

Results of the Pediatrics pilot of SCM-based discharge summaries

Proper and efficient communication about patient care is an integral part in maintaining high quality of care and strengthening relationship with physicians and health care centers outside of Boston Medical Center. One of the most important pieces of information that primary care physicians desire from area hospitals is complete and timely discharge summaries.

In an effort to create a more integrated electronic and communication system, a pilot program was initiated on the inpatient pediatric service. Over the past several months, discharge summaries have been written on SUNRISE instead of the traditional SOFTMED system. With assistance of the informational technology (IT) staff and the pediatric chief resident, the housestaff has been trained concerning how to use this new application. The housestaff commented that data entry format was user friendly; the macros allowed simple input of hospital course data, and switching to SUNRISE allowed one less computer system to master. Constructively, they would appreciate more free text space to enter the hospital course and autopopulation the medication list. Overall, it has worked smoothly without any major obstacles or difficulties.

Movement to a single integrated system will naturally decrease errors by minimizing extra steps within any given process. Other possible improvements include autopopulating history, medications, allergies, past medical history, and social history in the SUNRISE discharge system. The information technology group would be applauded for taking steps in the right direction in improving care for our patient at Boston Medical Center.

C Huang

In the next few months, a pilot on the Medicine Service will begin utilizing SCM for discharge summaries.

Stay tuned!

BMC's 7 Cultural Beliefs

Own it!

Team work!

Step up!

Patients first!

Build trust!

Deliver!

I can!

THE INPATIENT TIMES

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The Inpatient Times

All the news that makes you more fit to treat!

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Drug Reps:

Rules and regulations for conduct

This article will represent the beginning of a two-part series on the rules and regulations surrounding the conduct of pharmaceutical representatives at Boston Medical Center. This article focuses on the way representatives may promote their products and travel within the institution. In the next edition of The Inpatient Times, there will be an article on appropriate interactions with pharmaceutical representatives.

The BMC Policy and Procedure regarding the conduct of pharmaceutical representatives has been recently updated to ensure that the activities of the representatives within our institution remain within the boundaries deemed appropriate by the Pharmacy and Therapeutics (P&T) Committee. These boundaries encompass various legal and ethical matters, and most importantly these restrictions are in place to ensure that BMC patients receive the best pharmacologic therapies based on evidence-based medicine endorsed by the P&T Committee. These changes were implemented to ensure that accurate and unbiased information is conveyed to all BMC healthcare professionals. Ensuring that accurate and bias-free information only is conveyed to healthcare professionals is of paramount importance since misleading information often generates interest in medications that may not be better, and perhaps inferior, to existing formulary agents. This unfounded promotion of medications may lead to an agent being requested for formulary addition when such addition to formulary may not be appropriate.

Drug representatives cannot promote medications that are not currently on the BMC formulary anywhere on the BMC campus unless permission is granted by the Pharmacy Clinical Manager or delegate. The promotion of medications for indications other than what the P&T Committee has deemed appropriate is strictly prohibited. The promotion of medications for indications outside of FDA-labeling is illegal and is strictly prohibited. Representatives must work with attending physicians, Clinical Pharmacy Specialists, or the Clinical Pharmacy Manager when planning educational activities on the BMC campus. Other healthcare practitioners wishing to plan educational activities with pharmaceutical representatives must consult with and get the approval of the aforementioned healthcare professionals before scheduling these activities.

The combined help of all BMC healthcare professionals is needed to facilitate the enforcement of these important changes. Please inform any drug representative who does not have a pharmacy-issued identification badge that he or she must immediately sign-in at the East Newton Pharmacy Administrative office located on the second floor. Copies of the updated policy will be given to each representative, and a log will be maintained to document that each representative has been given a copy of the policy and has read it completely.

Please report violations of the updated policy and procedure to the Pharmacy Administrative office. The updated policy and procedure can be viewed on the Pharmacy intranet website at:

www.internal.bmc.org/pharmacy/policies/policies_index.html#V.

J Forgione

Avoiding “Empty Folder Syndrome”

Attending: “My password does not work.” “I completed that evaluation already.” “The system crashed and lost it.” “My resident wasn’t listed.”

Going through three different on-line evaluation systems in less than 3 years and dealing with the multiple “kinks” in the latest (and hopefully, last) system, New Innovations, has led to these and many other similar comments from faculty, regarding the timely completion of your rotation evaluations. Add the sometimes less than smooth running computer program to a busy attending schedule that includes patient care commitments, grant and abstract deadlines, numerous committee meetings, papers in progress with submission deadlines- and on and on – and evaluations might slip lower on the “To Do” list. Despite all of the best intentions, life on the fast moving treadmill gets in the way. The end result: an empty or pretty skinny evaluation folder to look at during the resident’s fireside chat. The kinks are getting worked out of the system and we hope to eventually have a smooth and effortless flow of completed evaluations to your file, but in the meantime, a reminder from you for your attending to fill out your evaluation before you finish the rotation will go a long way!

And, residents, don’t forget to complete the evaluation for your attending. Program directors read all of the evaluations that you complete, and a copy is sent to the section chair that are reviewed with the attending during *their* fireside (yes, the fireside is a pleasure that you never grow out of). Attendings are eager for the feedback. They want to hear what worked and what they could do differently. End of the rotation evaluations are also a good way to get feedback about specific rotations back to the program directors and firm chiefs.

Evaluations for students are important, because they serve as the basis for the all important **GRADE** (“What? I didn’t get Honors?!!?”), but are just as important or even more so, to faculty and residents. They are a very important tool for professional development. As physicians, we no longer receive grades or class “ranking” - but aim to develop our skills as clinicians, communicators and teachers to the best of our abilities, so that we

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can provide top level care for our patients, now and once training is over. Input from faculty is even more meaningful if framed around the learning goals that you set together at the beginning of the rotation.

So residents, ask for feedback during the rotation, and remind faculty to complete your evaluation. Your reminder is much more effective than a hundred email reminders from New Innovations! And remember to fill out your evaluations of your attendings. We do care!

A Jackson

Smoothing discharges: Introducing the Post Discharge Clinic!

Patients of the primary care clinic in the Yawkey Ambulatory Care Center now have another option for post discharge follow up. If a patient you are discharging from the hospital has specific issues needing follow up within the week, and their own PCP is not available, please ask the clinic staff (617-414-5951) for a post discharge clinic appointment within the Same Day Sick clinic.

We require (a) the name and beeper number of a member of the discharging team and (b) a fax of either the preliminary discharge summary or a legible list of the specific issues to be addressed. We will text page you back with the appointment time and date upon receipt of these items and would be happy to notify you of the results of the follow up appointment.

Questions or concerns can be emailed to Laura Wung, medical director of the Same Day Sick clinic at Laura.Wung@bmc.org.

L Wung

**Need a patient seen after discharge
whose YACC PCP doesn’t have an
available appointment for 3 months?**

**Send them to the new
POST-DISCHARGE CLINIC!!**

See information above!

Transitions of Care –

How to write a “good” discharge summary

Imagine the scenario... It’s 12:30 P.M. and you have clinic scheduled in 45 minutes. The case manager informs you that Mrs. Jones just got a bed at Goddard House and the ambulance is booked for 1:30 PM. You opened the discharge summary when she came in but it is far from complete. How can you finish the paperwork, grab lunch and still make it to clinic on time?

The discharge summary is often seen as the bane of any intern’s existence. You have spent days, sometimes weeks, providing care for a patient and now it all needs to be summarized in a brief document. Ideally, this document should take no more than a few minutes for the receiving practitioner to review and ascertain the salient details of the hospitalization. In conveying this information, it can be helpful to think of the discharge summary as an admission H & P. If you were admitting the patient, what would you want to know?

- **Diagnosis (a.k.a. Principal Diagnosis)** – This should be as accurate as possible. For example, cough is a symptom. Was the patient ultimately diagnosed with pneumonia, bronchitis, or a COPD exacerbation? The diagnosis will guide the outpatient practitioners care plan.
- **Past Medical History and Secondary Diagnoses** – What is pertinent in providing comprehensive care for this patient? It is more important that the new provider knows the most recent ejection fraction for a patient discharged after a CHF exacerbation than know that the patient has a history of onychomycosis. When admitting a diabetic patient, one would take a different approach for an individual with a glycosylated hemoglobin of 14.1 than person with a glycosylated hemoglobin of 6.9.
- **Medications (and allergies)** – The list you provide in the discharge summary will be used as a guide for the admission orders at the nursing home. If the patient is admitted over the weekend, the patient may not be

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seen for several days by a doctor or nurse practitioner. It is important to list all the medications that the patient is currently taking and note those which were held (i.e. poor oral intake so glipizide held or dose reduced). Cutting and pasting the outpatient medication list without review can result in medication errors and adverse outcomes.

- **Procedures and Significant Tests** – It is not necessary to list every test which was performed during hospitalization. As mentioned in this section’s title, only significant test **results** should be reported. For example, it is not necessary to report the daily chest x-ray of a patient was intubated in the ICU with a multilobar pneumonia. Mention test results which were important in patient outcomes and medical management decisions. Also, the full text of the report is not always needed. A condensed report will suffice in most cases.
 - **Reason for admission and hospital course** – This section is dedicated to communicating the “story” associated with the patient’s hospitalization. How did the patient present? What was the key history that provided clues to the diagnosis and severity of presentation? Were there any events that affected management during the course of hospitalization? This section is generally the most time consuming to write. Conveying the relevant details in a **succinct, cohesive** manner is truly an acquired skill.
 - **Outstanding Issues** - Use this section to convey what is needed to provide continued care. This can be as mundane as “check potassium in one week” to “needs CT chest in three months to follow up lung nodule.” This is also a good place to include labs or studies pending at discharge so the subsequent caregivers are aware of follow-up issues.
 - **Follow-up appointments** – Where, when and with whom? If known, provide phone numbers in case appointments need to be rescheduled.
- One final point to remember is that perhaps some time in the future, you will be on the receiving end and will appreciate a document well done.

K Dodd

New Antimicrobial Agents

Daptomycin, ertapenem, and tigecycline are antimicrobial agents the FDA has approved since 2001. Although they remain nonformulary at BMC, it is useful for the clinician to be aware of these agents and clinical scenarios for which these drugs might be indicated.

Daptomycin is the first FDA-approved drug in the novel class, cyclic lipopeptides. The drug disrupts the bacterial membrane by forming transmembrane channels which depolarize membranes and inhibit macromolecular synthesis. Daptomycin can be given once daily due to concentration-dependent pharmacodynamics and a strong post-antibiotic effect. It is active against gram-positive organisms, including resistant *Staphylococcus aureus*, *Enterococcus faecalis* and *E. faecium*. It is rapidly bacteriocidal. The main adverse drug effects are myopathies producing pain, weakness, and elevated creatine phosphokinase, and nerve conduction deficits manifested by paresthesias or reversible paralysis (e.g. Bell's palsy). It has been approved for treatment of complicated skin and soft tissue infections (cSSTIs). A recent study using a higher daptomycin dose than that for cSSTIs found it was not inferior to standard therapy for *S. aureus* endocarditis and bacteremia. However, daptomycin-treated patients had a higher rate of microbiologic failure and ~25% had some skeletal toxicity (although it was only considered a serious adverse event in 6.7%). It is not indicated for bronchopneumonia; the drug interacts with and is inhibited by pulmonary surfactant. Daptomycin can be useful for infections with resistant gram-positive organisms requiring bacteriocidal activity or for patient intolerant to β -lactam agents and vancomycin.

Ertapenem is a carbapenem agent similar to meropenem. It has a long half-life, allowing for once-daily dosing. It is bacteriocidal. It has good activity against enterobacteriaceae including those producing extended-spectrum or AmpC β -lactamases, anaerobes, methicillin-sensitive *S. aureus*, and streptococci. It lacks activity against methicillin-resistant *S. aureus* (MRSA), ampicillin-resistant enterococci, *Pseudomonas aeruginosa*, or *Acinetobacter*.

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Adverse effects include allergy, gastrointestinal distress, phlebitis and *C. difficile* infection. Unlike imipenem, it does not appear to lower the seizure threshold or cause nephrotoxicity. Clinical studies have shown efficacy for community-acquired pneumonia, complicated urinary tract infections, cSSTIs, complicated intra-abdominal infections, and acute pelvic infections. Recently, it was superior to cefotetan in a study of surgical prophylaxis. The drug has not been placed on formulary because of the potential for inappropriate use and the concern it will promote cross-resistance with other carbapenems, often the antibiotics of last resort. However, in patients requiring carbapenem treatment for infections caused by certain resistant organisms e.g. ESBL-producing *Klebsiella*, ertapenem rather than imipenem might be appropriate.

Tigecycline is the first glycylycylcline antibiotic approved for use. It is a derivative of minocycline and shares many of the characteristics of other tetracycline antibiotics. It is bacteriostatic; it interferes with bacterial protein synthesis by binding to the 30S ribosomal subunit. It has good gram-positive activity that includes enterococci and MRSA, gram-negative coverage that includes *E. coli*, *Klebsiella*, *Enterobacter*, *Citrobacter*, and *Acinetobacter*, and anaerobic activity. However, it lacks *P. aeruginosa* activity. It has important drug interactions e.g. with oral contraceptives, warfarin, and digoxin. Tigecycline causes vomiting in a significant number of patients on treatment. In addition, in a study of intra-abdominal infections, there was an increased risk of sepsis or septic shock. Although this finding was not statistically significant, the company issued a precaution for risk of septic shock if the drug is used as monotherapy for complicated intra-abdominal infections. This agent might be useful for certain infections with resistant organisms, but its role remains to be defined.

If you believe that your patient would be a candidate for one of these agents, a non-formulary drug request can be made. Please contact the Antibiotic Management Team, Beeper 8523 if you have questions about these agents.

T Barlam

Standardizing patient hand-offs

In our complex medical system which includes coverage and transfer of care, handoffs are common. A handoff is the transfer of responsibility for a patient. This is also known as "sign-out." In 2006, the Joint Commission on Accreditation of Healthcare Organization (JCAHO) introduced a new National Patient Safety Goal (2E) that requires healthcare organizations to "implement a standardized approach to 'hand-off' communications, including an opportunity to ask and respond to questions." The method by which patient information is communicated between caregivers during a hand-off is vital to overall patient safety. An organizational structure that comprises a standardized patient hand-off process ensures that all pertinent information is communicated between caregivers at the time of patient transfer from one caregiver to another.

These hand-offs or transfers of responsibility occur hospital-wide and include examples such as:

- Resident to resident transfer of on-call responsibility
- Admission from ED to Medical/Surgical physician team
- Nurse to nurse change of shift reports
- Transfers of patient from unit to nursing floor
- Nurse to physician reports/hand-offs
- Transporter to ancillary Services

To comply with JCAHO National Patient Safety Goal 2E, an effective handoff:

- Is interactive and allows the opportunity for questions between the caregivers (giver and receiver) of patient-related health information.
- Includes accurate information regarding the patient's care, treatment, services, condition, medical history, and anticipated changes.
- Is in an area where there are limited interruptions to ensure all information is communicated clearly.

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- Includes a process for verification of the information received such as repeat-back.

A cross-functional project team has been established led by the Performance Improvement Department in order to standardize the patient hand-off process between caregivers. The team is in the process of implementing a formalized hand-off process known as "I-SBAR" – within the "SBAR" family; an industry best practice "I-SBAR" stands for **I**ntroduction, **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation. The format acts as an acronym for ensuring that all pertinent information is exchanged during the hand-off. Guidelines include:

- I (Introduction):** Introduce the patient (ex. name, age, gender, communication limitations, etc).
- S (Situation):** State the patient's present condition and any additional concerns.
- B (Background):** Provide any relevant background information on the patient.
- A (Assessment):** Provide a current assessment of the patient's condition.
- R (Recommendations):** Provide the receiving caregiver with recommendations for care or treatment.

The final step in the process is the opportunity to ask and respond to questions.

Currently the team is focusing efforts in three priority areas including: Medicine Resident to Medicine Resident, ED Nurse to Unit/Floor Nurse, and PACU Nurse to Unit/Floor Nurse. Ultimately, I-SBAR will be implemented for all hand-offs hospital-wide.

There are numerous hospitals using the SBAR/I-SBAR format including Hartford Hospital in Hartford, CT (I-SBAR), Kaiser Permanente (SBAR) and OSF St. Joseph Medical Center in Bloomington, IL (SBAR). By incorporating the I-SBAR tool into hand-off communication, Boston Medical Center is putting its patients first by making their safety our priority.

N Radhakrishnan
S Kumra
B Jones

Snort, snuffle and sneeze!

This the season for sharing not only gifts from loved ones but, communicable diseases from patients. During the past several months, HealthCare Workers (HCW's) and patients have been exposed to patients and staff with undetected Tuberculosis, Pertussis and Chicken Pox.

Early diagnosis, treatment and implementation of the following basic infection control measures should be implemented at the first point of contact with a potentially infected person. Ask patients and HCW's to:

- Cover the nose/mouth when coughing or sneezing;
- Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use;
- Perform hand hygiene (e.g., hand washing with non-antimicrobial soap and water, alcohol-based hand rub, or antiseptic handwash) after having contact with respiratory secretions and contaminated objects/materials.

In addition, if diseases such as Tuberculosis or Avian Flu are suspected, **all HCW's must wear an N-95 respirator when having contact with the patient. HCW's must be medically cleared and fit tested prior to wearing an N-95 respirator. N-95 respirators are reusable and should be stored for reuse.** Because of the increasing fear of Avian Flu hospitals there is a shortage of N-95 respirators. To conserve the current supply of 3M N-95 respirators, the hospital has purchased a different respirator to be used by visitors. This Kimberly Clark "duckbill" type respirator is for visitors only. HCW's should not wear any respirator that they have not been fitted for.

One additional important preventative measure is Influenza vaccination. Please get vaccinated and give Influenza vaccine to all susceptible patients. Thank You for your assistance in keeping patients and staff healthy.

C Korn

10 ways to improve your rounds

1. Make sure pre-rounding expectations are clearly set for the interns and medical students.
2. Identify possible discharges the night before and have their paperwork prepared in advance when possible.
3. Prioritize rounds with sick patients first and discharges second (who you prepped the night before!!) and aim to get one or two discharges (if they are simple) out *before* lunch!
4. Round with charts and near a computer so you can quickly look up consults, notes, or data in real time.
5. Make sure each team member knows who is going to lead the discussion with and about the patient both inside and outside the room.
6. Residents should clarify what that discussion should entail (e.g. "briefly state who the patient is; comment about events of last 24 hours; new complaints and vitals for the morning.").
7. Avoid split rounds unless absolutely necessary to avoid time lost hinting down other members of the team, (not to mention good teaching opportunities for the team).
8. While setting the final plan for the day, have one person present and another person putting basic orders in the computer right then rather than writing them down on a "scut" list.
9. Get feedback from team members on your rounds. Keep what works. Fix what doesn't!
10. Clarify that when rounds go smoothly, there is more time for teaching!

J Greenwald

Med-Surg nurses stay prepared even after the JCAHO survey!

Now that this year's JCAHO surprise survey is over, it is important for all nursing units to remain "JCAHO-Ready," as JCAHO could still return at any time, unannounced. The Nurse Managers and the staff are working hard on many fronts to maintain a current state of readiness. Here is some of the work that is in progress:

Facilities: We are, as always, continuing to work on the condition of our environment. This includes: patchwork and painting, repairs to walls, installing new locks where needed, replacing old furniture and removing equipment we no longer use.

Housekeeping: We are working with housekeeping on the cleanliness of the environment. This includes: thorough cleaning of med rooms, floor stripping, replacing shower curtains and other projects.

Staff Education: The staff are getting prepared by working on the patient safety goals. We have updated 2007 VSSC Goals and Patient Safety Goal Posters as we displayed on the unit. A soon to be ready web-based video about the Patient Safety Goals, featuring "Mr. Patient Safety" as well as updated JCAHO Booklets and ID badge reminders of the dangerous abbreviations will be available soon. In addition, we are working on cleaning up the bedside books with new binders and updated JCAHO specific laminated information contained in them. We are also doing JCAHO ongoing patient tracers on the unit with the staff so that we can be prepared on how to "speak" about the care we provide.

- 1) Several other noteworthy projects are also underway: A house wide audit on the BMC Red Socks Falls program to evaluate the effectiveness of the program is being ordered (a JCAHO requirement of any falls program).

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- 2) Expansion of telemetry monitored beds across both campuses stated for late winter / early spring.
- 3) Potential upgrades, enhancements and modifications to Nurse Call / wireless system.
- 4) Roll out of online nursing documentation and computer upgrades across both campuses (pilot to begin week of January 8th).

... and many more projects are underway for 2007
How you can help us in a improving patient safety and JCAHO preparedness!

Nurses and Physicians are partners in care and a successful survey and good patient care depends on collaboration. Our key priority areas are:

- 1) Medication Reconciliation
- 2) Avoiding the use of any dangerous abbreviations
- 3) Limiting / avoiding verbal orders
- 4) Keeping our patient care areas clean and free of food or drink
- 5) Protecting patient privacy and
- 6) Continuing to participate and promote Falls Prevention Interventions for our patients

...and the list goes on.

Thank you for all you do for our patients.

L Guy

The Inpatient Times
would like to congratulate the
Medicine Residency Program
on another successful
recruiting season!

A special thanks to the
Medicine Program Staff for
their hard work!!!

CMO Corner:

Improving our care of CHF patients

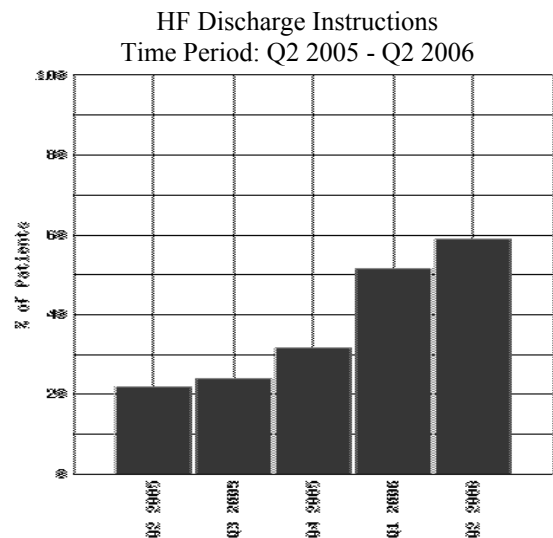
At BMC we are committed to providing exceptional cardiac care! In our effort to improve the safety and quality of care for our CHF patient population, a multidisciplinary improvement initiative around discharge instructions is ongoing. The primary focus of this initiative is to improve our compliance with providing written heart failure discharge instructions to all appropriate patients.

Identifying the CHF patient to insure prompt initiation of our CHF Clinical Pathway continues to be a challenge that impacts our primary aim. The following interventions have been implemented to date:

- Education provided to house officers and physicians to increase utilization of our evidence-based CHF Clinical Pathway.
- Random audits performed to insure that patients admitted with diagnosis suggesting CHF have had CHF pathway ordered.
- If pathway has not been ordered, Cardiology Clinical Service Manager/NP contacts team to determine working diagnosis, and if appropriate ask that the pathway be ordered and used for patient management and education.
- Daily notification to Nurse Managers of patients with active CHF pathway order to insure that pathway resources reach patient at the bedside.
- Trialing of an electronic alert for patients with predefined criteria, who receive IV Lasix and do not have a CHF pathway order. When IV Lasix is ordered a prompt will appear to ask if patient should be placed on Heart Failure Pathway?
- Written Heart Failure discharge instructions have been translated into French, Spanish, Portuguese, Chinese and Vietnamese.

The chart displays our compliance with providing written discharge instructions to CHF patients discharged from BMC. The median score nationally and for Council of Teaching Hospitals (COTH) through March 2006 is 60% and 62 % respectively, a percentage we reached in Qtr 2, 2006. *Continued →*

Reaching 100% is the goal. As data shows, it is challenging for everyone.



How can you make a difference?

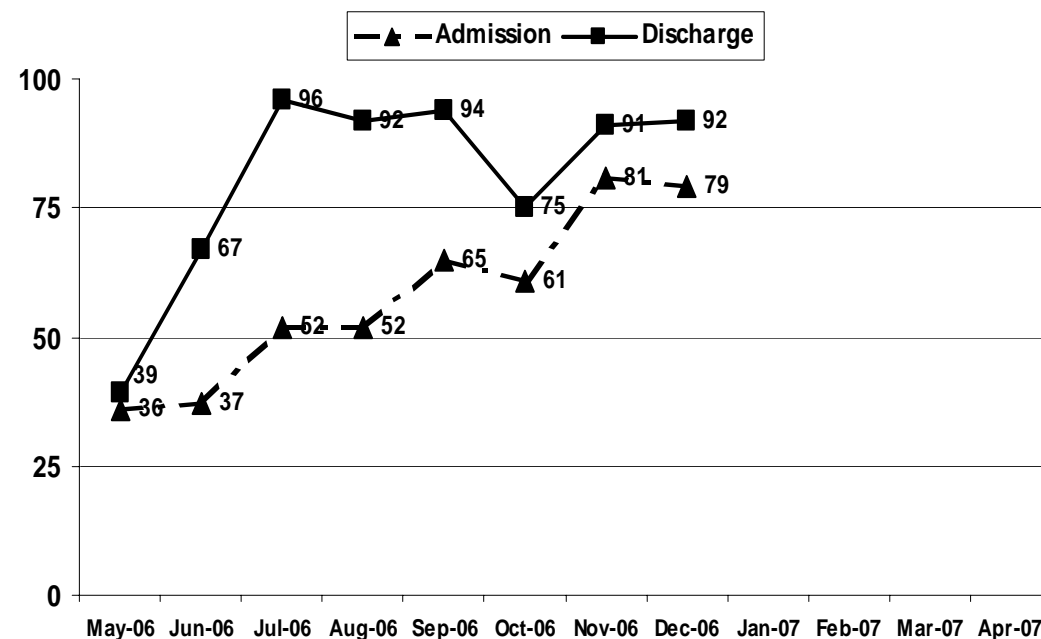
Begin by understanding the importance of clear discharge instructions for all patients and particularly heart failure patients. These instructions review diet, exercise, medication issues, what to do if their condition worsens, and other important issues.

So, take deliberate time out as a new patient is admitted or transferred to your team and ask is this patient appropriate for placement on the CHF pathway. If the answer is “Yes,” initiate a CHF pathway order. This order can be placed at any time during the hospitalization. The pathway contains the discharge instructions for the patient.

You can also help through your documentation in the chart. We recognize our heart failure patients have many co-morbidities and can be admitted for many reasons unrelated to their heart failure. It can be challenging for our coders to assign the Principle Diagnosis. If this is not an admission for heart failure, be clear in stating this in your Progress Notes and Discharge Summary. This type of documentation can help us be sure that only CHF patients whose admission was precipitated by their heart failure are included in our publicly reported data and truly does reflect how well we care for heart failure patients.

*S Haas
D Thomases
D Whalen*

Confidential Peer Review % of Correctly Completed Medication Reconciliations Medicine



Progress being made in medication reconciliation:

Good work but more to do!

As you can see from the chart above, the Medicine Service has made significant strides in the area of medication reconciliation. Thank you! It is a major patient safety effort and already, numerous errors have been caught which could have had profound effects on our patients.

“Real” medication reconciliation is hard. It takes time and thoughtfulness and clearly helps reduce the number of medication related adverse events, the #1 modifiable cause of adverse events in patients. It requires you to be sleuths as you consider what the “true” pre-hospital medication list consists of. It takes an ounce or two of your Type A personalities on transfers and discharge to make sure that all the medications that should be stopped are stopped all the appropriate new medications are added, considering the pre-hospital list. Moreover, it takes good communications skills so that your patients understand these changes and their subsequent providers are also crystal clear on the medication changes that have occurred. Like I said, this isn’t easy. But it is important.

The data we have collected from audits tells us we, in Medicine, are doing a pretty good job making sure the medication calendar is generated. We hope, though the audit cannot confirm this, that they are also accurate. That is clearly critical! In terms of the biggest room for improvement, we continue to be lax in completing medication reconciliation on admission in about 1 in 4 patients. This means filling out the entire medication list, including whether the medication is to be continued or not and why. Please continue your hard work and focus on medication reconciliation to protect your patients. Thank you.

J Greenwald

**The inpatient service redesign:
Improving patient care and education**

In an effort to address significant issues regarding our current admissions process and its effect on patient care, resident education, hours of work, and patient flow, a committee was charged to openly explore solutions for all of these issues. The committee included representation from the training program, faculty, nursing and all PGY levels of housestaff. The goals of this committee were to openly explore and propose solutions to improve:

- Improved patient safety and flow - reducing the need for hand offs (e.g. short call admissions)
- Maximize educational opportunities for teaching
- Be in full compliance with the ACMGE work hours
- Optimize numbers of admissions and team census
- Promote patient centered care (including geographic localization)

Over the past ten years (1996-2006) since the merger and formation of the Boston Medical Center, our success as an institution has resulted in increasing numbers of inpatient admissions. It is readily apparent that this increased volume has led to a number of serious concerns regarding patient care and education. These concerns include: teams are admitting too many patients to be able to adequately accomplish the simultaneous missions of patient care and education. For example, teams routinely care for greater than 80 and at times greater than 100 admissions per month. The previous analysis of our current system suggests that a more appropriate number of admissions/month is in the mid 70's.

In addition attending physicians are finding it increasingly difficult to have enough dedicated time to do an optimum inpatient teaching job. The night float system, as currently structured, has led to many patients being passed on the following morning as short call admissions to teams staffed by physicians other than those who initially admitted the patient.

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This has led to serious problems with patient hand offs, patient flow problems, and a significant duplication of work. Other systems have become more complex including the discharge planning process. This has also impeded patient flow. The discharge process is being addressed by a separate committee, chaired by Dr. David Halle. The overall number of patients, patient flow problems, and overall work load of this system has led to problems complying with the 80 hour work week and more specifically with the 10 hour off between long call shifts rule.

The committee met weekly on Monday evenings from 5-8 PM for 2 months and openly explored proposals to improve patient care and educational systems. Committee meetings were lively and purposefully considered creative solutions that would be both robust and durable for years to come. Our proposed solutions were guided by the following agreed upon goals:

- Interns should admit their own patients. (eliminate short call)
- House officer call hours should adapt to patient "flow". (stagger shifts)
- Handoffs should be only within teams. (internalize night float system)
- Increase educational time. (optimize number of admits and team census)
- Limit long call shifts to 16 hours. (decrease acute and chronic fatigue)

Plans for next year include:

- Leave Heme-Onc and Geriatrics teams as is.
- Increasing the number of general medical teams on Menino to 8.
- Increasing the number of teams on ENC to 6. (4 general medicine, 1 Family medicine, 1 renal)
- Continue to support and expand PA's and Hospitalists on ENC.

These changes will allow all the goals outlined above to be accomplished. Details of the call schemes and admitting schedules are being vetted and plans for a pilot are being developed for late spring in order to be fully ready for July '07.

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These detailed plans will be distributed over the coming weeks.

Importantly we are able to achieve these goals without increasing the compliment of our house officer numbers, improving hours of work, increasing educational time, decreasing weekend coverage responsibilities, and not increasing percentages of inpatient time per house officer.

These changes are a remarkable achievement and advance for our program. We thank all involved for their creativity, thoughtfulness, and long hours involved. Stay tuned.

D Battinelli

FLU SEASON IS NOT OVER!!!

NEITHER IS FLU SHOT SEASON!!

See our progress below towards our goal of vaccinating 1500 intients this season!

Please help us protect our patients and reach our goal!

