the April 5, 2007 issue of Caring Headlines (OOD 14).

**Professional Practice Model**

![Diagram of Professional Practice Model](image)

Patient Care Delivery Model

At the MGH, the center piece of the PPM, Patient Centeredness describes the Patient Care Delivery Model which is patient- and family-centered and interdisciplinary in nature. It articulates a care-delivery system that is supported by a philosophy of care and an environment that enhances patient outcomes. These elements include staffing patterns, strategies for aggregating patient populations, reimbursement methods, and effective communication systems that report and document outcomes of patients’ hospitalizations.

Patient care is expected to be of the highest quality, comprehensive, accessible, supportive, and personalized. The vision statement for Patient Care Services says, “Patients are our primary
focus, and the way we deliver care reflects that focus every day.” Patient- and family-centered care optimizes this relationship. It creates a care-delivery system that is centered around the patient.

**Patient- and Family-Centeredness**

The diagram above depicts the patient and family at the center of the work. Involvement with the patient and family is central to professional practice at MGH. Value is placed on the dynamic and therapeutic interactions that occur between the nurse, the patient, and the family.

Decisions about care and the environment of care are made at the practice level by clinical staff and unit leadership through the patient care delivery model (as depicted in the figure on the following page). Authority, responsibility, and accountability for the nursing care of patients and families rest with Registered Nurses. Nursing care is prescribed by a Registered Nurse and delivered by a Registered Nurse (or delegated to competent Patient Care Associates, when appropriate). Accountability for nursing care and outcomes of nursing interventions is always assumed by the Registered Nurse assigned to the patient. Patient care is influenced by the patient’s overall health status and a variety of contributing biophysical, psychosocial and cultural influences. Within the nurse-patient relationship, the nurse creates a therapeutic environment that ensures mutual trust, safety, privacy, and respect. As a Staff Nurse comes to know a patient and the patient’s unique response to certain situations, he/she designs a care plan based on that knowledge and best practices. The nurse’s practice has two components: *doing for* and *being with*. *Doing for* includes assessment, diagnosis, planning, intervention, and evaluation of outcomes; while *being with* refers to behaviors that create an environment where patients can heal. Nursing care requires nurses to be
present to patients and families — to listen, to know, to advocate for throughout the healthcare experience. Our culture encourages professional autonomy and clinical decision-making and supports interventions that promote optimal patient care across a variety of healthcare settings.

**MGH Patient Care Delivery Model**

Nurses are creative in their approach to care and use knowledge to improve outcomes. They optimize patient strengths and provide support for limitations. Staff Nurses at MGH are afforded an environment that optimizes professional practice and enhances patient care. The nurse-patient relationship, central to the work of nursing, is based on mutual trust and respect and is therapeutic in nature. The partnership forged between a nurse and patient, as well as family and community, is essential to promoting health, managing illness, and negotiating changes in lifestyle patterns. Nurses identify concerns related to the human experience (i.e., birth, health, illness, and death) and engage in clinical reasoning processes to identify problems, define outcomes, and generate interventions based on goals shared by the nurse, the patient, and the family.
Nursing Documentation and Communication Project

The focus of the Nursing Documentation and Communication Project was to design a nursing documentation system that effectively captures the patient’s story, identifies the patient’s unique needs, and facilitates the patient’s plan of care. The components of this initiative ensure that the elements of the Patient Care Delivery model are translated into action, and more importantly, communicated to other members of the healthcare team.

The objectives were to:
♦ Enable nursing to know the patient, develop and communicate the plan of care to other clinicians,
♦ Provide continuity and communication to enhance nursing practice,
♦ Improve patient safety and enhance quality of care,
♦ Apply technology to design processes as appropriate,
♦ Identify workforce transformation and change management strategies, and,
♦ Increase patient and clinician satisfaction.

A Documentation/Communications Project Committee comprised of nursing leadership and staff (attachment 5.5.a) was launched and a comprehensive assessment of current reality was articulated at a nursing retreat focused on this initiative (attachment 5.5.b). A detailed implementation plan was crafted to address documentation issues. The vision of the future was presented by Staff Nurse, Betsy Baumgartner, RN, to the Nursing Director group (attachment 5.5.c). It was titled, “The Future State Story: Mr. Cole’s Experience.” This was a vision that leadership and Staff Nurses throughout MGH could envision.

Unit-based feedback about the implementation of the Documentation/Communication project follows:

“Fourteen Staff Nurses (representing units from across the Hospital) were members of the initial Documentation/Communication Project Committee. This committee, consisting of hospital leadership, administrators, Staff Nurses and IBM consultants, was charged with developing goals and a plan to execute an enhanced nursing documentation/communication process on all inpatient care units at MGH. This process design included a newly-created nursing data set and introduced an improved structure for shift-to-shift nursing report utilizing patient specific problems and intervention care plans. This initiative has been extremely successful. Documentation has increased 110%, patients are satisfied since they have the opportunity to contribute to their plan of care, and communication among nursing and the multidisciplinary teams has improved.”

- Shannon Dacunha, RN, CMSRN. Staff Nurse, White 8 General Medicine
“The nursing documentation project has been implemented in the Pre-Admission Testing Area (PATA) since late January 2007. PATA is the initial point for perioperative nursing services to begin building relationships with patients and developing our plan of care for approximately 50% of the patients having surgery at MGH. We perform over 25,000 surgical cases 18,000 endoscopic procedures annually. Each perioperative setting is unique in its nursing assessment, nursing interventions and care planning to meet our individual patient and family’s needs. The nursing documentation begins with the PATA visit in which the nursing assessment is completed with patient problems identified, patient teaching specific to the individual surgery and patient needs are reviewed as well as the plan of care addressing the patient problems and anticipation of the patient’s surgical experience at MGH. Specific patient care needs are identified in PATA and communicated via documentation to the perioperative team such as patient language/interpreter needs on the day of surgery. An another example of specific care interventions related to skin care/positioning elements is described including the patient’s preferences and communicated to the pre-operative, intra-operative and post-operative staff that will care for the patient. Families are given information as to our OR nurse liaison program to maintain communication and a link for families to ask questions on the day of surgery.

Staff throughout PATA met with the Nursing Director and Clinical Nurse Specialist to dialogue about the value of this documentation and communication process in ensuring that the patient’s “story” is documented. The goal is to ensure that the nursing dataset is complete when the patients leave PATA so that all caregivers within peri-operative services and throughout the continuum of the patient’s stay, understand the patient’s needs and expectations and are able to effectively develop and follow-through with a plan of care specific to each individual patients. PATA staff has been made aware of the important nursing documentation project as we have representation on the Nursing Practice Committee in which this project was initially reviewed and discussed last year.”

- Donna Slicis, RN, Staff Nurse, PATA

Department of Medicine Retreat

On May 19, 2006, a Department of Medicine Retreat was held in which nursing leadership and staff participated in the planning and Staff Nurses from all medical units attended (attachment 5.5.d). This retreat provided nursing with the opportunity to dialogue with their physician counterparts about key issues facing them.

The following questions derived from input solicited from leadership and staff prior to the retreat guided the small group discussions:
Multidisciplinary Education/Community/Collaboration

♦ How do we create a multidisciplinary learning environment?
♦ How do we support education and learning while continuing to operate safely and efficiently?
♦ How do we support learning curves across all disciplines?
♦ How do we incorporate the development of interpersonal skills and professionalism into the learning process? And how do we evaluate?
♦ How well do we educate one another around a patient’s care?
♦ What are the barriers to this?
♦ Ideally what would we like to do this?
♦ Practically what could we do starting in one month?
♦ What is working well with Physician-Nurse Communication?
♦ What isn’t working well with Physician-Nurse Communication?
♦ How can we provide more consistent messages to patients and families?
♦ Should we have combined nursing-physician Morbidity and Mortality conferences?

Integrating Wireless Technology

♦ How should the process or roll out of new technology be defined?
♦ Who should be involved in planning, implementation and evaluation?
♦ Are there best practices with introduction of new clinical equipment, i.e. monitors, pumps etc. that apply?
♦ How should the teams round using the new wireless technology?
♦ Is this making things more efficient/safer for house staff, nurses, support staff, patients and families?
♦ What is the best morning schedule for using the computers on wheels (COWs) on the Bigelow Service?

Communication on the Ellison Service

♦ What are the barriers to effective communication?
♦ What would enhance communication?
♦ How can we build in accountability for timely decision-making and care management?
♦ Redesign morning rounds on the Ellison Service.
♦ How can we identify and connect to the correct members of the care team?
Quality and Safety/Handoffs/Continuity

♦ What is the impact of the current MD teaching structure on unit workflow and care delivery?
♦ Highlight positives and opportunities for ongoing improvement.
♦ How might we incorporate input from other disciplines toward the most effective structure of the model?
♦ Define the problems and possible solutions around hand off.
♦ Where are their gaps in our handoff communications strategies? Why are there gaps?
♦ How can we streamline the handoff process?
Documentation/Communication Initiative Teams

**Documentation/Communication Steering Team**
Debbie Burke, RN, Associate Chief Nurse
Diane Carroll, RN, PhD, Clinical Nurse Specialist and Nurse Researcher
Mandi Coakley, RN, PhD, Staff Specialist
Patty Dykes, RN, PhD, Information Systems Specialist
Joanne Empoliti, RN, Clinical Nurse Specialist
Theresa Gallivan, RN, Associate Chief Nurse
Dottie Jones, RN Ed,D, Director, Yvonne L. Munn Center for Nursing Research
Sally Millar, RN, Director, Patient Care Services Information Systems
Rosemary O'Malley, RN, Staff Specialist
Peggy Settle, RN, Nursing Director
Chris Schifilti, RN, Information Systems Specialist
MaryEllin Smith, RN, Professional Development Coordinator
Jackie Somerville, RN, PhDe, Associate Chief Nurse, Chairperson
Cindy Spurr, RN, Director, Information Systems, Partners HealthCare
Dawn Tenney, RN, Associate Chief Nurse
Pam Wrigley, RN, Clinical Nurse Specialist

**Documentation/Communication Project Team**
Debbie Adair, Director, Health Information Systems
Lillian Ananian, RN, Clinical Nurse Specialist
Michelle Anastasi, RN, Clinical Nurse Specialist
Chris Annese, RN, Staff Specialist,
Betsy Baumgartner, RN, Staff Nurse
Marjorie Blundon, Project Specialist, Health Information Systems
Sharon Bouvier, RN, Nursing Director
Diane Boye, RN, Staff Nurse
Caitlin Callahan, RN, Staff Nurse
Annie Cassels-Turner, RN, Staff Nurse
Coleen Caster, RN, Nursing Director
Chelby Cierpial, RN, Clinical Nurse Specialist
Scott Ciesielski, RN, Nursing Director
Mandi Coakley, RN, PhD, Staff Specialist
Greg Conklin, RN, Staff Nurse
Erin Cox, RN, Clinical Nurse Specialist
Darlene Crisileo, RN, Staff Nurse
Trish Crispi, RN, Staff Specialist
Shannon Dacunha, RN, Staff Nurse
Jackie Davis, RN, Staff Nurse
Leslie Delisl, RN, Staff Nurse
Tony Digiovone, RN, Nursing Director
Joanne Empoliti, RN, Clinical Nurse Specialist
Charlene Feiltreau, RN, Project Specialist
Joanne Ferguson, RN, Staff Specialist
Ellen Fitzgerald, RN, Nursing Director
Carol Ghiloni, RN, Staff Specialist
Grace Good, RN, Nurse Practitioner

Elaine Grassa, RN, Staff Nurse
Mary Guanci, RN, Clinical Nurse Specialist
Sioban Haldeman, RN, Clinical Nurse Specialist
Liz Johnson, RN, Clinical Nurse Specialist
Lauren Kattany, RN, Clinical Nurse Specialist
Ann Kennedy, RN, Nursing Director
Sue Kilroy, RN, Clinical Nurse Specialist

Cindy LaSala, RN, Clinical Nurse Specialist

George Lillie, RN, Staff Nurse
Bessie Manley, RN, Nursing Director
John Murphy, RN, Nursing Director
Kathie Myers, RN, Nursing Director
Rosemary O'Malley, RN, Staff Specialist
Jill Pedro, RN, Clinical Nurse Specialist
Marion Phipps, RN, Clinical Nurse Specialist

Maryalyce Romano, RN, Staff Nurse
Maureen Schnider, RN, Nursing Director
Judy Silva, RN, Nursing Director

Donna Slicis, RN, Staff Nurse
MaryEllin Smith, RN, Professional Development Coordinator
Amanda Stefancyk, RN, Nursing Director

Jean Stewart, RN, Staff Nurse
Laura Sumner, RN, Clinical Educator
**Agenda**

7:00-7:15 Introduction of the project
7:15-7:30 The Visionary Story
7:30-8:15 Overview of the three components
8:15-8:45 Breakout session
8:45-9:45 Update from units
9:45-10:00 Break
10:00-11:00 Breakout session

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**Project Overview and Scope**

The overall goal of the Nursing Communication and Documentation Project is to design a nursing documentation system that effectively captures the patient’s story, identifies the patient’s unique needs, and facilitates the plan of care.

**Objectives**

- Enable nursing to know the patient, develop and communicate the plan of care
- Provide continuity and communication to enhance nursing practice
- Improve patient safety and enhance quality of care
- Apply technology to design processes as appropriate
- Identify workforce transformation and change management strategies
- Increase patient and clinician satisfaction

**Scope**

This project is focused on nursing documentation that supports inpatient care at MGH; specifically, the project will focus on one General Medical Inpatient Care Unit (White 8) and one Vascular Surgical Unit (Bigelow 14).

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**There are 13 Key Forms Currently Used for Nursing Documentation**

### There are 13 Key Forms Currently Used for Nursing Documentation

**Staff RN Survey**
- Nursing Orientation
- White 8 and White 9 (MGH)

**Advance Directives: Health Care Proxy Questionnaire**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

**Nursing Admissions Note**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

**Nursing Assessment Form**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

**Nursing Discharge Note**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

**Post Hospital Care Plan**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

**Nursing Progress Notes**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

**Nursing Transfer/Acceptance Notes**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

**Interdisciplinary Patient/Family Education Sheet**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

**Problem/Intervention/Outcome Sheet**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

**Nursing Intervention Sheet**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

**Nursing Treatment Record**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

**Patient Risk for Injury**
- Patient Agreement
- Communication effectiveness
- Communication of changing documentation and communication

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**Current State Assessment: Methodology**

A Current State Assessment was conducted over a two-week period.

- Interviews/Observations/Focus Groups
- Staff RN Survey
- Key nursing documentation forms
- Key nursing documentation forms
- Nursing Admission forms
- Nursing Discharge forms
- Interdisciplinary Patient/Family Education forms
- Problem/Intervention/Outcome forms
- Nursing Intervention forms
- Nursing Treatment forms
- Patient Risk for Injury forms

- Medical Record/Forms/P&P Reviews
- Site Visits/Literature/Regulatory Reviews

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If there was one thing I could change about nursing communication and documentation it would be:

- Report should be standardized and more succinct.
- Change from problem-oriented to systems documentation.
- Time-consuming to retrieve information to care for patients.
- Absolutely dislike the current flow sheet.
- Make documentation computerized.
- Educate & review MGH documentation policies and procedures.
- Keep Kardex up to date.
- Lots of different types of paperwork.
- Better communication needed between units.
- Combine/Streamline documentation - it seems to be getting more time consuming.

This floor is efficient and effective at delivering care, people have their roles and things run pretty well.

Individualized Green Books are more user-friendly than one large medication box.

I would not like electronic documentation - we do enough electronic discharge work and physician orders.

I don’t wish for electronic documentation because patient’s have specific needs that need to be communicated verbally to other staff and not be placed in the record.

Individuals I work with say ‘I can’t read the handwriting’.

slow-up on new forms - please issue 1 at a time instead of 3 to 4 at once.

I would not like computerized documentation - it is too bulky.

Change from problem-oriented to systems documentation.

Individually Green Books are more user-friendly than one large medication box.

No more paperwork - no new format.

I need to review current forms and make changes.

NEVER change the treatment Kardex tool because we love it & it works really well!

The Kardex system is wonderful.

Taped report should stay.

I don’t want the Kardex report time consuming to retrieve information to care for patients.

Change in the current flow sheet.

I wouldn’t decrease staffing levels because there must be time for doc. & com.

I’d like to see the hardness to use the handwriting less.

I am open to revamping the system.

There is no reference to the plan of care by nurses

The priority is on individual components

Assessment

Problem List (Interventions and Outcomes)

Nursing Progress Notes

Nurses state that documentation of the progress helps them to utilize critical thinking skills

Information is in the chart, but it is fragmented and documents do not appear to be linked

Documentation rarely reflects problem resolution

Frequently, a new Problem list is initiated as the patient is transferred from unit to unit

Nursing Documentation

There is a lack of documentation of the ongoing discharge plan by nursing

Progress Notes are written in both problem and system-oriented models

Even within one patient record, there is variation from nurse to nurse and shift to shift

Progress Notes are written with a shift focus, resulting in a lack of real-time documentation

Development of the Plan of Care

Goals

- Change from a task to a goal-oriented perspective
- Create a Nursing Database
  - Will contain a defined minimum data set of elements that are entered upon entry to any department at MGH
  - Dynamic and used for ongoing plan of care and shift reports
  - Serves as a tool for feedback shared between nursing
- Include goals of the patient

Roadmap

- Construct database to drive the goals/problem list
- Change the report method - read the most recent note and use database
- Work with admitting to promote continuity of care
- Some unit over time with re-admits
- Change culture to create accountability, vision, and consensus

Recommendations

- Define Nursing Assessment as a Nursing Database
- Identify minimum data set to be collected upon entry into system
- Change to goal-oriented charting
- First goal includes discharge planning (goal to go back where they came from)
Attachment 5.5.b continued

Communication of Clinical Information

- Hand off (shift report) methods and tools are inconsistent between units (departments) with varying degrees of staff satisfaction
- Kardexes used for hand offs contain valuable data that are (is) not recorded in the permanent medical record (i.e., system assessment, discharge planning)
- Nurses report satisfaction with utilization of the Kardex for report followed by brief verbal updates; nurses not utilizing a Kardex verbalized that report is time consuming

Communication: Shift Report

Goals
- To create an effective and efficient means of communicating the patient's story to any clinician caring for the patient
- Each patient will feel "known" by the nurse caring for him/her
- Information exchanged during a handoff will be standardized to ensure that pertinent patient problems, goals and current clinical status are highlighted

Changes
- Report will be based on the oncoming nurse reviewing the patient's care plan, problem/outcome/intervention/results, treatment record, patient care flow sheets and nursing progress notes...
- After reviewing the written information, there will be opportunity for dialogue between nurses to clarify any of the documentation, plan, etc.
- Progress notes will be completed before the end of the shift
- Kardexes and taped report are gone
- The oncoming and off going nurse will have the opportunity to view patient information before transfer (via fax or tube) with verbal follow up
- View patient information before transferring (e.g., fax or phone call) with verbal follow up
- The oncoming nurse can receive an updated chart, review ongoing patient's status and check patient turnaround before the patient arrives, and in whatever manner is easiest for receiving nurse

Roadmap
- Merge the best elements/qualities of both taped report and Kardex
- Pull out relevant info from handout and create one system
- Develop a framework for what needs to be reported consistently
- Involve clinical nursing in development of future automation
- Recommendations
- View patient information before transfer (i.e., fax or phone calls) with verbal follow up
- The oncoming nurse can receive an updated chart, review patient status and check patient turnaround before the patient arrives
- Standardized system for all units for patient transfer with accountability for follow through
- Potential of integrating the report in a standardized framework
- Dual purpose form/medication administration note to make patient care consistent

Level of Accountability: Patient Assignments

Goals
- Provide continuity of care so the patient feels known and the nursing staff know the patient
- Correlate patient acuity with staff skill mix/learning needs
- Roadmap
  > Develop the role of Care Leader/Care Team to provide continuity of care for the patient over the LOS
  > Responsible for developing a plan of care with the patient/’family to achieve optimal outcomes
  > Resource Nurse with “global perspective” empowering the nurse at the bedside
  > Leverage at variables including staff schedule, skill mix, acuity, census

Recommendations
- Utilize care team (group of nurses to care for patients) with decision making
- Balance between schedule changes and continuity of care for patient

Continuity of Care: Patient Assignments

Patient Assignments
- Nurses rarely sign up for primary and associate nurse roles
- Focus is on the shift, not the patient’s LOS
- For difficult patients, a core team is identified to provide continuity of care
- Nurse is the keeper of the information
- Nursing stress levels and patient load may drive the assignment
- Nurse orientation and educational needs may take priority when assigning patients

Continuity of care
- Focus on the patient over the LOS
- Established team working with the pt
- Clear accountability in creating team
- One standard of care for all patients
- Would need to work the Resource Nurses to assess continuity of care amongst the team
- For orientees, may need to look at what is a “good” experience and how to adjust their assignment to accommodate this
- Consistency in assignment is maintained as much as possible from workday to workday
- Challenges on evening 12 hours versus 8 hour shift challenges
- Question whether we can schedule “partnership” or teams in advance
- Partnerships could pair novice with experienced staff
Accountability for Plan of Care

- Care Leader/Team assignment should be a priority.
- Assignment sheet has a 24 hour focus from the perspective of care team assignments.
- Need to do continued work around addressing cultural perspectives that impact unit assignments, patient care perspective of staff.
- Barriers- resistance to change- change would need to be thoughtful.

Break Out Session: Nursing Practice

Breakout Session: Nursing Practice

Question to Answer:
- Independent of physician orders, what kind of care would you as a nurse provide to your patients?
- What patient outcomes would you impact?

A Summary of the Nursing Practice Break-Outs

Independent of physician orders, what kind of care would you as a nurse provide to your patients?

- Psychosocial care (getting to know the patient as a person)
- Advocate for the patient
- Therapeutic touch, end-of-life, and comfort care
- Physical hygiene and ADLs
- Work with educating the patient & family
- Promote rest
- Liaison and coordinator of care
- Interpret medical information
- Create safe care environment
- Address patient specific issues around medications (ie, swallow
- Keep patient free from injury and preventing adverse events
- Increase patient’s perception of quality of care
- Increase ability of patient to participate in care
- Prevent complications
- Manage patient expectations

Gordon’s Functional Health Patterns

- Pattern of health perception & health management
- Nutritional - metabolic pattern
- Pattern of activity & exercise
- Cognitive - perceptual pattern
- Pattern of sleep & rest
- Pattern of self perception & self concept
- Role - relationship pattern
- Sexuality - reproductive pattern
- Pattern of coping & stress tolerance
- Pattern of values & beliefs

Three Focus Areas Have Been Identified For The Morning Design Session
The sense of urgency comes from Partner moving towards automation. Workforce Transformation: Change Management

Recommendations: Workforce Transformation

Nursing Communication & Documentation Vision:

Guiding Principles

Guiding Principles

Workforce Transformation: Change Management

Workforce Transformation: Change Management

Recommendations: Workforce Transformation
A Future State Story: Mr. Cole's Experience

Background
Mr. Cole is a 78-year-old man who lives alone. Mr. Cole's daughter found him this morning to be unusually weak and confused. She called an ambulance to bring him to MGH Emergency Department (ED), where he has been a patient in the past.

Patient History
Annie, the ED RN, is able to look up Mr. Cole's medical history and nursing database from previous encounters at both the hospital and primary care physician visits. Annie continues to document new patient goals and interventions in the computer system.

Transfer Report Upon Admission
Mr. Cole is going to be admitted. Because the registration system shows that Mr. Cole has been a patient on White 8 in the past, he will be placed on that unit again. The resource nurse reviews the system and assigns him to Shannon since she has cared for him in the past.

After notification of the admission, Shannon uses a portable computer to review documentation entered in the ED including his admitting diagnosis of Urosepsis, history of Type II Diabetes, and nursing goals including 'free from falls' identified by Annie. Shannon selects a room close to the nurses station, and prepares it by posting safety signs before Mr. Cole arrives.

While Annie gives report using a mobile communication device, Shannon is able to view a computer screen and has an opportunity to ask questions. Shannon notes that he has a fever, views the eMAR and asks if Mr. Cole has had any Tylenol for his fever. Annie confirms that she plans to give him some and proceeds to use bar-code technology to assist in verification of the 5 rights and document the dose of Tylenol administered.
Patient Transport
Shannon proceeds to care for her other patients. She is able to see on her portable computer that Mr. Cole has left the ED and is on his way to the floor based on his RFID wristband. This allows her to be readily available when he arrives on the unit.

Admission Assessment
Upon arrival to White 8, Shannon greets Mr. Cole and his daughter, and acknowledges that she has spoken to Annie about his history and plan of care. Information previously documented by Annie populates the current Nursing Database. Shannon is able to quickly confirm the information and add any further input given from his daughter using a portable computer.

Based on the information obtained, goals and appropriate nursing interventions are triggered in the system. Shannon individualizes and then reviews the plan of care with Mr. Cole and his daughter. There is a link available to view current evidence based practice and research results supporting that plan of care. This helps Shannon to explain to the daughter the purpose of her interventions.

Upon validation of the “free from falls” goal, the computer system automatically sends a cue to the physician to initiate orders including a consult to Physical Therapy. Discharge planning needs are also identified and Shannon is able to initiate subsequent coordination with other caregivers immediately upon admission.

Meanwhile, the unit based Physical Therapist on White 8 views the order to evaluate Mr. Cole on a mobile hand held device. The PT is able to evaluate the patient immediately, follow as needed throughout his stay, and assist to prepare for anticipated discharge needs.

Mr. Cole’s daughter feels comforted because good communication has been provided between all of the clinicians caring for Mr. Cole. Shannon provides her with a print out of information with caregiver names, contact information, information about the unit, and the plan of care. Mr. Cole’s daughter states that she feels it is safe for her to leave now.

Multiple Contributors

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The Clinical Nurse Specialist (CNS) views a daily report reflecting the interventions and their impact on the patient. Outliers are prioritized and she is able to consult with Shannon immediately in the morning about Mr. Cole’s variable blood sugars.

Shannon assesses Mr. Cole’s vital signs and blood sugar, which are automatically downloaded and immediately added to his electronic medical record using wireless technology. The physician is able to view these results from a remote location and places orders for Insulin according to his blood sugar levels. Shannon views the new orders on a mobile device immediately after they are placed by the physician.

Shannon assesses Mr. Cole’s vital signs and blood sugar, which are automatically downloaded and immediately added to his electronic medical record using wireless technology. The physician is able to view these results from a remote location and places orders for Insulin according to his blood sugar levels. Shannon views the new orders on a mobile device immediately after they are placed by the physician.

The CNS and Nurse Managers are able to utilize the electronic data related to fall risk and care of the diabetic to monitor the effectiveness of nursing goals and interventions. The data are used to provide feedback to staff on the units at MGH and implement process improvement measures. The data is also extracted and provided to a national database in order to monitor and support the effectiveness of interventions and make global recommendations for nursing practice as a whole.

At 7:00 pm, the oncoming nurse assigned to Shannon’s patients reviews the electronic care plan. She is also able to develop a picture of the patient plan of care outlined by Shannon and any other pertinent data. She uses the system to see a customized view of data and graph trends over time.

Shannon meets the oncoming nurse and brief verbal updates are shared, with an introduction to Mr. Cole. A standardized framework assists in communicating pertinent information in a consistent, timely manner.

Shannon continues to coordinate care given by all clinicians who continue to work collaboratively and provide safe care to Mr. Cole while preparing him for discharge. Upon treatment of his infection, Mr. Cole’s mental status returns back to normal and he is able to email his daughter from the room and tell her that he is going to be discharged home.
Shannon reassures Mr. Cole and his daughter that all of the information will be available to the primary care physician electronically when he goes for his follow-up appointment. Mr. Cole and his daughter thank Shannon and the other staff for their wonderful care on their way out of the unit.

**Discharge**

Shannon has arranged for Mr. Cole’s daughter to pick him up by 10:00am. The follow-up appointment information, caregiver and unit contact information are all documented electronically and provided to his daughter. Shannon verifies in the system that all of the education has been provided and that Mr. Cole and his daughter state understanding of the instructions.
# Nursing Participation at MGH Department of Medicine Retreat

<table>
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<tr>
<th>Unit</th>
<th>Nursing Directors</th>
<th>CNSs</th>
<th>Operations Coordinators</th>
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