The Nursing Organizations Alliance (The Alliance) was formed when two long-standing coalitions of nursing organizations united to create an enduring collaborative that would promote a strong voice and cohesive action to address issues of concern to the community of nursing. The historic vote to create The Alliance occurred on Nov. 17, 2001, at a special meeting of the Nursing Organizations Liaison Forum (NOLF) and the Nursing Organizations Liaison Forum (NOLF) member organizations in Salt Lake City, UT. The purpose of the Alliance is to provide a forum for identification, education and collaboration building on issues of common interest to advance the nursing profession. Membership in the Alliance is open to any nursing organization whose focus is to address current and emerging nursing and health care issues. Structural nursing components of a multi-disciplinary organization are also welcome to join.

Infusion Nurses Society
American Association of Critical-Care Nurses
International Association of Forensic Nurses
American Association of Diabetes Educators
Association for Radiologic & Imaging Nursing
American Society of PeriAnesthesia Nurses
American Nephrology Nurses’ Association
National Student Nurses’ Association Inc
National Association of School Nurses
American Association of Heart Failure Nurses
American Association of School Nurses
American Society of Plastic Surgical Nurses
American Academy of Nurse Anesthetists
Association for Radiologic & Imaging Nursing
American Academy of Nurse Practitioners
American Association of Hospital Pharmacists
American Society of PeriAnesthesia Nurses
The Alliance Nursing Organizations Alliance
American Society of PeriAnesthesia Nurses
National Council of State Boards of Nursing
American Society of PeriAnesthesia Nurses
Academy of Medical-Surgical Nurses
American Society of PeriAnesthesia Nurses
Society of Trauma Nurses
American Nephrology Nurses’ Association
American Association of Critical-Care Nurses
Association of Pediatric Hematology/Oncology Nurses
American Nephrology Nurses’ Association
American Nephrology Nurses’ Association
American Nephrology Nurses’ Association
American Nephrology Nurses’ Association
American Nephrology Nurses’ Association
ADVANCE IN DOCUMENTATION TOOLS VALUABLE IN NURSING CLINICAL EXCELLENCE (ADVANCE)

Authors: Wendy Kloepk, RN, MSHI, PMP and Maria Carter, RN, BSN - Innovation Integration Center - Vanderbilt Medical Group - Vanderbilt University Medical Center

OBJECTIVE:
To describe integration opportunities developed within the Electronic Health Record (EHR) and the importance of this technology to support nursing clinical workflows within the outpatient care setting.

INTRODUCTION:
Vanderbilt University Medical Center (VUMC) has an estimated 1.25 million visits across the outpatient clinical enterprise, which comprises over 100 clinics. Nurses and clinical staff often have to navigate throughout the EHR to complete clinical documentation for an outpatient encounter, this results in inefficient time being spent navigating for documents and further delays the pre-encounter process and the time it takes to be seen by a provider.

ADVANCE:
ADVANCE provides a consolidated view of all the clinical documentation required to support an encounter thereby streamlining workflows and offering visual reminders of documentation requirements.

Key Features Include:
- Data integration of Documentation Tools
- Faster Review & Entry of Key Clinical Elements
- Visual Prompts for Required Documentation

Benefits of Consolidated View:
- Reduced Frequency of Documentation
- Streamlined Workflow
- More Complete Documentation
- Improved Compliance with Local, State, and Federal Regulatory Agencies
- Support for HITCOH Meaningful Use Mandates

Unintended Benefits:
- More Efficient and Timely Training of New Nurses
- Expanded use by other disciplines

CONCLUSION:
The documentation and data integration offered by ADVANCE has resulted in more efficient and timely training of new nurses and clinical staff. The development of the ADVANCE tool has been met with widespread praise due to the cooperative effort between nurses providing clinical care and the nursing informatics development team. This iterative process ensured an adoptable tool that met requirements stated by the nurses.

WORKFLOW:

ADVANCE USER INTERFACE:

Data Integration in ADVANCE
Clinical documentation tools are available within the ADVANCE user interface, eliminating the need for staff to navigate within the EHR to complete the documentation process.

Customizable Tabs in ADVANCE
Nurse can hide tabs that aren’t used in the clinical workflow and reorder tabs to support different clinical workflows.

Visual Reminders: Patient Quality & Safety Initiative
ADVANCE is used as the mechanism to standardize the Universal Protocol/timeout process in all patient procedural areas. A “new “Procedure”” tab was added as a visual indicator for staff. The tab can be positioned anywhere within the interface to support the different workflows.

Reporting: Universal Protocol Timeout Compliance
All documentation within ADVANCE is linked to a clinical encounter. If the nurse launches ADVANCE outside of an appointment, a prompt will appear. This helps to track compliance with outcome measures.

Faster Review & Entry of Key Clinical Elements
When the nurse clicks on a tab, the information is prefilled, eliminating the need for waiting for information to become available. When the nurse saves the information on a tab, the information is saved to the patient chart and the system automatically advances to the next tab, streamlining the documentation process. If there is any unresolved work, the tab turns red.

Print Encounter Documents
When documentation process is complete, nurse can print the necessary documentation for the provider and/or patient.
Nursing Informatics + Care Management = Success!

Martha Badger, MSN RN-BC CPHIMS
Marie Shea, RN BSN
Neighborhood Health Plan, Boston MA

Summary

Neighborhood Health Plan (NHP) is a not-for-profit managed care organization in Boston, Massachusetts, that insures more than 250,000 members. Sixty-three percent of our membership is Medicaid, 12% is Commonwealth Care, and 25% is commercial. The National Committee for Quality Assurance (NCQA) has accredited NHP since 2008, and has ranked NHP as one of the top 10 Medicaid plans and one of the top 100 commercial plans for the last five years.

In August 2009, NHP implemented an electronic care management system that has helped streamline care management of NHP’s diverse population. NHP’s nurse informaticians harnessed the technology to streamline the care management of NHP’s diverse population, thus reducing the amount of time that care managers spend on administrative tasks and redundant documentation, and increasing the time available for care management activities.

Evidence-based Practice

NHP’s nurse informaticians designed and built additional content such as assessments and care plans, which mimic the functionality of the system’s standard content. This additional content, unique to NHP and its populations, standardizes care management and ensures evidence-based practice.

Collaboration & Communication

The care management system allows care managers to easily communicate and collaborate regarding patients with multiple care management issues.

For example, a diabetes care manager can refer a member who has financial and housing issues to a social care manager by using a Care Management Referral Form. The social care manager in turn completes a Referral Action Form that documents the outcome of the referral. While the patient is co-managed by these two programs, care managers can view each other’s cases and plan their care to meet the patient’s needs.

Lessons Learned

1. Be very liberal with the time frame for project completion
2. Engage end users in the process of workflow modeling, content development, and end user testing
3. Accurately document and continually update design, build, and testing records
Challenges in Utilizing Health Information Technology (HIT) for Clinical Quality Reporting: Analysis of the eMeasure

Amy Sheide, RN, BSN, MPH 3M Health Information Systems Inc.

Historically, the extraction of quality data was obtained through claims information and manual chart review. Today, the Electronic Health Record (EHR) can be leveraged in quality reporting using automated tools. This requires patient data be consistently mapped to standardized terminologies. This poster examines the validity, homogeneity and reliability of the value set components in the 2014 Meaningful Use (MU) eMeasures.

Background:

Goals of the eMeasure

Support best practice according to evidence based care models

Allow comparison of clinical practice across organizations

Uniquely identify clinical concepts

Represent clinical concepts using Data Elements

Implement computer aided data collection

Convert knowledge to clinical practice

Purpose:

Assessment of the 2014 MU eMeasure value sets

Validity

Are the values represented effectively across provider settings?

Are the values representative of the intended audience?

Homogeneity

Are the values generated by the eMeasure values consistent across domains?

Are the values generated by the eMeasure values consistent across providers?

Reliability

Do the values represent the same level of clinical context?

Are the values consistent within and across organizations?

Do the values represent the same level of clinical context?

Methods:

Validating 2014 eMeasure Value Set Metadata

Examining data elements and value sets agreement

Comparing value sets within and across domains

Analyzing values in standard terminologies

Application:

Value sets should be incorporated into a single repository that contains all eMeasure standard terminologies.

The repository must leverage an information model that supports value set metadata.

Organizing clinical data within the repository into domains promotes harmonization of data capture and limits deviation in the current value set creation and implementation process.

Results:

Identical Value Sets with Different OIDs

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<thead>
<tr>
<th>OID</th>
<th>Value Set Name</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.684.0.1132553.1.111 784 2 70 1.7</td>
<td>Palliative Care</td>
<td>103.250009 307563309 507.350009 755761309</td>
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<tr>
<td>2.1.684.0.1132553.1.111 784 2 70 1.7</td>
<td>Hospice Care (regimen therapy)</td>
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</table>

Inconsistent Values for Synonymous Value Sets

<table>
<thead>
<tr>
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<th>Value Set Name</th>
<th>Terminology/Value Count</th>
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<tbody>
<tr>
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<td>CM5355/2</td>
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<tr>
<td>0455, 0638</td>
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<tr>
<td>0730, 0712</td>
<td>Decedent</td>
<td>SNOMED CT 2.1</td>
</tr>
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</table>

Duplicate Value Sets Names

<table>
<thead>
<tr>
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<th>Value Set Count</th>
</tr>
</thead>
<tbody>
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<td>115</td>
</tr>
<tr>
<td>0730, 0712</td>
<td>Decedent</td>
<td>130</td>
</tr>
</tbody>
</table>

Ambiguous Data Category Naming conventions

<table>
<thead>
<tr>
<th>NFO eMeasure</th>
<th>Value Set Name</th>
<th>Terminology/Value Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0046.0062</td>
<td>Kidney Transplant</td>
<td>SNOMED CT 1.2</td>
</tr>
<tr>
<td>0730, 0712</td>
<td>Decedent</td>
<td>SNOMED CT 2.1</td>
</tr>
</tbody>
</table>

Use of Acronyms within Value Set Names

<table>
<thead>
<tr>
<th>Value Set Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Measures - AMI</td>
<td>AMI</td>
</tr>
<tr>
<td>Acute Myocardial Infarction</td>
<td>AMI</td>
</tr>
</tbody>
</table>
**INTRODUCTION**
Cullman Regional Medical Center (CRMC) is a 145-bed medical center in Cullman, AL that serves more than 155,000 residents in a six-county area.

CRMC reengineered its discharge process by implementing an innovative communication solution to improve patient understanding, engagement and compliance of post-hospital care instructions, which resulted in better patient experience and reduced readmissions.

**OBJECTIVES**
1. Blend best practices with technology to improve patient and family engagement in the personalized care plan.
2. Describe ways to engage and empower patients to manage and comply with care directives, follow-up appointments, medications, etc. after discharge.
3. Define ways to audit caregiver and patient communication and monitor compliance.
4. Measure impact on patient satisfaction and readmissions.

**APPROACH**
**Blending Best Practices and Technology**

**Caregivers use the solution to:**
- Record “Live” discharge sessions at the patient’s bedside using a HIPAA/AHIMA compliant application.
- Capture baseline images and instructional care videos.
- Attach or link patient education and other CRMC resources.
- Engage patients (and/or family) using touch back and asking them to listen to the conversation and clarify instructions.

**Patients and families use the solution to:**
- Access “Live” instructions and education 24/7 using any phone, tablet or computer.
- Connect to a personalized website from CRMC to hear, see, and manage discharge instructions.
- Experience a better connection with the hospital.

**OUTCOMES**
**Impacting Readmissions**
Post-implement results within a six-month period indicated a 15% reduction in readmissions when patients accessed their audio discharge instructions via the solution compared to patients who did not.

**Increasing Patient Satisfaction**
Since implementing the solution, CRMC has experienced increases in HCAHPS scores.

Did you get information about what symptoms or health problems to look for after you left the hospital?

Optimizing the Solution
CRMC is expanding the features and functionality of the solution to include tools for:
- Performance and readmission root-cause analysis
- Patient risk stratification and intervention
- Care round workflow management
- Care coordination with skilled nursing facilities
- Measurement of patient and family satisfaction

**Winners**
- 2013 Robert Wood Johnson Foundation Care About Your Care Content Award
- 2013 Nursing IT Innovation Award by Health Data Management
- 2012 Modern Healthcare Spirit of Excellence Award for Patient Safety
Developing a Nurse Driven Vaccine Protocol for an Inpatient Population

David Stabile, MSN, RN; Craig A. Umscheid, MD, MSCE, FACP; Terese Kornet, MSN, RN; Raymond Sutter; Christine Vanzandbergen, MPH, PA-C; Deborah Christopher, MSN, RN, CPHQ;
Denise Gillanelli, RN, BSN, MS; Mary McCann, MBA, RN; Gordon Tait, BS; Asaf Hanish, MPH; Neil Fishman, MD; Mika Epps, MSN, RN
University of Pennsylvania Health System

Introduction

- To comply with new regulations for vaccine administration introduced by the Centers for Medicare and Medicaid Services (CMS) effective January 1, 2012, our health system implemented a nurse-driven vaccine protocol using native functionality in our inpatient electronic medical record (EMR) to ensure for and administer pneumococcal (pneumonia) and influenza (flu) vaccines.

Objectives

- Recognize the teams with the pre-existing workflow in which vaccine assessments and orders were processed
- Describe the technical aspects of the vaccine protocol
- Demonstrate the process and workflow for the same data entry protocol that had been facilitated through the EMR

Project Process/Data Collection

- A multidisciplinary team developed the protocol based on current state vaccine process mapping (Table 1) and Pareto analysis (Table 2) (Figure 1)
- The protocol was developed in an enterprise-wide inpatient EMR system (Allscripts, Chicago, IL) to address all identified barriers and solutions (Figure 2)
- Vaccine policy was updated and mandatory online education modules were provided to nurses to promote education to all nurses
- The vaccine protocol was implemented on August 20, 2012 for pneumococcal vaccine
- Influenza vaccine assessment added at the start of the flu season on September 24, 2012
- We monitored five outcomes (comparisons were tested using chi-square test):
  1. Process improvement outcomes based on vaccine process mapping and Pareto analysis data
  2. Vaccine assessment pre- and post-implementation (Figure 3)
  3. Vaccine administration pre- and post-implementation
  - Pre-implementation data – January 24 to March 3, 2012 (60 days)
  - Post-implementation data – September 25 to November 1, 2012 (46 days)
  4. Immunization score measures pre- and post-implementation
  - Pre-implementation data – March 2012
  - Post-implementation data – October 2012

Process Improvement Tools (Figure 1)

- This figure displays the process flow and the key processes identified for improvement.

The Nurse Driven Vaccine Process in the Inpatient EMR (Figure 2)

- This figure illustrates the nurse-driven vaccine process in the inpatient EMR, focusing on the data entry protocol.

Vaccine Administration Pre and Post Implementation (Figure 4)

- This figure compares the vaccine administration data pre- and post-implementation.

Core Measure Outcomes Pre and Post Implementation (Figure 5)

- This figure shows the core measure outcomes pre- and post-implementation.

Summary

- Process Improvement: Over 90% of identified barriers through vaccine process mapping were addressed, and 17 new vaccine-related items from the CMS were incorporated into the new protocol
- Pareto Analysis: Implementation of an electronic nurse-driven vaccine protocol (Figure 1)
- Vaccine Administration: Both pre- and post-vaccine ordering and assessment compliance rates for vaccine administration were significantly reduced. This indicated the efficiency of the vaccine process and assessment protocol was improved through nurse-driven vaccine protocol (Figure 4)
- Core Measures: Core measure rates were improved and the overall rate for pre- and post-vaccine assessment was significantly increased. This was measured by T-tests (Figure 5)
- Innovation: The key innovation was adopting nurse-driven global vaccine ordering and assessment compliance. By doing this, we were able to reduce the number of vaccine administration errors, and designing the automatic nurse ordering system based on the assessment choice.

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Medication Claim History—Helping Clinicians Give the Best Care

The external medication history, one of the features of ePrescribe, provides a summary of the prescriptions that patients have filled under their prescription plans. The list includes prescription information regarding pharmacy, date filled, and prescribing providers.

Upon registration, the patient information entered is verified against a third party database, pulling in the external medication claim history provided by the patients’ prescription insurance. A year’s worth of information regarding filled prescriptions populate EHR system where clinicians can view details, select medications from the list to add to the patient reported meds, as well as check eligibility for prescriptions.

Having an accurate reported medication list is critical in caring for patients.
The medication claim history helps in ensuring the accuracy of the information provided by patients and family members.

The medication claim history helps in identifying health history information that some patients and family members might fail to remember such as specialty physicians and other pharmaceutical information.

Scenario #1:
Mrs. Jones comes in from home not knowing the name of the medication she is taking. She tells the nurse that she takes 1 white pill for her thyroid. The nurse then looks in Mrs. Jones’ external med claim history and finds out that she has filled 50 mg of Synthroid. The nurse then verifies the last time Mrs. Jones took the medication and adds it to the patient home med list as part of the Medication Reconciliation process.

Scenario #2:
Mrs. Jones comes through the ER with chest pains and states that she’s being managed by a Cardiologist for her arrhythmias. She, however, does not remember his name. The physician then uses the external med claim history to see who Mrs. Jones Cardiologist is and is able to confer with him regarding her care.

Scenario #3:
Mrs. Jones is ready to go home but needs prescriptions. Her daughter offers to pick up the prescriptions but does not remember the name of the pharmacy two blocks from where she lives. The physician looks up Mrs. Jones pharmacy through the external med claim history and sends the prescription electronically.

The external medication claim history puts health care informatics in practice. With the help of this technology, clinicians are able to provide the best possible patient care.
Implications of mobile information communication technology for clinical practice: Can it help clinicians manage interruptions and cognitive overload?

Introduction

Teamwork is an essential aspect of the healthcare delivery system. Timely and accurate information exchange among care team members is a prerequisite for safety and optimum outcomes of the patient. Despite this, clinical team communication has been challenging, and perhaps increasing in today's acute-care environments with older patients requiring timely multiple clinicians coordination in an ever complex system.

At the same time, smartphones and other mobile information communication technology (ICT) are almost ubiquitous now. Clinicians are using varying degrees of mobile ICT for their practice.

An increasing number of studies examine the effects of mobile ICT on clinical team communication. However, most existing studies are limited to descriptions of ICT usage and ad hoc design. This poster attempts to take a high-level approach in analyzing clinical team communication and its surrounding concepts, then discusses specific features of mobile ICT that may assist in overcoming the challenges clinicians face today.

Objectives

1. Describe the nature of clinical team communication and the state of mobile ICT utilized among clinicians in acute care settings.
2. Identify important factors and features of mobile ICT that may be relevant and beneficial for nursing/clinical practice.
3. Discuss the implications of mobile ICT for clinical/healthcare practice in the current context of rapidly evolving technologies and time critical acute-care environment.

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Arapel Kelemen, PhD
Associate Professor
University of Maryland School of Nursing

Methods

The main method employed was a scholarly literature review of nurse-practitioner information communication, clinical teamwork, clinical workflow disruption and clinical communication via mobile ICT, using a meta-analysis approach.

Scholarly literature was supplemented by current reputable news articles (such as Healthcare IT News and white papers on HIMSS), due to the extremely rapid development and deployment of ICT in healthcare.

As the findings were synthesized, various interconnected concepts around clinical team communication emerged. These concepts were then arranged based on distinct aspects of the clinical environment. A model was created in order to visualize these intricate and complex relationships.

Clinical Team Communication, Interruptions and Cognitive Load of Clinicians

Interruption has been cited as a major stressor for clinicians; at the same time traditionally regarded as an important safety feature of clinical work.

Cognitive (also referred to as communication or information) load of clinicians appears as a potentially important link between clinician performance, communication and technology (which may also be related to usability of the system, including EHR). Evidence from psychology also suggest association of the clinical environment, interruptions and cognitive load of clinicians.

The State of Mobile ICT in Acute-Care Environment

- Clinical mobile ICT usage in hospital setting - 49% of hospital nurses use their smartphones for clinical and personal use.
- Hospital IT has struggled to keep up with staff demand for ICT and mobile computing technologies. Clinician’s priority “Bring Your Own Device” (BYOD) policy which is difficult to enforce.
- An increasing number of ICT products available e.g. integration of nurse calls to mobile ICT via middleware, various apps for smartphones, and industry reports that some hospitals embrace them.
- There is a variety of security and privacy concerns related to mobile ICT. Hospitals and vendors have been working to strengthen them, primarily technologically and administratively (Crime Tech), but not as much on how staff use it.
- 75% of surveyed organizations (N=166, Feb, 2012) allow clinicians to access clinical data via mobile devices using policy network.
- Although still limited, evidence is emerging on advantages and disadvantages of mobile ICT for acute-care clinical teams (depicted in the table on the right).

Discussion & Implications

Because of the unique requirements of the clinical environment, "verbal" communication and interruption would remain necessary for time-critical situations. The important implications for mobile ICT then may be controlling unnecessary interruptions and cognitive overload.

Evidence suggests asynchronous modality (e.g. email, SMS) may be support for most clinical communication. Although usable system for clinicians should be developed. However, a few studies claim that ICT may deteriorate interprofessional communication as users struggle with proper use of new technology. Proper training, particularly developing guidelines for ICT team communication would be necessary.

It is important for clinicians to consider specific features that would actually support their practice and how they may communicate most effectively. Especially, nursing responsibilities can be extremely multiple and require physical teamwork. A hands-free feature may be helpful for quick team communication or obtain help. Additionally, nurses frequently at the center of the patient care team, may have a role to gain with the right mobile ICT, therefore, they should be active participants in developing the right products.

Summary

A cross-disciplinary literature review on clinical team communication suggests that interruption and cognitive overload may be leading to clinical safety and efficiency. However, they may be closely associated with various requirements of clinical environments which are difficult to change.

The emerging mobile ICT literature indicates a wide range of features that can be either beneficial or problematic for clinical team communication. There is evidence that ICT offers the capability of reaching the right clinician at the right time; at the same time, it can produce unnecessary interruptions.

Mobile ICT appears to have almost unlimited potential, and it is actively being developed and deployed rapidly. It appears extremely important for clinicians to be aware of possible advantages and disadvantages of this technology now, and be active participants in creating a better clinical environment for clinicians and the patient.
Solutions to the Challenges of Bar Code Scanning Failures

Carmel B. Sanchez, MA, RN
Department of Veterans Affairs New York Harbor Healthcare System

Raymond Fletcher, RN

Setting
Bar Code Medication Administration (BCMA) system is designed for patient safety and to enhance patient care. BCMA Managing Scanning Failures (MSF) software captures every scanning failure event. Its purpose is to create reports notifying Nursing Informatics (NI) & Pharmacy of scanner by-pass events to resolve issues of scanning failures.

Learning Objectives
1. Identify factors resulting in medication scanning failures.
2. Formulate solutions based on identified UTS events.
3. Develop a plan to reduce incidences of medication scanning failures.

Problems
- Damaged medication label: smudged, faded, crimped, torn.
- No bar code: Medication sent to the units without a bar code.
- Unable to determine: Pharmacy failed to scan medication in the drug file.
- Dose discrepancy: Pharmacy processing error with discrepancy between dose dispensed in BCMA & medication on hand.
- Scanning equipment failure: loss of connectivity of scanner gun on the scanner base.

Outcomes
BCMA MSF results in July 2012 indicate reductions in the incidences of medication scanning failures in all 3 campuses.
- Brooklyn 82%
- New York 73%
- Saint Albans 38%

Further Measures
- Identify NI as the champion.
- Run UTS report & resolve issues daily.
- NI conduct unit rounds, daily communication with nurses, check equipment & collect unscanable medication packets.
- Email is sent to inaccessible staff.
- Medication pass observation.
- Educate nurses on BCMA MSF via web-based training.

Conclusions
Data reveal the BCMA MSF software identifies scanning failures. Its ability to generate reports alert NI and pharmacy to provide immediate support to the nurses in correcting unscanable medications. As a result, such actions improve patients’ safety, care delivery, satisfaction and efficiency in medication administration.

Conclusion
Nurses are informed to charge scanner when not in use and to dock scanner properly.
Nurses report defective scanner to IRM & WHEN supervisor.

Medication UTS Reasons

Medication By-pass Unable To Scan (UTS) Events

<table>
<thead>
<tr>
<th>Location</th>
<th>May 09</th>
<th>July 12</th>
</tr>
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<tbody>
<tr>
<td>Brooklyn</td>
<td>584 (1.18%)</td>
<td>81 (0.21%)</td>
</tr>
<tr>
<td>New York</td>
<td>986 (1.26%)</td>
<td>265 (0.36%)</td>
</tr>
<tr>
<td>Saint Albans</td>
<td>347 (0.4%)</td>
<td>184 (0.25%)</td>
</tr>
</tbody>
</table>

Total Medication Attempts: 49,476

Medication UTS Reasons

- No Barcode: Pharmacy confirm that all medications are bar coded. Pharmacy to affix medication bar code label. Inform the National bar code office.
- Unable to Determine: Pharmacy scan all new medications into VISTA drug file. Pharmacy eliminate duplicate entries in the drug file. Nurses save unscanable medications. NI educate nurses on proper barcode scanning technique & to select the appropriate UTS reason.
- Dose Discrepancy: Pharmacy confirm correct dispense medications before sending meds to the units. Nurses call pharmacy to correct dispense dose in BCMA to match medication on hand.
- Scanning Equip Failure: Nurses are informed to charge scanner when not in use and to dock scanner properly. Nurses report defective scanner to IRM & WHEN supervisor.
Scoring a GOAL!
Transitioning the Plan of Care from Paper to Electronic

Lynn Mullin MSHI, RN; Marcie Brostoff MSN, RN; Stephanie Altavilla, MSMI, RN

Purpose:
Regulatory agencies require a plan of care for every patient. CMS relaxed their regulations in 2011 to allow one plan of care for all disciplines, no longer requiring a nursing specific plan of care. This, along with a decline in use of paper management plans, led us on a mission to build a plan of care that would tell a story of our patients hospitalization.

Methods:
The Caredex was a view within the EMR which displayed information from various parts of the chart to provide a patients clinical picture to clinicians. To get a complete picture though, RNs were required to also use a paper management plan that would outline the problems and/or goals for the patient. Being the only piece of documentation that remained on paper, it was difficult to keep up to date and ultimately was not utilized. Initially we compared existing paper managements plans to find a common themes amongst problems and goals. We then worked with a core group of RN Subject Matter Experts (SMEs) to collaborate and defined a list of 30 patient oriented goals. The group also came up with a common list of expected completion timeframes for every goal. Moving from problem oriented care plans to goal oriented plans was a tremendous change in practice. With the incorporation of the patient goals, it made sense that the name of the view be changed from the Caredex to the Plan of Care.

Outcomes:
The Plan of Care was implemented with the help of SMEs and unit based educators. Daily monitoring occurred for 4 weeks to provide immediate feedback to staff regarding the use of the new goals section. Sustained use of the plan of care including the patients goals has remained high. Staff remain satisfied with the change in semantics and the streamlined documentation into the electronic medical record.

Future Steps:
- Widespread implementation and knowledge sharing of goal driven care
- Develop into an interdisciplinary plan of care
- Mobile app development for goal driven care plan

Lessons Learned for Successful Implementation:
- Provide feedback about clinician usage with daily reports
- Determine if design limitations or workflow issues exist prior to implementation by obtaining clinician input