

# Advancing Patient Safety in the ED: Risks, Challenges and Corrective Initiatives

Tuesday, May 5<sup>th</sup>, 2015



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# Speaker



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- Call with Questions No emails

# Objectives

- Describe suicidal patient safety measures for the ED.
- Describe restraint standards that must be followed.
- Explain why verbal orders are some of the most common problematic standards.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

# Headlines About Patient Safety in Hospitals

## How to Survive Your Hospital Stay

Hospitals aren't always safe havens, as hazards include surgical errors, infections and falls.



# Evidenced Based Study on Patient Harm

- IOM estimated that there are 98,000 patients a year who die from medical errors
- Study published in the Journal of Patient Safety in 2013 estimated that there are 400,000 premature deaths associated with preventable harm to patients
- Serious harm seems to be 10-20 fold more common than lethal harm
  - Use the Global Trigger Tool
- Author said the epidemic of patient harm in hospitals must be taken more seriously to be curtailed

# 400,000 Preventable Deaths a Year

## REVIEW ARTICLE

[http://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A\\_New,\\_Evidence\\_based\\_Estimate\\_of\\_Patient\\_Harms.2.aspx](http://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A_New,_Evidence_based_Estimate_of_Patient_Harms.2.aspx)

### A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care

*John T. James, PhD*

**Objectives:** Based on 1984 data developed from reviews of medical records of patients treated in New York hospitals, the Institute of Medicine estimated that up to 98,000 Americans die each year from medical errors. The basis of this estimate is nearly 3 decades old; herein, an updated estimate is developed from modern studies published from 2008 to 2011.

**Methods:** A literature review identified 4 limited studies that used primarily the Global Trigger Tool to flag specific evidence in medical records, such as medication stop orders or abnormal laboratory results, which point to an adverse event that may have harmed a patient. Ultimately, a physician must concur on the findings of an adverse event and then classify the severity of patient harm.

**Results:** Using a weighted average of the 4 studies, a lower limit of 210,000 deaths per year was associated with preventable harm in hospitals. Given limitations in the search capability of the Global Trigger Tool and the incompleteness of medical records on which the Tool depends, the true number of premature deaths associated with preventable harm to patients was estimated at more than 400,000 per year. Serious harm seems to be 10- to 20-fold more common than lethal harm.

**Conclusions:** The epidemic of patient harm in hospitals must be taken more seriously if it is to be curtailed. Fully engaging patients and their advocates during hospital care, systematically seeking the patients' voice in identifying harms, transparent accountability for harm, and intentional correction of root causes of harm will be necessary to accomplish this goal.

**Key Words:** patient harm, preventable adverse events, transparency, patient-centered care, Global Trigger Tool, medical errors

*(J Patient Saf 2013;9: 122-128)*

the national level. The amount of new knowledge generated each year by clinical research that applies directly to patient care can easily overwhelm the individual physician trying to optimize the care of his patients.<sup>1</sup> Furthermore, the lack of a well-integrated and comprehensive continuing education system in the health professions is a major contributing factor to knowledge and performance deficiencies at the individual and system level.<sup>2</sup> Guidelines for physicians to optimize patient care are quickly out of date and can be biased by those who write the guidelines.<sup>3-5</sup> At the system level, hospitals struggle with staffing issues, making suitable technology available for patient care, and executing effective handoffs between shifts and also between inpatient and outpatient care.<sup>6</sup> Increased production demands in cost-driven institutions may increase the risk of preventable adverse events (PAEs). The United States trails behind other developed nations in implementing electronic medical records for its citizens.<sup>7</sup> Hence, the information a physician needs to optimize care of a patient is often unavailable.

At the national level, our country is distinguished for its patchwork of medical care subsystems that can require patients to bounce around in a complex maze of providers as they seek effective and affordable care. Because of increased production demands, providers may be expected to give care in suboptimal working conditions, with decreased staff, and a shortage of physicians, which leads to fatigue and burnout. It should be no surprise that PAEs that harm patients are frighteningly common in this highly technical, rapidly changing, and poorly integrated industry. The picture is further complicated by a lack of transparency and limited accountability for errors that harm patients.<sup>8,9</sup>

There are at least 3 time-based categories of PAEs recog-

# HHS Report May 7, 2014

- HHS announces that data shows a reduction in hospital induced harm
- QI and patient safety initiatives prevented 15,000 deaths in hospitals, avoided 560,000 patient injuries
  - It also reduced health care spending by \$4 billion
  - Shows a 8% decrease in hospital readmissions
  - Reduced HAI from 145 to 132 per 1,000 discharges
- The public and private partnerships are working to help spread best practices
  - <http://innovation.cms.gov/Files/reports/patient-safety-results.pdf>

## News

FOR IMMEDIATE RELEASE  
May 7, 2014

Contact: HHS Press Office  
(202) 690-6343

### **New HHS data show quality improvements saved 15,000 lives and \$4 billion in health spending**

*Hospital Readmissions Fall by 8 percent among Medicare beneficiaries*

Today, the Department of Health and Human Services announced that new preliminary data show an overall nine percent decrease in hospital acquired conditions nationally during 2011 and 2012. National reductions in adverse drug events, falls, infections, and other forms of hospital-induced harm are estimated to have prevented nearly 15,000 deaths in hospitals, avoided 560,000 patient injuries, and approximately \$4 billion in health spending over the same period.

The Affordable Care Act is also helping reduce hospital readmissions. After holding constant at 19 percent from 2007 to 2011 and decreasing to 18.5 percent in 2012, the Medicare all-cause 30-day readmission rate has further decreased to approximately 17.5 percent in 2013. This translates into an 8 percent reduction in the rate and an estimated 150,000 fewer hospital readmissions among Medicare beneficiaries between January 2012 and December 2013.

"We applaud the nationwide network of hospital systems and providers that are working together to save lives and reduce costs," said HHS Secretary Kathleen Sebelius. "We are seeing a simultaneous reduction in hospital readmissions and injuries, giving patients confidence that they are receiving the best possible care and lowering their risk of having to be readmitted to the hospital after they get the care they need."

These improvements reflect policies and an unprecedented public-private collaboration made possible by the Affordable Care Act. The data demonstrates that hospitals and providers across the country are achieving reductions in hospital-induced harm experienced by patients. These major strides in patient safety are a result of strong, diverse public-private partnerships and active engagement by patients and families, including efforts from the federal Partnership for Patients initiative and Hospital Engagement Networks, Quality Improvement Organizations, the Centers for Medicare & Medicaid Services, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Administration on Community Living, the Indian Health Services, and many others.

The public-private partnerships are working collaboratively – along with health care providers – to identify and spread best practices and solutions to reducing hospital acquired conditions and readmissions.

# Measuring Patient Safety in the ED

- Recent article recommend developing performance indicators to measure patient safety in the ED
- Practical score cared for measuring patient safety over time has been lacking
- Article proposes a frame work through 4 domains
  - How often are patients harmed
  - How often are appropriate interventions delivered
  - How well errors are identified and corrected
  - ED safety culture
- Am J Med Qual. 2014 Mar-Apr;29(2):99-104

Impact Factor: 1.471 | Ranking: 53/83 in Health Care Sciences & Services

## Measuring Patient Safety in the Emergency Department



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### Abstract

As a safety net for the health care system, quality and safety performance in emergency medicine (EM) is important for policy makers, insurers, researchers, health care providers, and patients. Developing performance indicators that are relevant, valid, feasible, and easy to measure has proven difficult. To monitor progress, patient safety should be measured objectively. Although conceptual frameworks and error taxonomies have been proposed, a practical scorecard for measuring patient safety over time in EM

# ED Patient Safety Issues

- There are many patient safety issues
- Inpatient suicides, falls, medication errors, alarm fatigue, fatigue, wrong site surgery, restraint injuries, elopement, retained foreign objects, delay in diagnosis, infant abduction, misdiagnosis, communication errors, transfusion errors, surgical site infection, Heparin complications, Warfarin complications, critical lab results, skin tears, alarm fatigue, improper hand offs, MRI safety, infections like MRSA and VRE,

# The Faces We Should Remember



- Josie King died at 18 months as a result of a hospital error from severe dehydration and misused narcotics
- Condition H now allows families to call a RRT
- Sorrell King has started a foundation to improve patient safety in healthcare

# The Faces We Should Remember



- Ben Kolb, a 7 year old scheduled for elective ear surgery
- The surgeon injected with Lidocaine around the ear to numb the area
- He went in a cardiac arrest and died
- Martin Memorial Hospitals does a full investigation
- He had accidentally been given concentrated Epi which was poured into a unmarked sterile container
- Many Epi medication errors in the ED

# ERCI 2015 Top 10 Patient Safety Issues

- ECRI Institute publishes list of top ten patient safety issues in 2015
- ECRI is a PSO and the list is the result of patient safety event reports, research requests, and root-cause analyses (RCA) submitted to ECRI
- Also from knowledge gained through investigating incidents, observing and assessing hospital practices, and reviewing health-technology-related problem reports
- Mislabeled lab specimens and patient falls while toileting still remains a concern

# ERCI 2015 Top 10 Patient Safety Issues

## Top 10 Patient Safety Concerns for Healthcare Organizations

# 2015



# ERCI 2015 Top 10 Patient Safety Issues

1. Alarm hazards: inadequate alarm configuration policies and practices
  - Do you have a monitor watcher in the ED?
  - How do you make sure if a monitor goes off in the ED that someone goes in to assess the patient
  - Remember the issue of alarm fatigue where there are so many things that beep that staff may not hear the alarm
  - It is a Joint Commission (TJC) NPSG (National Patient Safety Goal) and as of 2016 must have P&P to manage alarms identified by the hospital
  - Discussed in detail later

# ERCI 2015 Top 10 Patient Safety Issues

2. Data integrity: incorrect or missing data in EHRs and other health IT systems
  - Create an EHR that includes all of the required documentation elements
  - Technology can create safety risks if not designed appropriately or implemented correctly
  - Missed data so no allergy recorded and ED patients gets medication she is allergic to
  - Initially missed diagnosis of EBOLA in Texas ED was reported to be due to ED physician not being able to see ED triage nurses notes but later recanted
  - Outdated information being copied and pasted into chart

# ERCI 2015 Top 10 Patient Safety Issues

## 3. Managing patient violence

- Major issue in the ED and with the Emergency Nurses Association (ENA) and American College of Emergency Physicians (ACEP)
- Accounts for 900 deaths and 1.7 million non-fatal assaults every year
- ENA has many excellent workplace violence resources along with a study of the problem and a violence position statement at [www.ena.org/government/State/Pages/WVResources.aspx](http://www.ena.org/government/State/Pages/WVResources.aspx)
- ENA has workplace violence toolkit at [www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/toolkitpg1.htm](http://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/toolkitpg1.htm)
- Staff need proper training to recognize : CPI, MOAB, etc.
- TJC requires de-escalation training. See PC.01.01.01 EP 4 and 24

# ACEP Violence in the ED Policy

## Protection from Physical Violence in the Emergency Department Environment

[www.acep.org/Clinical---Practice-Management/Protection-from-Physical-Violence-in-the-Emergency-Department-Environment/](http://www.acep.org/Clinical---Practice-Management/Protection-from-Physical-Violence-in-the-Emergency-Department-Environment/)

Revised and approved by the ACEP Board of Directors June 2011 and April 2008

Reaffirmed by the ACEP Board of Directors October 2001 and October 1997

Originally approved by the ACEP Board of Directors January 1993

The American College of Emergency Physicians (ACEP) believes that optimal patient care can be achieved only when patients, health care workers, and all other persons in the emergency department (ED) are protected against violent acts occurring within the department. As such, ACEP advocates for increased awareness of violence against health care workers in the ED and for increased safety measures in all EDs. Further, ACEP encourages all states to enact legislation that provides a maximum category of offense and criminal penalty against individuals who commit violence against health care workers in the ED.

To ensure the security of the ED environment, the hospital has the following responsibilities:

- Provide a best-practices security system including adequate security personnel, sufficient training of personnel, physical barriers, surveillance equipment, and other security components.
- Coordinate the hospital security system with local law enforcement agencies.
- Develop written emergency department protocols for violent situations occurring in the ED to ensure the safety of patients and health care workers alike.
- Educate staff on preventing, recognizing, and dealing with potentially violent situations.
- Conduct ongoing assessments of the ED security system performance.
- Maximum criminal prosecution will be pursued against those individuals who commit violent acts against health care workers, when deemed appropriate, based on the circumstances of the incident.

Additionally, ACEP recognizes that the EMS system is an integral component of emergency care and supports and encourages efforts to protect EMS personnel against physical violence in the prehospital

# ERCI 2015 Top 10 Patient Safety Issues

4. Mix-up of IV lines leading to misadministration of drugs and solutions
  - CMS now requires nurses to trace back or evaluate all IVs and tubes when getting out of report and to verify everything is current and consider labeling each infusion line
  - CMS requires the nurse to verify that the infusion rate is correct also and hospital should have a P&P
  - CMS has issued a tubing misconnection memo
  - TJC has issued a sentinel event alert
    - Case reported to ECRI was patient sent from the ED to the CCU and when arrived Heparin bag was empty because ED nurse mixed up the two IVs

# Luer Misconnections Memo

- CMS issues memo March 8, 2013
- This has been a patient safety issues for many years
- Staff can connect two things together that do not belong together because the ends match
  - For example, a patient had the blood pressure cuff connected to the IV and died of an air embolism
  - New connectors being developed
- Luer connections easily link many medical components, accessories and delivery devices

# Luer Misconnections Memo

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Center for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-23-18  
Baltimore, Maryland 21244-1890



Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-14-ALL

**DATE:** March 8, 2013  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Survey and Certification Group  
**SUBJECT:** Luer Misconnection Adverse Events

## Memorandum Summary

- **Luer Misconnections continue to result in adverse events and deaths** – Luer connectors easily link many medical components, accessories, and delivery systems. Clinicians, in any type of provider or supplier setting, can mistakenly connect the wrong devices and deliver substances through the wrong route. Despite numerous alerts and warnings, a patient's blood pressure tubing was recently misconnected to an intravenous (IV) line in an ambulatory surgery center (ASC) resulting in a patient death.
- **Adverse Event Complaint Investigation:** During a complaint investigation for an adverse event involving delivery of an incorrect substance or utilization of an incorrect delivery route, surveyors must be alert to whether the event involved misconnection of a Luer device. If so, surveyors must determine whether the facility has taken actions to ensure systems are in place to prevent recurrence of this type of adverse event.
- **Facility Reporting to Food & Drug Administration (FDA):** Surveyors should encourage health care facilities to report problems with Luer misconnections to the FDA, even if no adverse event occurred.

# PA Patient Safety Authority Article

**Table. Tubing Misconnections Reported to the Pennsylvania Patient Safety Authority, January 2008 to September 2009**

MISCONNECTION	NUMBER OF REPORTS
Secondary intravenous (IV) infusion connected to lower "Y" port of primary IV tubing set	8
Hemodialysis arterial and venous tubing lines reversed	5
G-tube and J-tube lines reversed	3
Incorrect tubing connection (no further explanation provided in reports)	3
Epidural and patient-controlled analgesia (PCA) tubing sets reversed	2
Nonhemodialysis arterial and venous tubing lines reversed	2
Cell saver tubing connected to cell saver reservoir	1
Feeding tube set connected to Broviac®	1
Feeding tube set connected to peripherally inserted central catheter (PICC) line	1
Feeding tube set connected to suction port	1
Imaging contrast tubing set connected to tracheostomy cuff	1
IV tubing set connected to dialysis catheter	1
IV tubing set connected to PICC line	1
IV tubing set connected to tracheostomy cuff	1
Knee irrigation connected to peripheral IV tubing	1
Miscommunication (arterial line noted in medical record as peripheral IV)	1
Oral medication delivered through peripheral IV line	1
Suction line connected to water seal	1
Suction and feeding tubing sets reversed	1
<b>Total</b>	<b>36</b>

# TJC Sentinel Event Alert #36

www.jointcommission.org

The screenshot displays the homepage of The Joint Commission website. At the top left is the logo for The Joint Commission. To the right of the logo are links for "Log In | Request Guest Access" and "Forgot password? | Log in Help". Further right are links for "Contact Us | Careers | JCR Web Store | Press Room". A search bar is located below these links. A navigation menu includes "Accreditation", "Certification", "Standards", "Measurement", "Topics", "About Us", and "Daily Update". Below the navigation menu is a breadcrumb trail "Home > Topic Details" and a date "Monday 9:14 CDT - April 23". A sidebar on the left contains a "Sign up for News and Alerts" box with a "Sign up here" button. The main content area is titled "Topic Library Item" and features the headline "Sentinel Event Alert, Issue 36: Tubing misconnections—a persistent and potentially deadly occurrence" dated "April 3, 2018". Below the headline is a "Download This File" button. The text below the button states: "Tubing and airway misconnection errors are an important and under-reported problem in health care organizations. In addition, these errors are often caught and corrected before any injury to the patient occurs. Given the reality of and potential for life-threatening consequences, increased awareness and analysis of these errors—including avoided errors—can lead to dramatic improvement in patient safety." To the right of the text is an image of a tangled piece of clear medical tubing. On the far right, there is a vertical social media sharing bar with icons for Twitter, Facebook, Pinterest, LinkedIn, and a plus sign for more options.

# Managing Risk During the Transition

## *Sentinel* Alert *Event*

A complimentary publication of The Joint Commission  
Issue 53, August 20, 2014

Published for Joint Commission accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

### Managing risk during transition to new ISO tubing connector standards

Tubing misconnections continue to cause severe patient injury and death, since tubes with different functions can easily be connected using luer connectors, or connections can be “rigged” (constructed) using adapters, tubing or catheters. This is why new ISO (International Organization for Standardization) tubing connector standards are being developed for manufacturers. Through an international consensus process, the standards are being developed, tested and approved to assure reliable designs and processes. The phased implementation of redesigned tubing connectors that are the result of these new ISO connector standards begins now. The Joint Commission urges health care organizations to be vigilant and begin planning for the upcoming period of transition, which will introduce changes and new risks into the health care environment. Under the new ISO connector standards, small-bore (less than 8.5 mm inner diameter) connectors will be engineered to make it nearly impossible to connect one delivery system to another delivery system that serves a completely different function<sup>1,2,3,4,5</sup> – for example, accidentally connecting a feeding administration set to a tracheostomy tube, or an intravenous (IV) tube to an epidural site.

The first new ISO connector standard (ANSI/AAMI/ISO 80369-1) has been adopted and others are expected to be introduced and adopted through 2014 and 2015. Health care organizations should begin preparing for changes in

# ERCI 2015 Top 10 Patient Safety Issues

## 5. Care coordination events related to medication reconciliation

- Get a list of all medications from every ED patient along with dose and frequency
- Consult list if any medication is ordered in the ED
- If patient is admitted then full reconciliation can occur
- Discussed later under the section on medication reconciliation which is TJC NPSG.03.06.01

# ERCI 2015 Top 10 Patient Safety Issues

## 6. Failure to conduct independent double checks independently

- CMS requires hospitals to have two practitioners check to make sure the blood is correct and one must be RN who is administering it
- CMS requires hospitals to have a list of high alert medication
- Hospital P&P must specify when independent double checks should occur
- So two nurses verify Heparin bolus amount and drip or the subq insulin is correct

# ERCI 2015 Top 10 Patient Safety Issues

## 7. Opioid-related events

- Use and prescribing of opioids has significantly increases
- So has the number of adverse events and overdoses with the number of overdoses doubling from 2004 to 420,000 in 2011
- Commonly involved is Dilaudid (HydroMORPHONE), oxycodone, PCA opioid, and fentanyl patches
- CMS implemented detailed process for hospitals on June 6, 2015 and discussed in more detail later
- Must have P&P, must train staff, P&P must be approved by MEC, must include how to monitor patients (VS, Pulse Ox, ETCO2 etc) and how often

# Medication and Safe Opioid Use

- CMS issues 32 page memo on medication administration and safe opioid use March 14, 2014 and effective June 6, 2014
  - Risk and patient safety need to review this besides nursing, pharmacy, MEC, and nurse educator
- Concerned about the number of patients with adverse events when taking opioids
- Must have a P&P
- Must train staff and include information that must be in the assessment
- Must document process
  - **Questions to [hospitalscg@cms.hhs.gov](mailto:hospitalscg@cms.hhs.gov)**

# CMS Memo Med & Safe Opioid Use

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850



## Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 14-15-Hospital

**DATE:** March 14, 2014

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Requirements for Hospital Medication Administration, Particularly Intravenous (IV) Medications and Post-Operative Care of Patients Receiving IV Opioids

### Memorandum Summary

- **Medication Administration:** We are updating our guidance for the hospital medication administration requirements to:
  - Make clear that the medication administration requirements under the nursing services condition of participation (CoP) are related to only some components of the overall hospital medication process, but that hospitals are expected, through this and the related requirements under the pharmaceutical services and quality assessment/performance improvement CoPs, to take a comprehensive approach to the medication process.
  - Update our guidance for IV medications and blood transfusions in general; and
  - Reflect the need for patient risk assessment and appropriate monitoring during and after medication administration, particularly for post-operative patients receiving IV opioid medications, in order to prevent adverse events.
- **Immediate Post-operative Care:** Clarification is also being made to the guidance for the surgical services CoP requirement for hospitals to have adequate provisions for immediate post-operative care, to emphasize the need for post-operative monitoring of patients

# ERCI 2015 Top 10 Patient Safety Issues

## 8. Inadequate reprocessing of endoscopes and surgical instruments

- ED instruments are wiped down after use, soaked in an enzymatic solution and sent to central supply for processing

## 9. Inadequate patient handoffs related to patient transport

- Have good report process and consider bedside report and when transferring patient to their bed and discussed in detail later (safe handoffs)

## 10. Medication errors related to pounds and kilograms

- ENA initiative and always weight in kg and not pounds

# ACEP and ENA Position Statements

- ED physicians and ED staff should always be aware of position statements by national association such as ACEP and ENA
  - American College of Emergency Physicians (ACEP) is [www.acep.org](http://www.acep.org)
  - Emergency Nurses Association is [www.ena.org](http://www.ena.org)
- CMS in the hospital Conditions of Participation (CoPs) states that hospitals must follow the acceptable standards of care and practice

# ACEP Policy Statements

**ACEP Policy Statements** [www.acep.org/policystatements/](http://www.acep.org/policystatements/)

Search this Section

ACEP board-approved policy statements highlight the scope of issues being addressed in emergency medicine. New policies are initially distributed to ACEP members via Annals of Emergency Medicine and posted here. In addition, the ACEP Board of Directors has directed that all policy statements undergo automatic review when they are seven years old. Unless a policy still contains relevant information, it will then sunset. Due to the extensive time required to review seven-year-old or older policies, some are still under review.

Breadcrumb: [Policy Statements](#)

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Policies:

 [2011 State of the Art - Observation Units in the ED 0511](#)

## Policies:

 [Advocating for Certified Emergency Nurses \(CENs\) in Departments of Emergency Medicine](#)  
Support of Emergency Nurses Association (ENA) and the Board of Certification for Emergency Nursing (BCEN)

 [Appropriate Interhospital Patient Transfer](#)

The optimal health and well-being of the patient should be the principal goal of patient transfer.

 [Availability of Hospital Diagnostic and Therapeutic Services](#)

Supports policies that endorse consistent 7-days a week availability of hospital diagnostic and therapeutic services

 [Boarding of Admitted and Intensive Care Patients in the Emergency Department](#)

Hospitals have the responsibility to provide quality patient care and optimize patient safety by ensuring the prompt transfer of patients admitted to inpatient units as soon as the treating emergency physician makes such a decision.

 [Deferral of Care After Medical Screening of Emergency Department Patients](#)

The American College of Emergency Physicians (ACEP) believes that every patient who seeks care in the emergency department (ED) should receive appropriate and necessary medical care.

 [Delivery of Care to Undocumented Persons](#)

Treatment of undocumented persons.

 [ED Planning Resource Guidelines 2014](#)

 [Emergency Department Nurse Staffing](#)

Support for registered nurses who are trained and experienced in the practice of emergency nursing.

 [Emergency Department Planning and Resource Guidelines](#)

Resources and planning needed to meet the emergency medical care needs of the individual and the

# Example of ACEP Clinical Policy



American College of  
Emergency Physicians\*



Menu

myACEP



## Clinical & Practice Management



### Reporting of Medical Errors

Reaffirmed and approved by the ACEP Board of Directors April 2014

Revised and approved by the ACEP Board of Directors June 2008

Originally approved by the ACEP Board of Directors September 2001

The American College of Emergency Physicians (ACEP) supports a standardized system of medical error reporting for the purpose of aiding practitioners and institutions in efforts to improve patient safety. Such a system should:

- Define procedures to identify and report errors.
- Utilize a set of definitions and taxonomy of errors developed through consensus.
- Use a centralized data repository that processes and evaluates the data submitted and assures its integrity and confidentiality.
- Ensure that information submitted to reporting systems will be comprehensively analyzed to identify actions that would minimize the risk that reported events recur that reduce recurrence of errors. Reporting systems should facilitate the sharing of patient safety information among providers and health care organizations and foster confidential collaboration with other health care reporting systems.
- Support a non-punitive culture for reporting health care errors focusing on preventing and correcting systems failures rather than on individual or organizational culpability.
- Include statutory protection from liability to providers and institutions that report data to the system.
- Eliminate redundancy in reporting to multiple agencies or governmental bodies.
- Be adequately funded.

# Professional Organizations & Patient Safety

- There are many ED organizations with patient safety committees and they develop research based programs
- ACEP has the QIPS Committee (Quality Improvement and Patient Safety)
- ENA has a patient safety position statement
- The Society of Academic Emergency Medicine (SAEM) also has a patient safety committee
- Others include AHRQ (Patient Safety Tools), ISMP, and IOM Redesigning Work Environment of Nurses

# ACEP Patient Safety Sections QIPS

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## Quality Improvement & Patient Safety Section

### EMPSF EDUCATIONAL CONTENT



The Emergency Medicine Patient Safety Foundation (EMPSF) is a national 501 (C)(3) non-profit organization dedicated to advancing patient safety in emergency care through education, research and collaboration. EMPSF has created a special page for QIPS members with

### QIPS TIPS

Get brief clinical safety and quality tips and illustrations to help you hone your knowledge today (*content to change monthly or quarterly*)

QIPS Section members may send an e-mail to all members of this section via the section e-list at [qips.section@elist.acep.org](mailto:qips.section@elist.acep.org)

[QIPs Tips](#)

On Tuesday, December 17th, 2013 QIPS held its quarterly All-Section conference call on "Opiate Use in the Emergency Department." Several state and local legislatures have taken an active role in the

# ACEP QIPS

## Quality Improvement and Patient Safety Section Newsletter - March 2015

### Letter from the Chair

Robert "Bobby" Turelli, MD, MA



As we launch into the Spring, it is valuable to reflect upon the section's accomplishments and emphasize and expound on the future goals of the Quality Improvement and Patient Safety (QIPS) section.

The QIPS Section is dedicated to engaging the members of ACEP and emergency medicine physicians nationwide and abroad, in achieving the goals of improving the safety and quality of patient care that we are delivering in our emergency departments.

As emergency physicians, we have now successfully evolved into a powerful consortium of health care leaders, who through the influence of healthcare reform, have taken ownership and, more importantly, the lead on the expansive efforts of quality reporting, as well as the development and evolution of cost-containment strategies and value-based purchasing. With our constantly changing and evolving health care system, the novel ideas and inspirational leaders that exist amongst our group make the work performed by the QIPS section an increasingly valuable and fundamental contribution to our specialty.

[Read More »](#)

### IOM's Committee on Diagnostic Error

David Meyers, MD, FACEP

Over the past year or so, I have been following the efforts of the **Institute of Medicine's Committee on Diagnostic Error**. The committee is charged to develop recommendations to reduce diagnostic error across health care and identify action items for key stakeholders who focus broadly on education, the culture of health care, information technology, systems engineering, measurement approaches, changes in payment, and further research - all areas which play a role in this problem.

Awareness of the scale of the problem of diagnosis errors has been growing in recent years as more and

### Letter from the Editor

David Somand, MD, FACEP



Thanks to all who made the QIPS section meeting at the ACEP *Scientific Assembly* a success, and welcome to all of our new members. For our first newsletter following ACEP14 in Chicago, I wanted to introduce the new QIPS Section Officers for

2014 and 2015.

Also in this month's issue are contributions from Dr. Meyers, who provides an update on the Institute of Medicine's Committee on Diagnostic Error. We will hear from Ryan Thompson, MD, who discusses a project aimed to decrease interruptions during patient care handoffs. Michael Bigham, MD, describes a project to capture transport quality data, and Samia Farooqi, MD, describes an airway and sedation quality improvement project. Shari Welch, MD, provides a QIPS Tips article on ED Laboratory Optimization. Enjoy!

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### Pardon the Interruption(s)

# Patient Safety Toolkit in the ED UK



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## The Safety Toolkit

<http://bit.ly/1bPvf6q>

Emergency Medicine in the UK is currently in a state of crisis. Many Emergency Departments are understaffed and facing an unprecedented increase in attendances whilst under intense pressure to achieve quantitative targets. These demands in conjunction with the findings of the Francis and Berwick Reports means that the absolute requirement to deliver high quality and safe care in Emergency Departments has never been greater.

To help support our membership in this the College of Emergency Medicine has developed The Safety Toolkit which aims to describe the structures, processes and skills required for a 'safe' department. There are resources identified within each section to stimulate, provoke and challenge, as well as guide personal development. There are overlapping references and differing perspectives but the vision is of a resource for change and development.

Download The Safety Toolkit (full document) [here](#)

Download separate sections of the toolkit here:

Download 'Designing a risk register' [here](#)

Download 'Learning from practice' [here](#)

Download 'Safe leadership' [here](#)

Download 'Supporting the Second Victim' [here](#)

Download 'Education' [here](#)

Download 'Safety scorecard' [here](#)

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Download 'Team working' [here](#)

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# ENA Position Statements

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## ENA Position Statements

[www.ena.org/about/position/position/Pages/Default.aspx](http://www.ena.org/about/position/position/Pages/Default.aspx)

Access to Health Care (12/2010)	<a href="#">Position Statement</a>
Advanced Practice in Emergency Nursing (2/2012)	<a href="#">Position Statement</a>
Appropriate Credential Use/Title Protection For Nurses With Advanced Degrees (5/2013)	<a href="#">Position Statement</a>
Care of Patients with Chronic/Persistent Pain in the Emergency Setting (1/2014)	<a href="#">Position Statement</a>
Chemical Impairment of Emergency Nurses (07/2010)	<a href="#">Position Statement</a>
Collaborative and Interdisciplinary Research (12/2010)	<a href="#">Position Statement</a>
Communicable Diseases in the Emergency Department (05/2010)	<a href="#">Position Statement</a>
Cultural Diversity in the Emergency Setting (5/2012)	<a href="#">Position Statement</a>
Deceased Patients for Procedural Practice (7/2010)	<a href="#">Position Statement</a>
Disaster and Emergency Preparedness for All Hazards (1/2014)	<a href="#">Position Statement</a>
Education Recommendations: Trauma Nursing (7/2010)	<a href="#">Position Statement</a>

# ENA Patient Safety in the ED

- ENA has a two page position statement on patient safety in emergency health care
- Implemented December 20, 2010
- Patients have a right to emergency care that is free from injuries or accidents from medical care
  - National Healthcare report notes that 15% of patients are harmed from the process

# ENA Patient Safety in the ED

- Patient safety program must focus on team work approach maintained within a culture of safety
- Culture of safety includes non-punitive environment
  - TJC and CMS Hospital CoP also requires
  - AHRQ Culture survey results show this is still a problem in hospitals
- Hospital must have a patient safety program in place
  - Including error reporting and improving processes
  - Non-punitive environment includes reporting of near misses

## **PATIENT SAFETY IN EMERGENCY HEALTH CARE**

**Patient safety is defined as freedom from accidental or preventable injuries produced by medical care. Emergency nurses have a unique opportunity to assess for risk of patient injury due to medical error and to prevent these events from occurring or recurring. Broad process and system improvements that include all members of the healthcare team are needed to address the specific complexity of the emergency care system. Patient safety programs in the emergency care setting must focus on a team based approach that is carefully developed, implemented, and maintained within a culture of safety. Improving the culture of safety within health care is an essential component of preventing or reducing errors and improving overall health care quality. Through the promotion of a culture of safety that incorporates non-punitive, respectful responses to disclosure and error reporting, health care organization leaders need to encourage and actively support emergency nurses in the delivery of safe patient care. Emergency nurses need to participate in error reporting, patient safety research, and ongoing patient safety education so that error and near-misses can be identified, trapped, and successfully mitigated.**

**It is the position of the Emergency Nurses Association that:**

1. Patients have a right to emergency health care that is free from injuries produced by medical care.
2. Emergency nurses are a critical member of the emergency health care team, providing identification of potential or actual risk, communication of safety threats and prevention of patient harm. Emergency nurses must work to establish and implement practice guidelines and standards that support safe nursing practice and safe patient care.
3. Health care organization leaders must ensure a multidisciplinary teamwork approach to the improvement of faulty processes and systems to improve patient safety. Such programs should include error reporting systems and focus on improving work processes, organizational culture, and

# ENA Patient Safety in the ED

- ED need to respectfully coach and challenge each other
- Leaders should encourage organizational learning
  - We need to learn from our mistakes and share the knowledge
- ED nurses must implement practice guidelines and standards that support safe practice
  - CMS and TJC will cite ED staff for failure to follow a standard of care
  - Violation of a SOC can be used against a practitioner in the court room
- Source: <http://www.ena.org/about/position/position/Pages/Default.aspx>

# ENA Patient Safety in the ED

- ED nurses need to be involved in patient safety research
- Equipment used should be standardized and universally interchangeable with like pieces of equipment
  - Human factor engineering can help us redesign safer systems
  - National Center for Human Factors Engineering in Healthcare MedStar Institute for Innovation is working on these issues at [www.MedicalHumanFactors.net](http://www.MedicalHumanFactors.net)
  - Source:  
<http://www.ena.org/about/position/position/Pages/Default.aspx>

# Nurse Can Not See Monitor When Sitting



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The National Center for Human Factors in Healthcare brings together a diverse set of human factors experts with clinical experts to improve quality, efficiency, reliability, and safety in healthcare. A part of the [MedStar Institute for Innovation \(MI2\)](#) and the [MedStar Health Research Institute \(MHRI\)](#), the Center's home and "research lab" is [MedStar Health](#), a \$4.5B not-for-profit healthcare organization with 10 hospitals and 20 diversified healthcare organizations, the largest healthcare provider in the Baltimore & Washington DC region.



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### EDUCATION

Resources for learning about the science of human factors and how it applies to you.

# Teamwork and Patient Safety Culture

- There are many studies that show the importance of team work on patient safety culture
- Teamwork training provides safer healthcare
- Teamwork is a powerful solution to improve patient safety
- Evidenced based teamwork system will improve both teamwork and communication among ED staff
- Common ones include crew resource management (CRM) or AHRQ TeamSTEPPS
  - AHRQ has many excellent free resources on teamwork and other patient safety tools

# AHRQ Teamwork Resources

<http://teamstepps.ahrq.gov/>

U.S. Department of Health & Human Services | www.hhs.gov

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## TeamSTEPPS®: National Implementation

### About TeamSTEPPS

TeamSTEPPS is a teamwork system designed for health care professionals that is:

- A powerful solution to improve patient safety within your organization.
- An evidence-based teamwork system to improve communication and teamwork skills among health care professionals.

[More...](#)

### National Implementation of TeamSTEPPS

About the TeamSTEPPS National Implementation Project

AHRQ and the Defense Department have teamed to build a national training and support network called the National Implementation of TeamSTEPPS Project.

[More...](#)

### Team Strategies and Tools to Enhance Performance and Patient Safety

#### TeamSTEPPS Training Eligibility

AHRQ and DoD are offering free TeamSTEPPS Master Trainer preparation training sessions to individuals from outside.

#### Are You Ready for TeamSTEPPS?

Use the [TeamSTEPPS Readiness Assessment Tool](#) to determine your organization's readiness to begin implementation of the TeamSTEPPS.

#### TeamSTEPPS Tools and Materials

TeamSTEPPS is presented in a multimedia format, with tools to help your health care organization plan, evaluate, and sustain the new team.

### Spotlight

- **New** - Using Simulation in TeamSTEPPS Training, a new guide on using simulation in TeamSTEPPS training.
- **New** - TeamSTEPPS Teamwork Perception Questionnaire (TTPQ), a new tool to measure perception of overall teamwork.
- **New** - Transcript for TeamSTEPPS Webinar 15 now available, "Seco-Technical Procedural Risk Assessment of Teamwork in Health Care".

[More...](#)

# AHRQ Patient Safety Tools

U.S. Department of Health & Human Services [www.hhs.gov](http://www.hhs.gov)

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## Patient Safety Tools: Improving Safety at the Point of Care Toolkit by Patient Safety Issue/Area

**Handoffs and Transitions**

- [Hospital Discharge](#)
- [Medication Safety-General](#)
- [Medication Reconciliation Work Processes](#)
- [Preventing Deep Vein Thrombosis \(DVT\) and Venous Thromboembolism \(VTE\)](#)
- [Communication and Patient-Centered Care](#)
- [Medical Education and Simulation](#)
- [Infection](#)

**Handoffs and Transitions** – These toolkits contain resources to help hospitals safely transition patients to other caregivers:

- + [Implementing Reduced Work Hours to Improve Patient Safety](#)
- + [Improving Hospital Discharge Through Medication Reconciliation and Education](#)
- + [Reducing Discrepancies in Medication histories and Orders at Handoffs](#)
- + [Taking the Re-engineered Hospital Discharge](#)

**Discharge** – These toolkits contain resources to help hospitals discharge patients safely without medication or other problems:

- + [Improving Hospital Discharge Through Medication Reconciliation and Education](#)
- + [Taking the Re-engineered Hospital Discharge](#)

# AHRQ Patient Safety Tools



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## AHRQ Patient Safety Tools and Resources

Publication # 13-M004

Previous Publication # 12-M008

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The Agency for Healthcare Research and Quality (AHRQ) offers tools for health care organizations, providers, policymakers, and patients to improve patient safety in health care settings. The free tools and resources listed here are available online and in print.

### Contents

- Tools for Health Care Organizations and Providers
  - Patient Safety Measurement and Reporting Tools
  - Implementation Guides for Improving Patient Safety
  - Patient Safety Training Tools
- Resources for Health Care Organizations, Providers, and Policymakers
- Tools for Patients and Families
- How To Order Resources

### Tools for Health Care Organizations and Providers

#### Patient Safety Measurement and Reporting Tools

The **Hospital Survey on Patient Safety Culture** examines patient safety culture from a hospital staff perspective and

[www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/pstools/index.html#pstt](http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/pstools/index.html#pstt)

# AHRQ Patient Safety Tools

- ESI triage tool for emergency care
- Crowding and boarding, ED Simulation Peds
- Medication reconciliation and handoffs
- Hospital survey on patient safety culture
- CUSP toolkit, Falls toolkit
- Evidence for Patient Safety Practices
- Mistake proofing the design of healthcare processes
- Patient safety indicators

# AHRQ ED Patient Safety Toolkits

## Patient Safety Tools: Improving Safety at the Point of Care

Information about medical errors, a leading health problem, and the Agency for Healthcare Research and Quality's efforts to reduce medical errors and improve patient safety.

These toolkits are designed to help health care institutions and clinicians provide—and consumers receive—safe, quality health care at various points in the health care process—in the hospital, in the emergency department, in the intensive care unit, in the pharmacy, and when being discharged from one setting to another.

These 17 toolkits were produced under AHRQ's Partnerships in Implementing Patient Safety (PIPS) grant program. The projects have produced a variety of evidence-based tools, including training materials, medication guides and checklists, that are easily adapted to other institutions and care settings. The tools were developed in the field and are designed to be implemented by multidisciplinary users.

### Toolkits by Setting Type

[Hospital — General](#)  
[Emergency Departments](#)  
[Hospital Care Units](#)  
[Outpatient Settings](#)  
[Consumer/Patient Care](#)

<http://archive.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/pips/index.html>

**Hospital—General** – These toolkits contain evidence-based resources to help inpatient facilities improve performance around some of the most common and most serious patient safety problems faced by hospitals today.

- [The Emergency Department Pharmacist as a Safety Measure in Emergency Medicine](#)
- [Improving Hospital Discharge Through Medication Reconciliation and Education](#)
- [Improving Medication Adherence](#)
- [Interactive Venous Thromboembolism Safety Toolkit for Providers and Patients](#)
- [Patient Multidisciplinary Training for Medication Reconciliation](#)
- [Implementing a Program of Patient Safety in Small Rural Hospitals](#)
- [Preventing Venous Thromboembolisms in the Hospital](#)
- [Reducing Central Line Bloodstream Infections and Ventilator-Associated Pneumonia](#)
- [Reducing Discrepancies in Medication Histories and Orders at Handoffs](#)
- [Testing the Re-Engineered Hospital Discharge](#)
- [Using Military Simulation to Improve Rural Obstetric Safety](#)

**Emergency Departments** – These toolkits contain resources to help hospitals apply evidence-based safe practices in the Emergency Department (ED) to improve patient flow, implement a multidisciplinary simulation-based safety curriculum, and improve medication safety by implementing a formal ED pharmacist program.

- [The Emergency Department Pharmacist as a Safety Measure in Emergency Medicine](#)
- [Improving Patient Flow in the Emergency Department](#)
- [A Simulation-Based Safety Curriculum in a Children's Hospital Emergency Department](#)

**Hospital Care Units** – These toolkits contain resources to help hospitals apply evidence-based safe practices.

- [Implementing Reduced Work Hours to Improve Patient Safety](#)
- [Improving Patient Safety Through Enhanced Provider Communication](#)
- [Reducing Central Line Bloodstream Infections and Ventilator-Associated Pneumonia](#)

# Patient Safety and Simulation

## A Simulation-Based Safety Curriculum in a Children's Hospital Emergency Department

Mary Patterson, M.D., Cincinnati Children's Hospital Medical Center, OH AHRQ Grant No. HS015841-01

### Overview

This project aims to decrease and mitigate the effects of medical errors in a pediatric emergency department through the implementation of a multidisciplinary, multi-clinician, simulation-based safety curriculum that emphasizes team behaviors. The project toolkit provides:

- A simulation-based curriculum.
- A re-evaluation and reinforcement plan involving all ED personnel and house staff.
- An abbreviated teamwork training course for multidisciplinary and interdisciplinary trauma teams.
- Instructional materials necessary to implement the 1.5-day safety course including a training agenda.
- Knowledge pre- and post-test questionnaires.
- Lectures, including a section on crew resource management concepts and video presentations.
- A link to a Safety Attitude and Safety Climate Survey.

### Target Audience

Physicians, nurses, quality and safety professionals.

<http://archive.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/pips/patterson.html>

### Health Care Setting

Emergency departments, pediatric hospital units.

### Toolkit Web Site

<http://www.cincinnatichildrens.org/ed/cme/ems/human-simulator.htm>

### Press Releases

AHRQ Awards More Than \$8 Million To Further Implementation of Evidence-Based Patient Safety Findings  
June 8, 2005

### Journal Articles

Educational and research implications of portable human patient simulation in acute care medicine. Kobayashi L, Patterson MD, Overly FL, Shapiro MJ, Williams KA, Jay GD. *Acad Emerg Med*. 2008 Nov;15(11):1166-74. Epub 2008 Jul 14.

<http://www.ncbi.nlm.nih.gov/pubmed/18638036>

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# Patient Safety Indicators



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## Patient Safety Indicators Technical Specifications - Version 4.5, May 2013

- All Patient Safety Indicators Technical Specifications, Version 4.5 (Zip File)
  - [EXP 01 Rate of Complications of Anesthesia](#)
  - [EXP 02 Obstetric Trauma Rate - Cesarean Delivery](#)
  - [PSI 02 Death Rate in Low-Mortality Diagnosis Related Groups \(DRGs\)](#)
  - [PSI 03 Pressure Ulcer Rate](#)
  - [PSI 04 Death Rate among Surgical Inpatients with Serious Treatable Conditions](#)
  - [PSI 05 Retained Surgical Item or Unretrieved Device Fragment Count](#)
  - [PSI 06 Iatrogenic Pneumothorax Rate](#)
  - [PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate](#)
  - [PSI 08 Postoperative Hip Fracture Rate](#)
  - [PSI 09 Perioperative Hemorrhage or Hematoma Rate](#)
  - [PSI 10 Postoperative Physiologic and Metabolic Derangement Rate](#)
  - [PSI 11 Postoperative Respiratory Failure Rate](#)
  - [PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate](#)
  - [PSI 13 Postoperative Sepsis Rate](#)
  - [PSI 14 Postoperative Wound Dehiscence Rate](#)
  - [PSI 15 Accidental Puncture or Laceration Rate](#)
  - [PSI 16 Transfusion Reaction Count](#)
  - [PSI 17 Birth Trauma Rate—Injury to Neonate](#)
  - [PSI 18 Obstetric Trauma Rate—Vaginal Delivery With Instrument](#)
  - [PSI 19 Obstetric Trauma Rate-Vaginal Delivery Without Instrument](#)
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  - [PSI 22 Iatrogenic Pneumothorax Rate](#)
  - [PSI 23 Central Venous Catheter-Related Blood Stream Infection Rate](#)
  - [PSI 24 Postoperative Wound Dehiscence Rate](#)
  - [PSI 25 Accidental Puncture or Laceration Rate](#)
  - [PSI 26 Transfusion Reaction Rate](#)
  - [PSI 27 Postoperative Hemorrhage or Hematoma Rate](#)
  - [PSI 90 Patient Safety for Selected Indicators](#)
  - [PSI Appendices](#)

[www.qualityindicators.ahrq.gov/Modules/psi\\_resources.aspx](http://www.qualityindicators.ahrq.gov/Modules/psi_resources.aspx)

# AHRQ Medical Errors and Patient Safety

- Can sign up to get emails on medical errors and patient safety
  - at [www.ahrq.gov/qual/patientsafetyix.htm](http://www.ahrq.gov/qual/patientsafetyix.htm)
  - Journals and primers on patient safety
  - Resources such as patient education material on patient safety
- Be sure to sign up to get the PSNet or patient safety network send to your email
  - Will send list of published research on quality and safety
  - You can do a search and locate articles of interest

# Sign Up for Patient Safety Resources



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Information about AHRQ efforts to reduce medical errors and improve patient safety.

## Conferences and Workshops

Conferences, Workshops, and Hearings focusing on Patient Safety topics

## Tools and Resources

### AFFILIATED CENTERS, PORTFOLIOS & INITIATIVES

[Center for Quality Improvement and Patient Safety \(CQuIPS\)](#)

[Patient Safety Portfolio](#)

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[Web M&M: Morbidity & Mortality Rounds Online](#)



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A national patient safety resource

# AHRQ PSNet Patient Safety Network



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Search within these results:   Date   Show Summary

## Emergency Departments (1-20 of 225):

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[How are these results ranked?](#)

1. **Commentary: [Identified safety risks with splitting and crushing oral medications.](#)**  
Paparella S. J Emerg Nurs. 2010;36:156-158.
2. **Commentary: [Duty hours in emergency medicine: balancing patient safety, resident wellness, and the resident training experience: a consensus response to the 2008 Institute of Medicine resident duty hours recommendations.](#)**  
Wagner MJ, Wolf S, Promes S, et al. J Emerg Med. 2010 Jul 13; [Epub ahead of print].
3. **Study: [Adverse drug events in the outpatient setting: an 11-year national analysis.](#)**  
Bourgeois FT, Shannon MW, Valm C, Mandl KD. Pharmacoepidemiol Drug Saf. 2010 Jul 7; [Epub

# PS Net Patient Safety Articles

The screenshot shows the PS Net Patient Safety Articles website. At the top, there is a blue header with the U.S. Department of Health & Human Services logo and the URL www.hhs.gov. Below this is the AHRQ Agency for Healthcare Research and Quality logo with the tagline "Advancing Excellence in Health Care" and the URL www.ahrq.gov. The main navigation bar includes "Home", "What's New", "The Collection", "Patient Safety Primers", "Glossary", "Subscribe", "My PSNet", and "About". A search bar with a "SEARCH" button is located on the right side of the navigation bar. A "webM&M" banner is also present, with the text "Visit Now morbidity & mortality rounds on the web".

The main content area is titled "The Collection > Emergency Departments". Below this, there are filters for "Narrow By" (clear selections, 1 - 20 of 363) and options to "Show Excerpt" or "Don't Show Excerpt". A "Sort by significance" dropdown menu is also visible.

On the left side, there are social media icons for email, Google+, Facebook, Twitter, and a plus sign. Below these icons are two sections: "Safety Target" and "Origin/Sponsor".

The "Safety Target" section lists the following categories and counts:

- Device-related Complications (9)
- Diagnostic Errors (60)
- Identification Errors (6)
- Discontinuities, Gaps, and Hand-Off Problems (84)
- Fatigue and Sleep Deprivation (5)
- Medication Safety (111)
- Medical Complications (21)
- Nonsurgical Procedural Complications (11)
- Surgical Complications (5)
- Transfusion Complications (2)
- Psychological and Social Complications (6)

The "Origin/Sponsor" section lists the following categories and counts:

- Africa (1)
- Asia (7)
- Australia and New Zealand (17)
- Central and South America (1)
- Europe (50)
- North America (271)

The main content area displays three articles:

**STUDY CLASSIC**  
**Emergency hospitalizations for adverse drug events in older Americans.**  
Budnitz DS, Lovegrove MC, Shehab N, Richards CL. N Engl J Med. 2011;365:2002-2012.

**STUDY CLASSIC**  
**Association between waiting times and short term mortality and hospital admission after departure from emergency department: population based cohort study from Ontario, Canada.**  
Guttman A, Schull MJ, Vermeulen MJ, Stukel TA. BMJ. 2011;342:d2983.

**TOOLKIT CLASSIC**  
**TeamSTEPS: Strategies and Tools to Enhance Performance and Patient Safety.**  
Washington, DC: Department of Defense. Rockville, MD: Agency for Healthcare Research and Quality; 2014.

**REVIEW CLASSIC**

# Use a Trigger Tools

- There are three trigger tools that could be used in the ED
- CMS in the hospital CoP manual and TJC say you can't just rely on incident reports
- Need another source to discover errors like medication errors
- In the hospital CoPs, there is a list of indicator drugs or IHI had trigger tools
  - August 11, 2010 Mayo Clinic publishes research that the global trigger tool is promising approach to measuring patient safety

# Measuring Hospital Adverse Events: Assessing Inter-rater Reliability and Trigger Performance of the Global Trigger Tool

James M. Naessens; Thomas J. O'Byrne; Matthew G. Johnson; Monica B. Vansuch; Corey M. McGlone; Jeanne M. Huddleston

Posted: 08/11/2010; International Journal for Quality in Health Care, 2010;22(4):266-274. © 2010 Oxford University Press

## Abstract and Introduction

---

### Abstract

**Objective.** To determine the inter-rater reliability of the Institute for Healthcare Improvement's Global Trigger Tool (GTT) in a practice setting, and explore the value of individual triggers.

**Design.** Prospective assessment of application of the GTT to monthly random samples of hospitalized patients at four hospitals across three regions in the USA.

**Setting.** Mayo Clinic campuses are in Minnesota, Arizona and Florida.

**Participants.** A total of 1138 non-pediatric inpatients from all units across the hospital.

**Intervention.** GTT was applied to randomly selected medical records with independent assessments of two registered nurses with a physician review for confirmation.

**Main Outcome Measure.** The Cohen Kappa coefficient was used as a measure of inter-rater agreement. The positive predictive value was assessed for individual triggers.

**Results.** Good levels of reliability were obtained between independent nurse reviewers at the case-level for both the occurrence of any trigger and the identification of an adverse event. Nurse reviewer agreement for individual triggers was much more varied. Higher agreement appears to occur among triggers that are objective and consistently recorded in selected portions of the medical record. Individual triggers also varied on their yield to detect adverse events. Cases with adverse events had significantly more triggers identified (mean 4.7) than cases with no adverse events (mean 1.8).

**Conclusions.** The trigger methodology appears to be a promising approach to the measurement of patient

---

# Trigger Tool Finds More Adverse Events

- Recent study found that an adverse event occurred in about one out of three admissions
- This is 10 times the number of previous estimates
- Found that trigger tool confirmed ten times more serious adverse events in hospitals
  - This compared to using the AHRQ 28 patient safety indicators
- Trigger tool has a much broader definition of adverse event
  - Global Trigger Tool Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Thought, Classen, David, Roger, Resar etc. Health Affairs, Vol 30, No.5, May 2011

# Health Affairs Global Trigger Tool

AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

## HealthAffairs

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### 'Global Trigger Tool' Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured Expand

David C. Classen<sup>1,\*</sup>, Roger Resar<sup>2</sup>, Frances Griffin<sup>3</sup>, Frank Federico<sup>4</sup>, Terri Frankel<sup>5</sup>, Nancy Kimmel<sup>6</sup>, John C. Whittington<sup>7</sup>, Allan Frankel<sup>8</sup>, Andrew Seger<sup>9</sup> and Brent C. James<sup>10</sup>

Author Affiliations

<http://content.healthaffairs.org/content/30/4/581.abstract>

\*Corresponding author

#### Abstract

Identification and measurement of adverse medical events is central to patient safety, forming a foundation for accountability, prioritizing problems to work on, generating ideas for safer care, and testing which interventions work. We compared three methods to detect adverse events in hospitalized patients using the same patient sample set

[« Previous](#) | [Next Article »](#)  
[Table of Contents](#)

#### This Article

doi:  
10.1377/hlthaff.2011.0190  
Health Aff April 2011 vol. 30 no. 4  
581-589

Abstract

Full Text

PDF

A correction has been published

Appendix

Erratum

Classifications

Errors & Adverse Events

Services

Email this article to a colleague  
Alert me when this article is cited  
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# Trigger Tool

- Use to find errors since incident reports are filled out only in small % of cases
- IHI has 44 page global trigger tool at [www.ihi.org](http://www.ihi.org)
- Has separate sections like medication trigger
- PTT greater than 100 seconds if on Heparin-if evidence of bleeding, or INR greater than 6 if evidence of bleeding
- C-diff positive assay if history of antibiotic use
- Review 20 charts per month and no longer than 20 minutes

# Trigger Tools

- Look for opportunities for improvement
- Separate trigger tool for measuring medication related harm at  
[www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Literature/DevelopmentPediatricFocusedTriggerTool.htm](http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Literature/DevelopmentPediatricFocusedTriggerTool.htm)
- See trigger tool to identify errors in pediatric hospitals at  
[www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Literature/DevelopmentPediatricFocusedTriggerTool.htm](http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Literature/DevelopmentPediatricFocusedTriggerTool.htm)
- Outpatient trigger tool has ED visit; look at reason for the visit and AE related to ED care



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## Introduction to Trigger Tools for Identifying Adverse Events

The use of "triggers," or clues, to identify adverse events (AEs) is an effective method for measuring the overall level of harm from medical care in a health care organization. Traditional efforts to detect AEs have focused on voluntary reporting and tracking of errors. However, public health researchers have established that only 10 to 20 percent of errors are ever reported and, of those, 90 to 95 percent cause no harm to patients. Hospitals need a more effective way to identify events that do cause harm to patients, in order to select and test changes to reduce harm.

There are various Trigger Tools available on IHI.org, including:

- [IHI Global Trigger Tool for Measuring Adverse Events](#) [Danish, German, Swedish, and UK [translations](#) also available]
- [Trigger Tool for Measuring Adverse Drug Events](#)
- [Trigger Tool for Measuring Adverse Drug Events in a Mental Health Setting](#)
- [Trigger Tool for Measuring Adverse Drug Events in the Nursing Home](#)
- [Surgical Trigger Tool for Measuring Peri-operative Adverse Events](#)
- [Intensive Care Unit Adverse Event Trigger Tool](#)
- [Pediatric Trigger Toolkit: Measuring Adverse Drug Events in the Children's Hospital](#)
- [Paediatric Trigger Tool for Measuring Adverse Events \(UK version\)](#)
- [Trigger Tool for Measuring Adverse Events in the Neonatal Intensive Care Unit](#)
- [Outpatient Adverse Event Trigger Tool](#)

### Related Information

- [Measures](#)
- [Changes](#)
- [Tools](#)
- [Improvement Tip: Focus on Harm, Not Errors](#)

### Join the Discussion

#### Free Trigger Tools Listserv

Join a free listserv with other users of IHI Trigger Tools.

1. Send a completely blank email (no subject, signature, or text in message body) to: [subscribe-triggertools@ls.ih.org](mailto:subscribe-triggertools@ls.ih.org).

2. You will receive a confirmation message.

3. Post messages to the listserv by sending emails to [triggertools@ls.ih.org](mailto:triggertools@ls.ih.org).

# ED Triggers in Global Trigger Tool

## F. Emergency Department (ED) Module Triggers

### Readmission to the ED within 48 Hours

Look for missed diagnoses, drug reactions, infections, or other reasons that events may have brought the patient back to the ED and then required admission.

### Time in ED Greater than 6 Hours

Long ED stays in some cases can represent less than optimal care. Look for complications arising from the ED such as falls, hypotension, or procedure related complications.

# Trigger or Indicator Drugs

- Benadryl, Vitamin K, Digibind, and Romazicon
- Droperidol, Narcan, Zofran, Phenergan, Vistaril, and Reglan
- Platelet count less 50,000
- Glucose less than 50
- Over sedation and fall or lethargy

## ➤ Trigger Tool for Measuring Adverse Drug Events

The use of “triggers,” or clues, to identify adverse drug events (ADEs) is an effective method for measuring the overall level of harm from medications in a health care organization. The Trigger Tool for Measuring Adverse Drug Events provides instructions for conducting a retrospective review of patient records using triggers to identify possible ADEs. This tool includes a list of known ADE triggers and instructions for collecting the data you need to measure the number of ADEs per 1,000 doses and the percentage of admissions with an ADE.

NOTE: You can use this tool in conjunction with the interactive Trigger Tool for Measuring ADEs in the Workspace area on IHI.org. Enter your detailed data from all of your ADE Patient Record Review Sheets into the interactive Trigger Tool for Measuring ADEs. The Tool will automatically calculate and graph two measures: ADEs per 1,000 Doses and Percent of Admissions with an ADE.

### **This tool contains:**

- ▣ Background

Trigger Tool for Measuring Adverse Drug Events

**ADE Patient Record Review Sheet**

**Patient Identification Number** \_\_\_\_\_

**Admission Date** \_\_\_\_\_ **Patient's Age** \_\_\_\_\_

**Discharge Date** \_\_\_\_\_ **Date** \_\_\_\_\_

**(Two-day minimum hospital stay required)**

- |   |  |
|---|--|
| <b>T1</b> Diphenhydramine (Benadryl)  | <b>T10</b> PTT > 100 seconds                       |
| <b>T2</b> Vitamin K (Aqua-mephyton)   | <b>T11</b> INR > 6                                 |
| <b>T3</b> Flumazenil (Romazicon)  | <b>T12</b> WBC < 3,000                             |
| <b>T4</b> Anti-emetics (Inapsine, Zofran, Phenergan, Vistanil, Compazine, Reglan) | <b>T13</b> Platelet Count < 50,000                 |
| <b>T5</b> Naloxone (Narcan)   | <b>T14</b> Digoxin Level > 2                       |
| <b>T6</b> Anti-diarrheals (diphenoxylate/Lomotil, loperamide/Imodium, Kaopectate) | <b>T15</b> Rising Serum Creatinine                 |
| <b>T7</b> Sodium Polystyrene (Kayexalate)   | <b>T16</b> Over-sedation/lethargy/fall/hypotension |
| <b>T8</b> Serum glucose < 50  | <b>T17</b> Rash                                    |
| <b>T9</b> C. difficile positive   | <b>T18</b> Abrupt Cessation of Medication          |
|   | <b>T19</b> Transferred to a Higher Level of Care   |

Triggers Found:	ADE Found?		Harm Category*	Description of ADE
	Yes	No		

# IHI Patient Safety Website

Welcome, Sue | My IHI | Log Out | Extranet | [Newsletter Sign Up](#) | [Blogs](#) | [Careers](#)



**Institute for  
Healthcare  
Improvement**

*Improving Health and Health Care Worldwide*

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**Patient Safety**

- Introduction**
- Overview
- Getting Started
- Education
- Resources



GETTING STARTED

Need some help [getting started](#)? We have some suggested resources for you.

TOOLS AND RESOURCES

- [IHI Global Trigger Tool for Measuring Adverse Events](#)
- [Leadership Guide to Patient Safety](#)
- [SBAR Technique for Communication](#)

[View More >>](#)

IHI TEAM

IHI Focus Area Content Leads



**Frank Federico**  
Executive Director

**Patient Safety**

Our goal: Work with countries, regions, organizations, and individuals to build safety into every system of care, ensuring that patients receive the safest, most reliable care across the continuum. [More >>](#)

**In the Spotlight**

<http://www.ihio.org/Topics/PatientSafety/Pages/Overview.aspx>

# Patients Identify Undocumented AE

- Trigger tools can help determine undocumented adverse events (AE) but what else?
- Do we really know the true adverse event rates for our ED patients?
- Telephone interviews with 201 patients after ED discharge
- Identified 10 AEs that had not been reported in their medical records
  - Source CJEM September 26, 2008

# Disclosure of Unanticipated Outcomes

- TJC requires now that patients be informed when unanticipated outcomes under RI.01.02.01
  - EP21 Patient or surrogate decision maker is informed about unanticipated outcomes (UO) of care that related to reviewable sentinel events
  - EP 22 LIP must inform patient if not aware
- Also one of the 34 National Quality Forum Safe Practices for Better Healthcare
- NPSF says patient have a right to receive a truthful and compassionate explanation about the error and remedies available to the patient

# Patient Safety Studies

- Many studies showed that a large percentage of the errors that occur in healthcare are due to system error
- They are not due because of the negligence of a staff member or physician
- It is not a blame and train mentality
- Studies found that healthcare facilities needed a non-punitive environment
- A healthcare facility can not fix a problem it does not know exists

# Patient Safety

- Having a **non-punitive environment** would encourage reporting of errors and near misses
- Both the Joint Commission (TJC) and the Centers for Medicare and Medicaid Services (CMS) require a non-punitive environment
- However, many healthcare facilities have balanced this with the **Just Culture theory**
- A person who is reckless or does something intentional to harm a patient should be terminated from employment

# Reporting Medical Errors and Near Misses

- Staff need to feel comfortable in reporting medical errors and near misses
- Reporting system should facilitate the sharing of patient safety information
  - In fact, this is a TJC requirement
  - We need a learning environment so we can learn from our mistakes
  - Need to use a system analysis approach and fix the system to prevent medical errors in the future
- The entire hospital needs to be focused on patient safety if a culture of safety is to be established

# ACEP Reporting of Medical Errors



## Clinical & Practice Management



### Reporting of Medical Errors

Reaffirmed and approved by the ACEP Board of Directors April 2014

Revised and approved by the ACEP Board of Directors June 2008

Originally approved by the ACEP Board of Directors September 2001

The American College of Emergency Physicians (ACEP) supports a standardized system of medical error reporting for the purpose of aiding practitioners and institutions in efforts to improve patient safety. Such a system should:

- Define procedures to identify and report errors.
- Utilize a set of definitions and taxonomy of errors developed through consensus.
- Use a centralized data repository that processes and evaluates the data submitted and assures its integrity and confidentiality.
- Ensure that information submitted to reporting systems will be comprehensively analyzed to identify actions that would minimize the risk that reported events recur that reduce recurrence of errors. Reporting systems should facilitate the sharing of patient safety information among providers and health care organizations and foster confidential collaboration with other health care reporting systems.
- Support a non-punitive culture for reporting health care errors focusing on preventing and correcting systems failures rather than on individual or organizational culpability.
- Include statutory protection from liability to providers and institutions that report data to the system.
- Eliminate redundancy in reporting to multiple agencies or governmental bodies.
- Be adequately funded.

# Safety Initiatives Any ED Can Do

- Recent article describes safety initiatives a hospital can take
  - Hospital in the study had a patient safety committee
  - This committee created a safety mission statement
  - Developed a non-punitive error reporting policy
  - Created information sheet of safety tips for patients and families
- Educated staff on the science of safety and how to disclose errors
- Developed a safety intranet site to share stories on patient safety
- Implemented senior safety walkabouts



## Evaluation of the culture of safety: survey of clinicians and managers in an academic medical center

P J Pronovost, B Weast, C G Holzmueller, et al.

*Qual Saf Health Care* 2003; 12: 405-410

doi: [10.1136/qhc.12.6.405](https://doi.org/10.1136/qhc.12.6.405)

---

Updated information and services can be found at:

<http://qshc.bmj.com/content/12/6/405.full.html>

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*These include:*

### References

This article cites 12 articles, 2 of which can be accessed free at:

<http://qshc.bmj.com/content/12/6/405.full.html#ref-list-1>

Article cited in:

<http://qshc.bmj.com/content/12/6/405.full.html#related-urls>

### Email alerting service

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### Notes

# Suicidal Patients

- Inpatient suicides is the 3<sup>rd</sup> most common sentinel event for hospitals (TJC)
  - April 2016, 2015 data of 11,186 SE and 8% of all sentinel events and has 856
- Don't let suicidal patient sit in ED lobby unattended
- If prevented from leaving then CMS seclusion standards apply
- Sitters or security with suicidal patients in the ED and have a safe room and be aware of policy
  - How to build a safe room Guidelines for the Built Environment of Behavioral Health Facilities at [www.naphs.org](http://www.naphs.org)



# **Design Guide for the Built Environment of Behavioral Health Facilities**

---

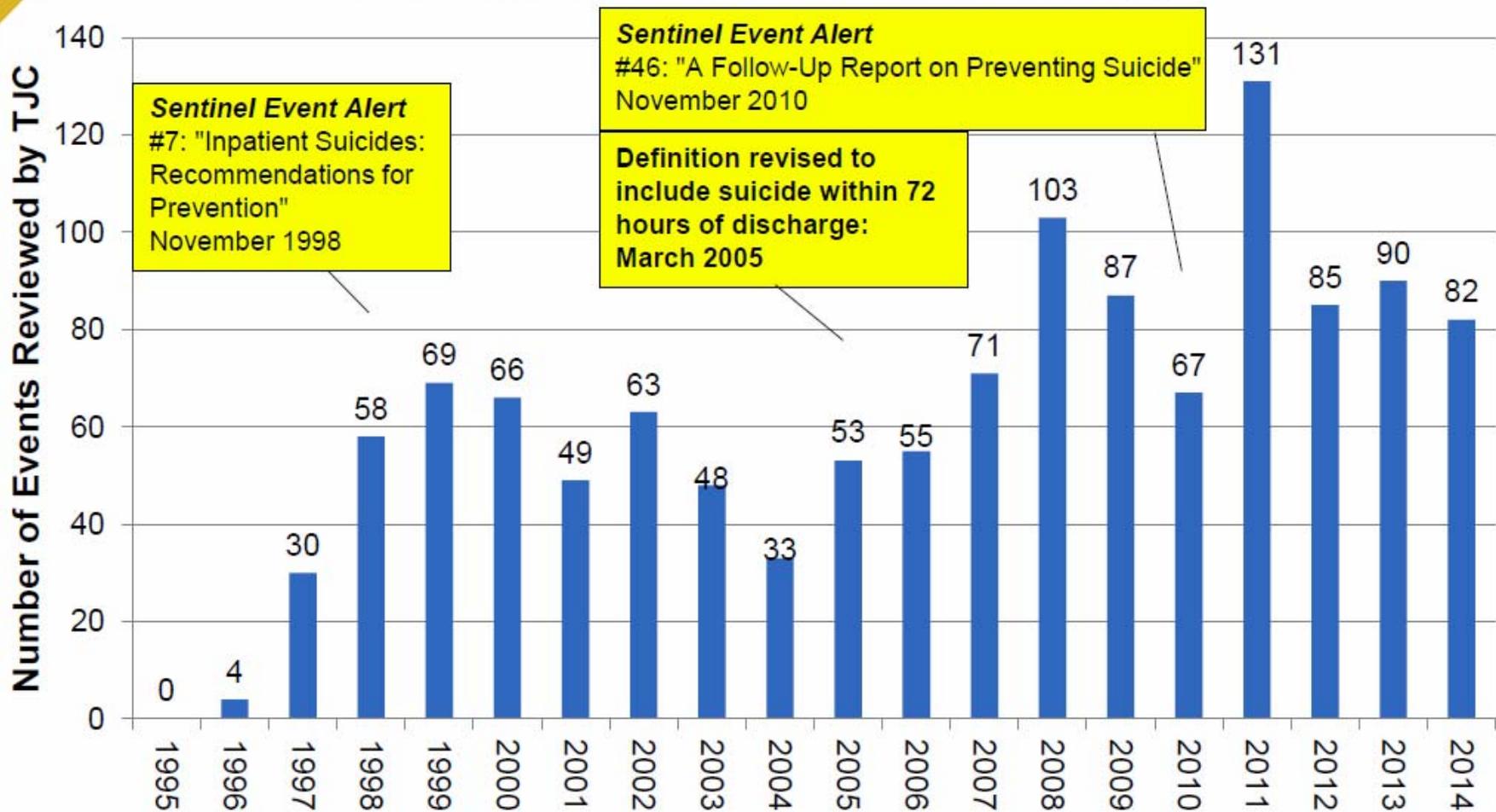
*Now with  
Patient Safety Risk Assessment (PSRA) tool*

---

by James M. Hunt, AIA, NCARB  
and David M. Sine, DrBE, CSP, ARM, CPHRM

# Suicide Events Reviewed by The Joint Commission

(Of any individual receiving care, treatment or services in a staffed  
around-the-clock care setting or within 72 hours of discharge)



# Root Cause Information for Suicide Events Reviewed by The Joint Commission

(Suicide of any individual receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge)

<b>2004 through 2014 (N=856)</b> <i>The majority of events have multiple root causes</i>	
Assessment	684
Communication	503
Human Factors	471
Leadership	440
Physical Environment	342
Information Management	190
Continuum of Care	163
Care Planning	158
Medication Use	51
Special Interventions	24

# Suicidal Patients

- A good assessment is mandatory
  - Provide training to ED nurses so they feel more comfortable about taking care of suicidal patients
  - Include suicide lethality scale
- Document if suicidal and if plan and document assessments
- Knowledge of state law on involuntary commitment if danger to himself or others
- It is imperative that the ED provide a safe environment to prevent suicidal patients from committing suicide

# Patient Suicide Risk

- TJC has a NPSG on this
- Goal 15, 15.01.01. states that the hospital identifies patients at risk for suicide
- Only 1 left of 2 standards
- NPSG.15.01.01 has 3 EPs
- This section only applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.
- See TJC Patient Flow Chapter in LD chapter and PC.01.01.01 EP 4 and EP 24.

# Patient Suicide Risk

1. Risk assessment must be conducted that includes factors that increase or decrease the risk for suicide
2. Need to address the immediate safety needs of a suicidal patient and the most appropriate setting
3. Must provide information to patients at risk for suicide when they leave the hospital such as a crisis prevention hotline

# Communication

- Communication break downs are the leading system failure that contributes to error
- TJC sentinel event data support this which is why it became a NPSG
  - Left with notifying physicians of panic values and document
  - Most common root cause of sentinel events is communication and accounts for 70% of all errors
- A communication model (like SBAR or standard report sheet form, ticket to ride, hall pass, or report template) could help
  - Improving communication in the emergency department. Redfern E, Brown R, Vincent CA. Emerg Med J. 2009;26:658-

# Communication Bedside Shift Report

- Important in giving report for ED nurses and physicians going off duty
  - TJC standard on handoff
  - NPSG.02.03.02
  - Bedside shift report improves patient safety and nurse accountability
  - Bedside shift report improves patient safety and nurse accountability. Baker SJ. J Emerg Nurs. 2010;36:355-358
  - Watch chasing zero by Dennis Quade at <http://safetyleaders.org/Quaid/>
- Good communication is also important for preventing lawsuits

# Watch This Video Bedside Nurse Report

The screenshot shows the SafetyLeaders.org website. At the top left is the TMIT Research Test Bed logo. The top right features the SafetyLeaders.org logo. A navigation bar contains several red buttons: I.I.M.D Hospital Initiatives, High Performer Survey & Resources, Research Programs, Workshops, Webinars & Meetings, Patient Programs, and Multimedia Center for PSOs. Below this is a secondary navigation bar with links for Home, Search, Web Meetings, How To SafetyLeaders?, About SafetyLeaders, and Login.

## Dennis Quaid: Our New SafetyLeaders TMIT Teammate

### The Quaid Foundation Has Merged with TMIT

As of April 12, 2010, The Quaid Foundation has merged with TMIT. The Quaid Foundation was formed by Dennis and Kimberly Quaid in 2007 after hospital personnel administered an overdose of heparin, a blood thinner, to their 12-year-old twins, pulling their lives at great risk. The Quaid family is joining forces with TMIT to raise public awareness about our broken medical system, to eliminate human error, and to make caregivers aware that patients have the right to know all information that could have an impact on their health and well-being, with major focus on increasing awareness of the dangers of medication errors.

Over the last year, Dennis Quaid and TMIT have been actively involved in a number of other initiatives that have global reach and impact.

Play Video

# Heparin Mix Up Almost Killed Their Twins



# Hand Offs

- Recent study examined handoff communications among ED physicians and found a number of communication errors
- There were errors in 13.1% and omissions in 45.1% of the handoffs
- Errors and omissions were associated with handoff time per patient and ED length of stay
- There were fewer errors with the use of written or electronic support materials
  - ED handoffs: observed practices and communication errors, Brandon Maughan, Lei Lei, Rita Cydulka, American Journal of Emergency Medicine, Volume 29, Issue 5, Pages 505-511, June 2011

# ENA Safer Handoff Tool



## PATIENT HANDOFF/ TRANSFER FORM

INSERT INSTITUTION  
LOGO

DATE OF TRANSFER: \_\_\_\_/\_\_\_\_/\_\_\_\_

TIME OF TRANSFER: \_\_\_\_:\_\_\_\_ AM PM

### PATIENT INFORMATION

\_\_\_\_\_  
*Last Name First Name MI*

\_\_\_\_\_  
*Street Address City*

\_\_\_\_\_  
*State/Province Zip/Postal Code*

\_\_\_\_/\_\_\_\_/\_\_\_\_  
*DOB*

GENDER: M F

### CONTACT PERSON/LEGAL GUARDIAN/DPOA

\_\_\_\_\_  
*Last Name First Name*

( )  
*Emergency Telephone* NOTIFIED Yes No

\_\_\_\_\_  
*Street, City, State/Province, Zip/Postal Code*

\_\_\_\_\_  
*Relationship to Patient*

### NAME OF FACILITY TRANSFERRING FROM

\_\_\_\_\_  
*Facility Name Address City State/Province Zip/Postal Code*

\_\_\_\_\_  
*NAME OF RN/LPN/MD in Charge of Patient at Time of Transfer*

( )  
*Telephone*

REASON FOR TRANSFER

SECONDARY DIAGNOSIS

**ACUTE CHANGES FROM BASELINE ASSOCIATED WITH TRANSFER**

**VITAL SIGNS AT TRANSFER** – TIME TAKEN: \_\_\_\_\_ : \_\_\_\_\_ AM PM

BP: / TEMP: PULSE: RESP: SAO<sub>2</sub>:  O<sub>2</sub> Therapy

**IMMUNIZATION STATUS**  *Attached*

T.S.T. (PPD)	Date: _____	Results: _____	Hepatitis A:	Date: _____	<input type="checkbox"/> UNK
Influenza	Date: _____	<input type="checkbox"/> UNK	Hepatitis B:	Date: _____	<input type="checkbox"/> UNK
Pneumococcal	Date: _____	<input type="checkbox"/> UNK	Measles, Mumps, Rubella	Date: _____	<input type="checkbox"/> UNK
Meningococcal	Date: _____	<input type="checkbox"/> UNK	Varicella	Date: _____	<input type="checkbox"/> UNK
D.T.P.	Date: _____	<input type="checkbox"/> UNK	Inactivated Poliovirus	Date: _____	<input type="checkbox"/> UNK
Tetanus	Date: _____	<input type="checkbox"/> UNK			

<i>TB Test</i>	Date	Type	Result	<i>Biochem</i>	Date	Result
<i>Chest X-Ray</i>	Date	Result		<i>Urinalysis</i>	Date	Result
<i>C.B.C.</i>	Date	Result		<i>Fasting Glucose</i>	Date	Result

**ALLERGIES**  None  UNK

Allergic To: _____	Reaction: _____	<input type="checkbox"/> UNK
Allergic To: _____	Reaction: _____	<input type="checkbox"/> UNK
Allergic To: _____	Reaction: _____	<input type="checkbox"/> UNK

**ISOLATION/PRECAUTION**

<input type="checkbox"/> None	<input type="checkbox"/> MRSA	Date: _____	Site: _____
<input type="checkbox"/> Contact	<input type="checkbox"/> VRE	Date: _____	Site: _____
<input type="checkbox"/> Droplet	<input type="checkbox"/> ESBL	Date: _____	Site: _____
<input type="checkbox"/> Airborne	<input type="checkbox"/> Other	Date: _____	
	<input type="checkbox"/> C-Diff	Date: _____	

**SKIN/ WOUND CARE**  Intact  Not Intact  
*Describe Decubitus/ Wound (Size, Site, Drainage):*

# Safer Sign Out Protocol ACEP EMPSF

## FEATURED PROJECT



### Safer Sign Out Protocol

The "Safer Sign Out" protocol provides simple but critical structure to the process of handing off ED patients during a shift change in the community hospital setting. See the process, download helpful documents, forms and tools.

[www.acep.org/qipssection/](http://www.acep.org/qipssection/)

# Tools for Safer Sign Out for LIPs and Physicians



[Safer Sign Out](#) » [Getting Started](#) » [Resources](#) » [Innovation Partners](#) » [Contact Us](#)



search

## Free Resources

[Home](#) » [Emergency Department Patient Safety](#)

<http://safersignout.com/resources-new/>

### Thank You for Registering for Our Safer Signout Patient Safety Tools

Use these FREE tools to help launch & maintain a safer sign out process at your hospital:

- [Introduction to Safer Sign Out](#)  
*Educate your admin & clinical team on SSO*
- [7 Minute Introduction Video from Citygate Films](#)
- [47 Minute Video from Dr. Fuller to the Maryland Patient Safety Conference](#)  
*Panel presentation at the Maryland Patient Safety Conference detailing the SSO genesis, process and lessons learned. Serves as thorough introduction for ED leaders that want to learn more.*
- [Executive Summary](#)
- [Safer Sign Out Form](#)  
*Professionally designed sign out forms for optimal team support.*

#### Innovation Partners

EMPSF teams up to bring you Safer Sign Out



## Safer Sign Out Form (v20)

Check if No Patients Signed Out     
 Off-Going Clinician\*: \_\_\_\_\_     
 Receiving Clinician: \_\_\_\_\_     
 Date Shift Started \_\_\_\_\_

Patient Name/Age	Problem List & Key Issues	Pending Items	Disposition	Receiving Clinician's Notes
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Room</div>   	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Diagnosis/CC:</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Key Issues:</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Potential Safety Issues or Precautions?</div>	   	Home _____ Admit _____ Transfer _____ NH _____ TBD _____ _____ _____	<input type="checkbox"/> Rounded on Patient <input type="checkbox"/> Communicated with Nurse _____
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Room</div>   	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Diagnosis/CC:</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Key Issues:</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Potential Safety Issues or Precautions?</div>	   	Home _____ Admit _____ Transfer _____ NH _____ TBD _____ _____ _____	<input type="checkbox"/> Rounded on Patient <input type="checkbox"/> Communicated with Nurse _____
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Room</div>   	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Diagnosis/CC:</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Key Issues:</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Potential Safety Issues or Precautions?</div>	   	Home _____ Admit _____ Transfer _____ NH _____ TBD _____ _____ _____	<input type="checkbox"/> Rounded on Patient <input type="checkbox"/> Communicated with Nurse _____
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*This form is a Quality Assurance Tool and is **NOT** part of the medical record*

# Hall Pass or Ticket to Ride

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PATIENT HAND OFF	
Date:	Room #:
Time:	
<b>S</b>	<b>Situation</b> Type Test <input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> US <input type="checkbox"/> Cardiology <input type="checkbox"/> MRI Mode of Transportation <input type="checkbox"/> Cart <input type="checkbox"/> Wheelchair <input type="checkbox"/> Ambulatory Multiple Tests Ordered <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>E</b>	<b>Background</b> Allergies <input type="checkbox"/> Yes (See band) <input type="checkbox"/> No DNR <input type="checkbox"/> Yes <input type="checkbox"/> No Precautions <input type="checkbox"/> Fall <input type="checkbox"/> Suicide <input type="checkbox"/> Seizure Isolation <input type="checkbox"/> Contact <input type="checkbox"/> Airborne <input type="checkbox"/> Droplet Impairment <input type="checkbox"/> Speech <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> None
<b>A</b>	<b>Assessment</b> Mental Status <input type="checkbox"/> Oriented <input type="checkbox"/> Disoriented Mobility <input type="checkbox"/> Self <input type="checkbox"/> Assist Staff 1 <input type="checkbox"/> Assist Staff 2 <input type="checkbox"/> Total Equipment <input type="checkbox"/> O2 ___ liters <input type="checkbox"/> Intubated <input type="checkbox"/> IV started Restraints <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Labs drawn NPO <input type="checkbox"/> Yes <input type="checkbox"/> No Catheter inserted <input type="checkbox"/> Yes <input type="checkbox"/> No Cath & Fill <input type="checkbox"/> Yes <input type="checkbox"/> No Department notified patient ready <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>R</b>	<b>Recommendation</b> Assistive device/Help needed for transfer:  Other comments:  RN Name: Contact Number
Return Trip:	

# Communication

- Have a culture where staff feel comfortable in asking questions and clarifying orders
- Hospitals accredited by TJC must do a culture survey which asks this question
- AHRQ has a survey that hospitals can use and can benchmark against other hospitals
- Can confirm communications by asking patient to repeat back information
- Study: [The Emergency Medical Services Safety Attitudes Questionnaire.](#) Patterson PD, Huang DT, Fairbanks RJ, Wang HE. Am J Med Qual. 2010;25:109-115.

[www.ahrq.gov/qual/patientsafetyculture/](http://www.ahrq.gov/qual/patientsafetyculture/)

The screenshot shows the AHRQ website with a blue header for the U.S. Department of Health & Human Services and the AHRQ logo. A search bar and navigation menu are visible. The main content area features a breadcrumb trail, a title for 'Surveys on Patient Safety Culture', and a link to an email update. Below this, a paragraph explains the agency's goal to support patient safety and quality improvement. A list of three surveys is provided, followed by a section on how health care organizations can use these surveys.

U.S. Department of Health & Human Services [www.hhs.gov](http://www.hhs.gov)

**AHRQ** Agency for Healthcare Research and Quality  
Advancing Excellence in Health Care

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You Are Here: [AHRQ Home](#) > [Quality & Patient Safety](#) > [Medical Offices & Patient Safety](#) > [Surveys on Patient Safety Culture](#)

## Surveys on Patient Safety Culture

[Sign Up for Surveys on Patient Safety Culture E-mail Updates](#)

As part of its goal to support a culture of patient safety and quality improvement in the Nation's health care system, the Agency for Healthcare Research and Quality (AHRQ) sponsored the development of patient safety culture assessment tools for hospitals, nursing homes, and ambulatory outpatient medical offices.

Three surveys on patient safety culture are available:

- [Hospital Survey on Patient Safety Culture](#)
- [Medical Office Survey on Patient Safety Culture](#)
- [Nursing Home Survey on Patient Safety Culture](#)

Health care organizations can use these survey assessment tools to:

- Raise staff awareness about patient safety.
- Diagnose and assess the current status of patient safety culture.
- Identify strengths and areas for patient safety culture improvement.
- Examine trends in patient safety culture change over time.

# Holding Admitted Patients in the ED

- Delays lead to overcrowding and boarding in the ED, ambulance unloading to ED cart or diversion, and patients who LWBS
- Holding patients in the ED causes delays in patient care
  - ENA and ACEP position statements
- Place patients at risk for poor outcomes
- Prolongs pain and suffering

# Holding Patients in the ED    Boarding

- Result in patient dissatisfaction
- Decreased staff productivity and frustration and violence
- Increased potential for errors and studies have confirmed increased mortality and morbidity
- GAO, CDC, and ACEP have issued reports on the effects of overcrowding
- TJC has standard in LD chapter called the Patient Flow standard and a Patient Flow Tracer

# TJC Patient Flow Tracer

- Patient flow standard is LD.04.03.11
  - Final changes in 2013 and 2014
- Patients can not get into the ED rooms and patients wait in ED for an inpatient bed
- LD has responsibility to evaluate and manage patient flow and take action to implement plans to improve
  - If patient flow problems are identified during survey will interview hospital leaders about their shared accountability with MS
- Will look at all of the standards on patient flow

# TJC Amends Patient Flow Standards



[www.jointcommission.org/standards\\_information/prepublication\\_standards.aspx](http://www.jointcommission.org/standards_information/prepublication_standards.aspx)

## Standards Revisions to Address Patient Flow Through the Emergency Department Hospital Accreditation Program

---

### **Standard LD.04.03.11**

The hospital manages the flow of patients throughout the hospital.

---

#### **Element of Performance for LD.04.03.11**

---

1. The hospital has processes that support the flow of patients throughout the hospital.
2. The hospital plans for the care of admitted patients who are in temporary bed locations, such as the post anesthesia care unit or the emergency department.
3. The hospital plans for care to patients placed in overflow locations.
4. Criteria guide decisions to initiate ambulance diversion.
5. The hospital measures the following components of the patient flow process:
  - The available supply of patient beds
  - The efficiency of areas where patients receive care, treatment, and services
  - The safety of areas where patients receive care, treatment and services

# Patient Safety Brief 2013 & 2014 Changes



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[www.empsf.org](http://www.empsf.org)

## **The Joint Commission New Patient Flow Standards**

By: Sue Dill Calloway RN MSN JD CPHRM  
Chief Learning Officer

Emergency Medicine Patient Safety Foundation  
July 2012

The Joint Commission is an organization that accredits about 82% of the hospitals in the United States. Any hospital accredited by the Joint Commission must be in compliance with all of their standards. The Joint Commission has standards on patient flow to prevent overcrowding and boarding of patients in the emergency department and in other temporary locations.

# TJC Patient Flow Standards

- TJC has revised their standards on patient flow effective January 1, 2013 and 2 changes in 2014
  - Not called JCAHO anymore
- LD.04.03.11 EP 6 goes into effect January 1, 2014 regarding setting a 4 hour window as the goal for boarding of patients in the ED before they get to their bed
- LD.04.03.11 EP 9 goes into effect January 1, 2014 regarding boarding of behavioral health patients in the ED

## LD.04.03.11 Patient Flow

- Standard: The hospital must manage the flow of patients throughout the hospital
- Managing patient flow is very important
- Patient flow **tracer** added in 2008 surveys and modified in 2012, 2013 and 2014
- Needed to prevent overcrowding that leads to patient safety and quality issues
- Hospital needs to use indicators to monitor process including admitting, assessment, and treatment, patient transfer and discharge

# TJC Final Pt Flow Changes 2013 & 2014

The screenshot shows the The Joint Commission website. At the top left is the logo and name "The Joint Commission". To the right are links for "Log In | Request Guest Access", "Forgot password? | Log In Help", "Contact Us | Careers | Press Room", and a search bar. A blue navigation bar contains "Accreditation", "Certification", "Standards", "Measurement", "Topics", "About Us", and "Daily Update". Below this is a breadcrumb trail: "Home > Standards > Prepublication Standards". There are social media icons for Twitter, Facebook, Google+, and LinkedIn. The date "Tuesday 7:16 CST, July 24, 2012" is displayed. The main heading is "Prepublication Standards" with a "Back" button. A sidebar on the left lists "Standards" and "About Our Standards". The main content area is titled "Topic Library Item" and features the article "Standards Revisions to Address Patient Flow through the Emergency Department" under "Prepublication Standards", dated May 6, 2012. A "Download This File" button is present. A "Prepublication Standards for the Hospital Accreditation Program - Effective 1/1/2013" notice is at the bottom. An advertisement for the "Electronic Standards Manual" is on the right.

[www.jointcommission.org/standards\\_information/prepublication\\_standards.aspx](http://www.jointcommission.org/standards_information/prepublication_standards.aspx)

# TJC Issues R3 Report

- Published December 19, 2012 and is 5 pages
  - Provides rationale, requirements, and references used
- Can be downloaded off TJC website at [www.jointcommission.org/r3\\_report\\_issue4/](http://www.jointcommission.org/r3_report_issue4/)
- Discusses LD.04.03.11 and PC.01.01.01
  - LD.04.03.11: The hospital manages the flow of patients throughout the hospital (Revises EP 5, 7, and 8)
  - PC.01.01.01: The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs (EP 4 and 24)
- LD EP 6 (4 hour time frame) and 9 (boarding behavioral health patients) go into effect Jan 1, 2014

# R3 Report Patient Flow Thru the ED

The screenshot shows the website for The Joint Commission. At the top left is the logo and name "The Joint Commission". To the right are links for "Log in | Request Guest Access", "Forgot password? | Log in Help", "Contact Us | Careers | JCR Risk Store | Press Room", and a search bar with a "Go" button. Below this is a navigation menu with "Accreditation", "Certification", "Standards", "Measurement", "Topics", "About Us", and "Daily Update". The main content area has a breadcrumb "Home > Topic Details" and a "Topic Details" heading. A URL is overlaid: [www.jointcommission.org/r3\\_report\\_issue4/](http://www.jointcommission.org/r3_report_issue4/). There are social media icons for Twitter, Facebook, Google+, LinkedIn, and Print. The date "Wednesday 9:47 CST January 2, 2013" is shown. A "Sign up for News and Alerts" box is on the left. The main content is titled "Topic Library Item" and "R<sup>3</sup> Report Issue 4 - Patient flow through the emergency department" with a date of "December 18, 2012". A "Download This File" button is present. Below is a paragraph of text: "Published for Joint Commission accredited organizations and interested health care professionals, R<sup>3</sup> Report provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also provide a rationale, the rationale provided in R<sup>3</sup> Report goes into more depth. The references provide the evidence that supports the requirement. R<sup>3</sup> Report may be reproduced only in its entirety and credited to The Joint Commission. To receive by e-mail, sign up to receive an [Email Alert](#)."

## Patient Flow Standard LD.04.03.11

- EP1. Must have processes that support the efficient flow of patients throughout the hospital
- EP2. The hospital plans for care of admitted patients who are in temporary-bed locations, such as the PACU and the emergency department (ED)
- EP3. The hospital plans for care to those patients who are placed in overflow locations
- EP4. Criteria guide decisions to initiate ambulance diversion

# Patient Flow Standard

- EP5. The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the ED
  - Boarding is the practice of holding patients in the ED or a temporary location after the decision to admit or transfer has been made.
  - It is recommended that hospital set goals with attention to best practices and its goals and boarding should not go over 4 hours in the interest of patient safety and quality of care

## LD.04.03.11 Boarding and the 4 Hour Rule

- EP6 EP was effective January 1, 2014
- The hospital must measure and set goals for mitigating and managing the boarding of patients who come through the ED
- It is recommended that patients not be boarded more than **4 hours**
- This is important for safety and quality of care

## LD.04.03.11 Review Measurement Data

- EP7 was effective January 1, 2013
- EP 7 Requires the staffs or individuals who manage the patient flow processes must review the measurement results
- This is done to assess if the goals made were achieved
- Data required was discussed in EP 5

## LD.04.03.11 Data Guides Improvements

- EP8 revision was effective January 1, 2013
  - EP8 Requires leaders to take action to improve patient flow when the goals were not achieved
- Leaders who must take action involve the board, medical staff, along with the CEO and senior leadership staff
  - References PI.03.01.01, EP 4, which states that the hospital takes action when it does not achieve or sustain planned improvement

## LD.04.03.11 Boarding of Psych Patients

- EP9 was effective January 1, 2014
- EP 9 States that the hospital determines if it has a population at risk for boarding due to behavioral health emergencies
- Hospital leaders must communicate with the behavioral health providers to improve coordination and make sure this population is appropriately served
- There is a shortage of behavioral health beds in this country leading to times where these patients have camped out in the ED sometimes for days

# Boarding of Behavioral Health Patients PC

- Hospitals should also be familiar with two sections of PC.01.01.01 under EP4 and EP24
- EP 4 Hospitals that do not primarily provide psychiatric or substance abuse services must have a written plan that defines how the patient will be cared for which includes the referral process for patient who are emotional ill, or who suffer from substance abuse or alcoholism
  - This means that hospitals that do not have a behavioral health unit or substance abuse unit, how do you care for the patient until you transfer them out?

# Boarding of Behavioral Health Patients PC

- PC.01.01.01 EP 24
- EP 24 requires boarded patients with an emotional illness, alcoholism or substance abuse be provided a safe and monitored location that is free of items that the patients could use to harm themselves or others
- Hospitals often use sitters and have a special safe room
- EP24 requires orientation and training to both clinical and non-clinical staff that care for these patients

# Boarding of Behavioral Health Patients PC

- PC.01.01.01 EP 24 (Continued)
- This includes medication protocols and de-escalation techniques
- Assessments and reassessments must be conducted in a manner that is consistent with the patient's needs
- Free guide on how to create a safe room called the Design Guide for the Built Environment of Behavior Health Facilities, at <https://www.naphs.org/index>

# Examples of Compliance

- LD should be aware of data to show if overcrowding has occurred
- Are patients camped out in the ED for hours awaiting a bed?
- If so what plans did leadership put in place to help resolve issue
- Was staff provided appropriate cross training?
- Evidence of minutes of patient flow committee
- Do pull to full

# Patient Flow Tracer TJC LD.04.03.11

- Look at patient flow and back flow issues
- Evaluate process issues leading to back flow
- Identify temporary holding area such as are patients held in the emergency department or waits for surgery or critical care units
- Treatment delays, medical errors and unsafe practices can thrive in presence of patient congestion
- TJC hospitals are expected to identify and correct patient flow issues

# Patient Flow Tracer TJC LD.04.03.11

- Look at how the hospital plans for staffing and trains staff about differences in emergent and hospital care
- What you have done to improve and plan for diversion
- Look at past data collection
- How do you identify problems and implement improvements
- LD needs to share accountability with MS

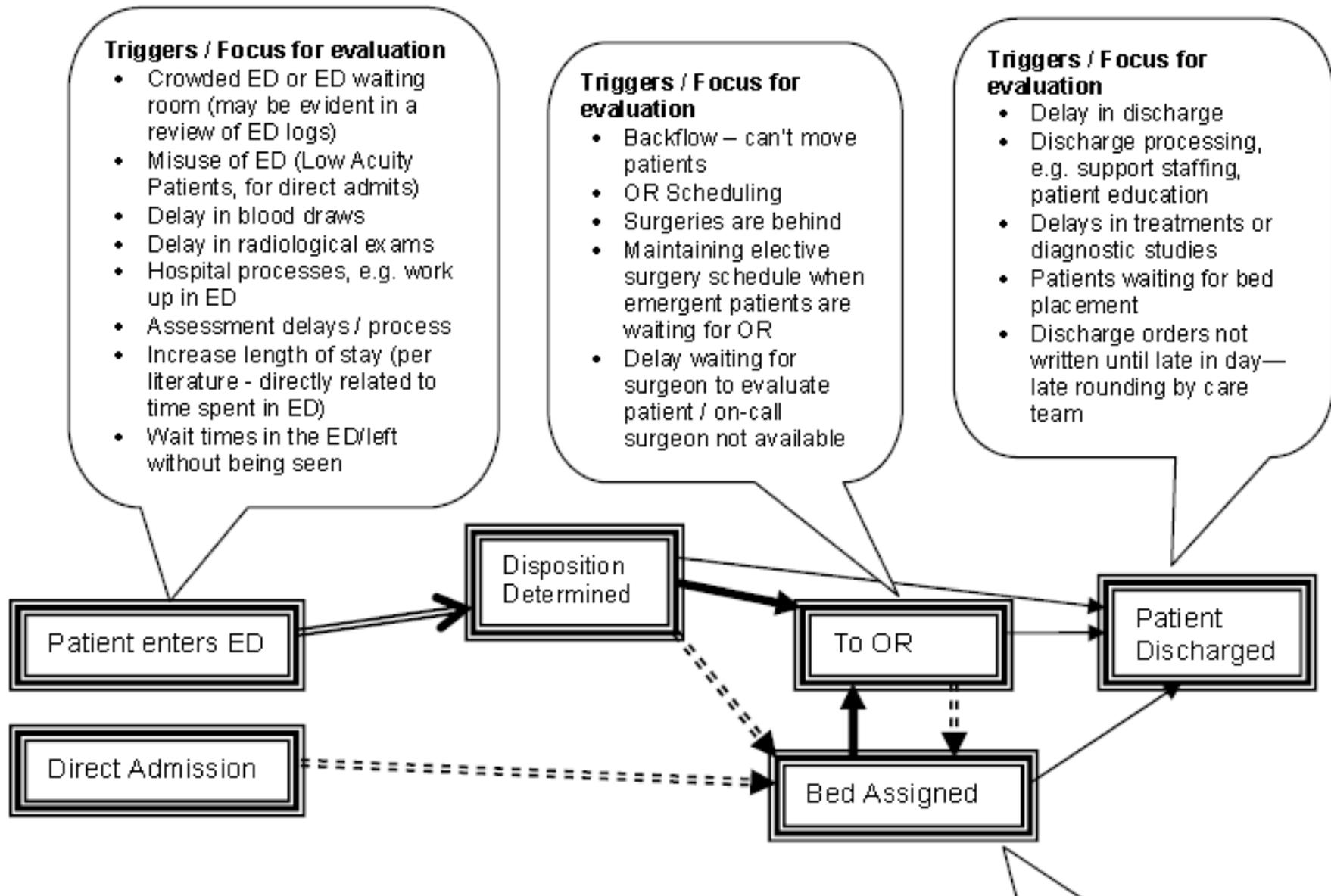
# Triggers Indicative of Patient Flow Problems

- Delay in blood draws or x-rays
- Delay in communication such as reporting handoff from one area to another
- Delay in discharge due to discharge processes
- Delay in OR scheduling
- Hospital process that stop flow of patient in ED such as work up in ED or housekeeping protocols
- Misuse of ED for direct admits

# Triggers Indicative of Patient Flow Problems

- Increase length of stay in the ED
- Insufficient support and ancillary staffing
- Misuse of ED for low acuity patients and direct admits
- Patients experiencing delays with transfers
- Indicators such as MI get ASA and beta blockers on arrival and fibrinolytic with 30 minutes and PCI within 90 minutes
- Pneumonia patients blood cultures and antibiotics timely?

# Patient Flow Triggers



# Patient Flow Tracer

- Look at back flow issues and identify temporary holding area
- How does the hospital plans for staffing and train staff about differences in emergent and hospital care
- What you have done to improve, plan for diversion, and what data has been collected
- How you identify problems and implement improvements
- ACEP has good resources at <http://www.acep.org/crowding/>

# Patient Flow Patient Safety Brief [www.empsf.org](http://www.empsf.org)



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## **The Joint Commission New Patient Flow Standards**

By: Sue Dill Calloway RN MSN JD CPHRM  
Chief Learning Officer  
Emergency Medicine Patient Safety Foundation  
July 2012

The Joint Commission is an organization that accredits about 82% of the hospitals in the United States. Any hospital accredited by the Joint Commission must be in compliance with all of their standards. The Joint Commission has standards on patient flow to prevent overcrowding and boarding of patients in the emergency department and in other temporary locations.

# ACEP Crowding Boarding Resources

## Emergency Medicine Crowding and Boarding

[www.acep.org/crowding/](http://www.acep.org/crowding/)

Search Crowding:

Search

As emergency departments throughout the country deal with the problems of crowding, boarding, and ambulance diversion, solutions have been sought. The resources on this page provide information, resources and examples of a variety of approaches to assist emergency physicians in addressing the crowding problems by working with hospital administrators, local stakeholders, policy makers and the public. Some ACEP chapters have sought relief through state legislative and regulatory action. These additional crowding resources are available in [ACEP's Advocacy area](#).

### [Emergency Department Crowding: High-Impact Solutions](#)

This comprehensive 2008 report from the ACEP Boarding Task Force includes low and no-cost solutions to the practice of boarding patients in the emergency department. [ACEP members get free CME](#).

### [ACEP's Suggested Boarding Solutions Generate National Support](#)

May 30, 2008

### [Crowding Case Studies](#)

Submit your case study for publication on [ACEP.org](#).

# ACEP Crowding Boarding Resources



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## Emergency Medicine Crowding and Boarding

Search this Section

Search

As emergency departments throughout the country deal with the problems of crowding, boarding, and ambulance diversion, solutions have been sought. The resources on this page provide information, resources and examples of a variety of approaches to assist emergency physicians in addressing the crowding problems by working with hospital administrators, local stakeholders, policy makers and the public. Some ACEP chapters have sought relief through state legislative and regulatory action. These additional crowding resources are available in [ACEP's Advocacy area](#).

### **ACEP Sends Comments to The Joint Commission on Patient Flow** **NEW**

ACEP supports the proposed definition, including the 4 hour timeframe, opinions among members are varied.

Jan. 19, 2012

### **Associations Join Forces to Reduce ED Crowding**

ACEP, ENA and seven other associations have signed a consensus statement that proposes standardized emergency department metrics to help reduce crowding and boarding in emergency departments.

[Consensus Statement: Definitions for Consistent Emergency Department Metrics](#) **NEW**

**[Emergency Department Crowding: High-Impact Solutions](#)**

This comprehensive 2008 report from the ACEP Boarding Task Force includes low and no-cost solutions to the practice of boarding patients in the emergency department.

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May 30, 2008

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**Related ACEP Policy Statements**

**Boarding**

[Boarding of Admitted and Intensive Care Patients in the Emergency Department](#)

[Boarding of Pediatric Patients in the Emergency Department](#)

[Definition of Boarded Patient](#)

[Health Care System Surge Capacity Recognition, Preparedness, and Response](#)

[Responsibility for Admitted Patients](#)

[Writing Admission and Transition Orders](#)

**Diversion**

[Ambulance Diversion](#)

[PREP for above policy:](#)

[Guidelines for Ambulance Diversion](#)

[Crowding](#)

[Emergency Ambulance Destination](#)

**Information Papers**

[Publishing Wait Times for Emergency Department Care, June 2012](#)

[Optimizing ED Front End Operations, February 2010](#)

[Approaching Full Capacity in the Emergency Department, October 2006](#)

# ACEP Boarding of Patients in the ED

## Boarding of Admitted and Intensive Care Patients in the Emergency Department

Approved April 2011

Revised and approved by the ACEP Board of Directors January 2007; April 2008; and April 2011

Originally approved by the ACEP Board of Directors October 2000

Optimal utilization of the emergency department (ED) includes the timely evaluation, management, and stabilization of all patients. Boarding of admitted patients in the ED contributes to lower quality of care, reduced timeliness of care, and reduced patient satisfaction. The ED should not be utilized as an extension of the intensive care and other inpatient units for admitted patients, because this practice adversely affects patient safety, quality, and access to care. ED leadership, hospital administrators, EMS directors, community leaders, state and federal officials, hospital regulators and accrediting bodies should work together to resolve this problem. ED boarding is a hospital-wide problem and the most effective care of admitted patients is provided in an inpatient unit. ED crowding is a direct result of diminished bed and resource capacity created by boarding. In order for the ED to continue to provide quality patient care and access to that care, the American College of Emergency Physicians (ACEP) believes that:

- Hospitals have the responsibility to provide quality patient care and optimize patient safety by ensuring the prompt transfer of patients admitted to inpatient units as soon as the treating emergency physician makes such a decision. If such a transfer cannot be promptly effected for whatever reason, the hospital must provide the supplemental nursing staff necessary to care for these inpatients boarded in the ED.
- In the event that the number of patients needing evaluation or treatment in an ED is equal to or exceeds the ED's treatment space capacity, admitted patients should be promptly distributed to inpatient units regardless of inpatient bed availability.
- Hospitals should have staffing plans in place that can mobilize sufficient health care and support personnel to meet increased patient needs.
- Hospitals should develop appropriate mechanisms to facilitate availability of inpatient beds.
- Emergency physicians should work with their hospital administration and medical staff to monitor and improve the use of inpatient resources.

• Staffing patterns applicable to other specialized areas/units of the hospital should apply equally to the

# ACEP Resources Crowding and Boarding

THE PRACTICE OF EMERGENCY MEDICINE/CONCEPTS

## Optimizing Emergency Department Front-End Operations

Jennifer L. Wiler, MD, MBA  
Christopher Gentle, MD  
James M. Halfpenny, DO  
Alan Heins, MD  
Abhi Mehrotra, MD  
Michael G. Mikhail, MD  
Diana Fite, MD

From the Division of Emergency Medicine, Washington University in St. Louis School of Medicine, St. Louis, MO (Wiler); the Department of Emergency Medicine, Christiana Care Health Services, Newark, DE (Gentle); Forrest Hills Hospital, Forrest Hills, NY (Halfpenny); the Department of Emergency Medicine, University of South Alabama College of Medicine and Medical Center, Mobile, AL (Heins); the Department of Emergency Medicine, University of North Carolina, Chapel Hill, NC (Mehrotra); the Department of Emergency Medicine, St. Joseph Mercy Hospital, Ann Arbor, MI (Mikhail); and the Department of Emergency Medicine, University of Texas Medical School at Houston, Houston, TX (Fite).

As administrators evaluate potential approaches to improve cost, quality, and throughput efficiencies in the emergency department (ED), "front-end" operations become an important area of focus. Interventions such as immediate bedding, bedside registration, advanced triage (triage-based care) protocols, physician/practitioner at triage, dedicated "fast track" service line, tracking systems and whiteboards, wireless communication devices, kiosk self check-in, and personal health record technology ("smart cards") have been offered as potential solutions to streamline the front-end processing of ED patients, which becomes crucial during periods of full capacity, crowding, and surges. Although each of these operational improvement strategies has been described in the lay literature, various reports exist in the academic literature about their effect on front-end operations. In this report, we present a review of the current body of academic literature, with the goal of identifying select high-impact front-end operational improvement solutions. [Ann Emerg Med. 2010;55:142-160.]

0196-0644/\$-see front matter  
Copyright © 2009 by the American College of Emergency Physicians.  
doi:10.1016/j.annemergmed.2009.05.021

### INTRODUCTION

**Emergency Department Crowding and the Need for Operational Improvement Strategies**

For nearly 2 decades, emergency department (ED) crowding has been recognized as a growing problem. From 1995 through 2005, the annual number of ED visits in the United States increased nearly 20%, from 96.5 million to 115.3 million, yet

has emphasized the need for smoothing ED patient flow and, in January 2005, implemented a new leadership standard, managing patient flow, which mandates that hospitals "...develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital."<sup>19</sup> Other organizations, including the Institute for Medicine, Agency for Healthcare Research and Quality

ACEP TASK FORCE REPORT ON BOARDING

---

# Emergency Department Crowding: High-Impact Solutions

<http://www.acep.org/crowding>



APRIL 2008

# Ideas to Reduce Crowding Boarding

- Diversion of ambulances when no beds or not enough staff
- Direct admits do not go through the ED
- Initial orders can be done on admitted patients who are stable and detailed orders can be written upstairs
- Bedside registration to allow rapid intake of patient into the system
- Tracking systems and white boards
- Triage based protocols/standing orders or protocols

# Ideas to Reduce Crowding Boarding

- Standardized pathways for specific disease conditions
- Addition of physician or physician extender to triage assessment
- Urgent care and fast track
- Immediate bedding (pull to full)
- Adequate staffing
- Consolidate all boarders in one area or over flow unit

# Ideas to Reduce Crowding Boarding

- Stat clean process when empty bed needs cleaned
- Hospital in-house protocol when operating at full capacity to get see if inpatients can be discharged or elective surgeries cancelled etc
- Discharge holding areas for patients to be discharged
- Sending one patient to each unit to care for until regular bed available
- Expand the size of the ED
- Examine reasons for delays

# Urgent Matters Crowding and Boarding

The screenshot displays the homepage of the Urgent Matters website. At the top left is the 'URGENT MATTERS' logo with the tagline 'An online journal of emergency medicine and disaster medicine'. To the right is the URL 'www.urgentmatters.org'. A navigation bar includes links for 'About Urgent Matters', 'E-Newsletter', 'Webinars', 'Forfeit', and 'Resources'. The main content area is divided into three columns. The left column features a blue sign with a white 'H' and an arrow, followed by an 'Announcements' section titled 'Urgent Matters Webinar: Reorganization of Emergency Services' with a 'Register Here' link. The middle column is the 'URGENT E-Newsletter' section, featuring articles on 'Airline Populations', 'The Green Palm Action Plan', and 'The issue's Perspectives article features Seattle Westchester'. The right column is titled 'Spotlight on Learning Network II' and features a 'Read More' link and a photograph of a building entrance.

# Alarm Fatigue

- Recent risk management issue
- Brought to light by several articles in the press including Boston Globe article
- Hospital staff fails to hear a cardiac monitor and patient was found flat lined for more than two hours
- With increased use of alarms they are either ignored or just not heard
- Staff have forgotten to turn them back on
- Staff can tune out the alarm noise

# Patient Alarms Often Unheard or Unheeded

SPECIAL REPORT

The Boston Globe

## Patient alarms often unheard, unheeded

The incessant din of beeping monitors can numb or distract hospital staff; the consequences can be deadly



# Alarm Fatigue

- ECRI Institute issues a report and finds 216 deaths from 2005 to mid 2010 in which problems with monitor alarms occurred
- ECRI published top hazards for 2014 and alarm hazards makes the top ten list
- Staff overwhelmed by sheer number of alarms
- Staff improperly modified the alarm settings
- Staff become desensitized to alarms leading to slow response time
  - CMS cited hospital under staffing when staff did not respond timely and hospital gets monitor watchers

# Alarm Fatigue

- Alarm settings not restored to their normal levels
- Alarms not properly relayed to ancillary notification systems
  - Paging systems, wireless phones, etc.
- ECRI makes recommendations
  - Establish protocols for alarm system settings
  - Ensure adequate staffing
  - Establish alarm response protocols and ensure each alarm will be recognized
  - Assign one person responsible for addressing the alarm

# Alarm Problems in the ED



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PATIENT SAFETY  
FOUNDATION

[www.empse.org](http://www.empse.org)

## Addressing Alarm Problems in the Emergency Department

By Kathryn M Pelczarski

Director, Applied Solutions Group, ECRI Institute

September 2012

Stand for a few moments in the middle of your emergency department (ED) to just listen and observe. How many alarms do you hear? Can you distinguish where each alarm is coming from and whether it's a physiologic monitor or ventilator or infusion pump alarm? Does each alarm connote the level of urgency needed for the nurse to respond promptly and appropriately? Do you observe the nurses scurrying to respond? Or do the alarms continue to perpetuate while no one responds?

Device alarms should provide an effective safety net to alert caregivers to critical changes in patient conditions or safety-related problems with devices. Does this statement hold true in your organization? Do device alarms provide an effective safety net in your ED?

Unfortunately, as many experts agree, there are serious problems with both the design and use of clinical alarms. In fact, ECRI Institute identified alarm hazards as Number 1 in its Top Ten Technology Hazards in 2011.<sup>1</sup> Many medical devices such as physiologic monitors, ventilators, and infusion pumps rely on alarms to help protect patients, but there are times when alarms actually contribute to the occurrence of adverse events. The reality is that alarm events frequently occur, and the consequences of these events are often serious. Alarm events are those accidents waiting to happen, the results of a perfect storm in a error-prone system.

Most EDs are plagued by a myriad of alarm problems, such as:

# TJC Sentinel Event Alert 50 Alarm Safety

## The Joint Commission Sentinel Event Alert

A complimentary publication of  
The Joint Commission

Issue 50, April 8, 2013

### Medical device alarm safety in hospitals

Published for Joint Commission accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel events, describes their common underlying causes, and suggests steps to prevent occurrences in the future.

Accredited organizations should consider information in an Alert when designing or redesigning relevant processes and consider implementing relevant suggestions contained in the Alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may only be reproduced in its entirety and credited to The Joint Commission. To receive by email, or to view past issues, visit [www.jointcommission.org](http://www.jointcommission.org).

Many medical devices have alarm systems; among them are bedside physiologic monitors that include ECG (electrocardiogram) machines, pulse oximetry devices, and monitors of blood pressure and other parameters; bedside telemetry; central station monitors; infusion pumps; and ventilators. These alarm-equipped devices are essential to providing safe care to patients in many health care settings; clinicians depend on these devices for information they need to deliver appropriate care and to guide treatment decisions. However, these devices present a multitude of challenges and opportunities for health care organizations when their alarms create similar sounds, when their default settings are not changed, and when there is a failure to respond to their alarm signals.

The number of alarm signals per patient per day can reach several hundred depending on the unit within the hospital, translating to thousands of alarm signals on every unit and tens of thousands of alarm signals throughout the hospital every day. It is estimated that between 85 and 99 percent of alarm signals do not require clinical intervention, such as when alarm conditions are set too tight; default settings are not adjusted for the individual patient or for the patient population; ECG electrodes have dried out, or sensors are repositioned.<sup>1</sup> As a result, clinicians become desensitized or immune to the sounds, and are overwhelmed by information – in short, they suffer from “alarm fatigue.” In response to this constant barrage of noise, clinicians may turn down the volume of the alarm, turn it off, or adjust the alarm settings outside the limits that are safe and appropriate for the patient – all of which can have serious, often fatal, consequences.<sup>2</sup> One such example occurred in the summer of 2010. According to a *Boston Globe* article, a 60-year-old man died in the intensive care unit of a hospital – not from the injury he suffered to his head from a fallen tree branch – but from a system failure that resulted in delayed response to an alarm signal that indicated significant changes in his condition.<sup>3</sup> These changes – that set off alarms – included rapidly increasing heart rate and falling blood oxygen levels. Staff responded only after one hour, when a critical alarm condition signaled that the patient had stopped breathing –

# Verbal Orders

- Common problematic standard with CMS and TJC
- Should not be a common practice
- Physician is not allowed to give if standing in nursing station absent an emergency
- May take if needed and physician not in the department
- Nurse needs to write it down and **read** it back
- Nurse needs to sign name, date and **time**
- Physician must sign name, date and **time** also

# Verbal Orders

- Physician must sign off the VO (including date and time) within time specified by state law
  - Most states say 24 or 48 hours
  - If state does **not** say then it use to 48 hours and now what your P&P says so many picked 30 days if no state law
- CMS will allow PA or NP to sign off VO for the physician if state and hospital allows and within their scope of practice
- Any physician on the case can sign off the VO for any other doctor including ED doctors signing for each other when relieving them (June 7, 2013)

# Verbal Orders

- Have a P&P on who can accept VO in your facility
  - Must be qualified staff
  - Policy may allow pharmacist for pharmacy orders, dietician for dietary orders, nurses, etc.
- Include in P&P when will not take VO
  - Such as many hospitals do not take a VO for chemotherapy
  - CMS 407-408 and 454 and 457
  - TJC RC.02.03.07. PC.02.02.07 and PC.01.01.01

# Restraints #1 Problematic CMS Standard

- Many changes were made to both TJC and CMS Restraint and Seclusion standards
- CMS Hospital CoPs has 50 pages of restraint standards from Tag 0154-0214
- TJC has 10 standards in PC chapter (deemed status)
- Need to rewrite policies and procedures, order sheet and documentation sheet to comply
- Need to train all staff in accordance with requirements
- Physicians must be trained on R&S P&P

# Restraint Patient Safety Brief

[www.empsf.org](http://www.empsf.org)



## **Restraint and Seclusion Patient Safety Briefing** Emergency Medicine Patient Safety Foundation

**Written by:** Sue Dill Calloway RN MSN JD CPHRM  
Michael Gerardi, MD, FAAP, FACEP  
John (Jack) Kelly DO, FACEP, FAAEM

March 2012  
Revised July 16, 2012

### **Introduction**

Restraint and seclusion is a very important patient safety issue. Appropriately applied restraints can protect patients from harming

# Emergency Medicine Pt Safety Foundation



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"Improving Patient Safety  
Through Education, Research  
Collaboration and Training"

# Restraint Worksheet

- Revised CMS restraint worksheet is available off the internet at
- R&S reports are to the regional office not the state agency
- List of regional offices (to put in your P&P) at [www.cms.hhs.gov/RegionalOffices/01\\_overview.asp](http://www.cms.hhs.gov/RegionalOffices/01_overview.asp)
- Must still notify regional office by phone the next business day and document this in medical record
- Patient dies in restraint, within 24 hours of being in a restraint or 7 day rule if death caused by R&S
  - Except if patient dies in **wrist restraints** as long as the restraint does not cause the death

# Reporting Deaths Unless 2 Soft Wrist Restraints

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850



## Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 14-27-Hospital-CAH/DPU

**DATE:** May 9, 2014

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Hospital Restraint/Seclusion Deaths to be Reported Using the Centers for Medicare and Medicaid Services (CMS) Form CMS-10455, Report of a Hospital Death Associated with Restraint or Seclusion

### Memorandum Summary

- ***Hospital Restraint/Seclusion Deaths to be Reported Using Form CMS-10455:*** Hospitals must use Form CMS-10455 to report those deaths associated with restraint and/or seclusion that are required by 42 CFR §482.13(g) to be reported directly to their Centers for Medicare & Medicaid Services (CMS) Regional Office (RO). This requirement also applies to rehabilitation or psychiatric distinct part units (DPUs) in Critical Access Hospitals (CAHs).
- ***RO to Provide Submission Instructions:*** CMS ROs must provide hospitals with instructions for submitting the form to the RO by fax and/or e-mail, based on RO preference.

**REPORT OF A HOSPITAL DEATH ASSOCIATED WITH RESTRAINT OR SECLUSION**

**A. Hospital Information:**

Hospital Name		CCN
Address		
City		State
		Zip Code
Person Filing the Report		Filer's Phone Number

**B. Patient Information:**

Name		Date of Birth
Primary Diagnosis(es)		
Medical Record Number	Date of Admission	Date of Death

Cause of Death

[www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10455.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10455.pdf)

**C. Restraint Information (check only one):**

- While in Restraint, Seclusion, or Both
- Within 24 Hours of Removal of Restraint, Seclusion, or Both
- Within 1 Week, Where Restraint, Seclusion or Both Contributed to the Patient's Death

Type (check all that apply):

- Physical Restraint
- Seclusion
- Drug Used as a Restraint

If Physical Restraint(s), Type (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> 01 Side Rails                  | <input type="checkbox"/> 08 Take-downs                            |
| <input type="checkbox"/> 02 Two Point, Soft Wrist       | <input type="checkbox"/> 09 Other Physical Holds (specify): _____ |
| <input type="checkbox"/> 03 Two Point, Hard Wrist       | <input type="checkbox"/> 10 Enclosed Beds                         |
| <input type="checkbox"/> 04 Four Point, Soft Restraints | <input type="checkbox"/> 11 Vest Restraints                       |
| <input type="checkbox"/> 05 Four Point, Hard Restraints | <input type="checkbox"/> 12 Elbow Immobilizers                    |
| <input type="checkbox"/> 06 Forced Medication Holds     | <input type="checkbox"/> 13 Law Enforcement Restraints            |
| <input type="checkbox"/> 07 Therapeutic Holds           |   |

If Drug Used as Restraint:

Drug Name	Dosage

# Restraint Death

- An exception is if the patient in the ED dies and only used two soft wrist restraints
  - Instead the hospital could just keep an internal log
  - The log would include the patient's name, date of birth, date of death, attending physician, primary diagnosis, and medical record number
  - Name of practitioner responsible for patient could be used in lieu of attending if under care on non-physician practitioner
  - CMS could request to review the log at anytime
  - Published in FR May 16, 2012 and effective July 16, 2012

# Restraint and Seclusion

- Patient has a right to be free from unnecessary R&S
- Leadership has responsibility to create culture that supports right to be free from R&S
- Should not be considered as part of routine part of fall prevention
- If use protocol you still need an order
- Know the CMS definition of restraint and seclusion
- Know if drug used as a restraint

# Restraint and Seclusion

- CMS calls it violent and or self destructive as opposed to TJC who calls it behavioral health
- CMS calls it non violent/non self destructive and TJC calls it non behavioral health patient
- Know what restraints do not include such as forensic restraints, orthopedically prescribed devices, holding for medical test, surgical dressings, or postural supports
- Mitt is restraint if boxing glove style

# Restraint and Seclusion

- Know what it does include such as freedom splints, and all 4 side rails if patient can not lower them
- Try or consider and document less restrictive interventions and alternatives
- Document the assessment
- Need order from physician or LIP
- If LIP gives order notify doctor ASAP
- Amend plan of care
- Consider debriefing although not required by CMS on V/SD patients

# Restraint and Seclusion

- End at the earliest time
- Do PI
- Use as directed
- If V/SD need one hour face to face
- Time limited orders for V/SD patients
- Need P&P on R&S
- Educate staff and document this
- Follow any stricter state law, and
- Report restraint deaths as required

# ACEP Position on Restraints 2014

## Use of Patient Restraints

Revised and approved by the ACEP Board of Directors with the same title April 2014, April 2001, June 2000, January 1996

[www.acep.org/Clinical---Practice-Management/Use-of-Patient-](http://www.acep.org/Clinical---Practice-Management/Use-of-Patient-)

[Restraints/http://www.acep.org/Clinical---Practice-Management/Use-of-Patient-Restraints](http://www.acep.org/Clinical---Practice-Management/Use-of-Patient-Restraints)

Reaffirmed by the ACEP Board of Directors October 2007

Originally approved by the ACEP Board of Directors January 1991

The American College of Emergency Physicians (ACEP) supports the careful and appropriate use of patient restraints or seclusion. ACEP recognizes that patient restraint involves issues of civil rights and liberties, including the right to refuse care, freedom from imprisonment, and freedom of association. However, there are circumstances when the use of restraints is in the best interest of the patient, staff, or the public.

Patient restraints should be considered when a careful assessment establishes that the patient is a danger to self or others by virtue of a medical or psychiatric condition and when verbal de-escalation is not successful.

ACEP endorses the following principles regarding patient restraints:

- Restraints should be instituted only after verbal de-escalation has been attempted.
- Restraint of patients should be individualized and employed in a manner that makes all reasonable attempts to maintain the patients' privacy and dignity.
- The method of restraint should be the least restrictive necessary for the protection of the patient and others.
- Staff should be properly trained in the appropriate use and application of restraints and in the monitoring of patients in restraint and seclusion.
- Protocols to ensure patient safety should be developed to address observation and treatment during the period of restraint and periodic assessment as to the need and means of continuing or discontinuing restraint.
- The use of restraints should be carefully documented, including the reasons for and means of restraint, alternatives to restraint, and the periodic assessment of the restrained patient.
- ACEP opposes any requirement by hospital representatives or medical staff that emergency physicians provide inpatient restraint or seclusion orders. Patient restraint or seclusion requires comprehensive patient assessment, and the emergency physician's principal legal and ethical responsibility is to patients who present to be seen and treated in the emergency department.
- The use of restraints should conform to applicable laws, rules, regulations, and accreditation

# Grievances and Complaints

- Every ED practitioner should be aware that CMS has grievance standards
  - CMS standards start at tag 118 and complete copy of the hospital CoP can be downloaded off the CMS website
  - TJC has also but calls them complaints under RI.01.07.01
- CMS has decided NOT to do proposed changes which would have required hospital to give all patients information including address, phone number, email address of QIO and SA and must document this in the medical record

# Location of CMS Hospital CoP Manuals

## Medicare State Operations Manual Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the "Download" column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers.

CMS Hospital CoP Manuals new address

[www.cms.hhs.gov/manuals/downloads/som107\\_Appendixtoc.pdf](http://www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf)

App. No.	Description	PDF File
A	Hospitals	 <a href="#">2.185 KB</a>
AA	Psychiatric Hospitals	 <a href="#">606 KB</a>

# Grievances and Complaints

- Patients have the right to file a grievance
- ED must investigate
- If meets definition of grievance then CMS requires the patient be given information in writing as to what was done and when it was done
- Must provide in writing the name of person at the hospital that patient can contact with a complaint
- Make sure know P&P
- Must investigate timely and can not resolve in 7 days must send the patient a letter

# Grievances and Complaints

- If patient is not competent then give information to surrogate decision maker
- A written complaint is always a grievance
- Billing issues are not generally a grievance unless a quality of care issue
- Information on a patient satisfaction survey is not a grievance unless patient asks for resolution
- Staff should know the definition of what constitutes a grievance
- Should document process in case CMS shows up

# Grievance Process A-0118

- **Definition:** A patient grievance is a formal or informal written or verbal complaint
  - When the verbal complaint about patient care is not resolved at the time of the complaint by **staff present**
  - By a patient, or a patient's representative,
  - Regarding the patient's care, abuse, or neglect, issues related to the hospital's compliance with the CMS CoP
  - Or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489.

# Have a Policy to Hit All the Elements

## **POLICY**

All internal and external customer (patient, physician, staff or visitors) complaints and problems will be addressed at the time of the occurrence in an effort to resolve the customer complaint or grievance and or review and improve the process. All patient and or family complaints received must be responded to promptly. Patients have a right to complain without any fear of reprisal. Any patient or patient's representative who expresses an issue or grievance is assured that this process is welcome and not fear that there would be any retaliation for initiating this action

Patients are informed to contact the Nursing Service Supervisor while in the hospital. Patients are also informed of their ability to contact the New York State Department of Health and the telephone number is provided to them at their request.

Any individual who believes his or her rights granted by the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations or any other state or federal laws dealing with privacy and confidentiality of health information have been violated may file a complaint regarding the alleged privacy violation to the Hospital's Privacy Officer (716)298-2047. The Privacy Officer will investigate alleged privacy violations and complaints made by patients or other individuals regarding alleged breaches of privacy

## **DEFINITION**

**Patient Grievance** – (as defined by Centers for Medicare & Medicaid Services, ref. 482.13(a)(2)) – is a written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient's representative, regarding the patient's care, abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (COP)

- **Staff Present** – includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (i.e. nursing supervisor, nursing administration, etc.)
- If a verbal patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is a grievance for the purposes of these requirements. A complaint is considered resolved when the patient is satisfied with the actions taken on their behalf.
- Billing issues are not usually considered grievances for the purposes of these requirements. However, a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489 are considered a grievance.
- A written complaint is considered a grievance, whether from an inpatient, outpatient, released/discharged patient or their representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with the COP.
- Information obtained with patient satisfaction surveys does not usually meet the definition of a grievance. If an identified patient writes or attaches a written complaint on the survey and requests resolution, then the complaint meets the definition of a grievance.

# MRI Guidelines

- Have patients completely undress and in hospital gown
- Use MRI screening form for all patients
- Consider doing FMEA on MRI safety
- Appoint a safety officer to make sure P&P in place
- Make sure consistent with ACR MRI recommendations
- Provide ear plugs to patients

# MRI Guidelines

- Audit compliance with MRI safety P&Ps
- Show staff multiple pictures of objects pulled into MRI machine
- Carefully screen all patients for magnetic objects in their hair or body
- Have ferromagnetic detector
- Know what devices are harmful
- Divide MRI into 4 zones
- Know the 5 G line of safety



# MRI Guidelines

- Do not bring anything of metal into the MRI room as it can become a missile
- Be aware of what can cause patient burns during MRI such as nitro patches or staples or touching the inside wall (bore) of the MRI scanner
- Be aware that the magnetic field can affect the operation and reliability of medical devices such as PCA pumps, ventilators, monitors
  - FDA just approved first MRI safe pacemaker
- Injury can occur from dislodging implants such as cochlear implant, cerebral aneurysm clips etc

# MRI Safety

- Consider a yearly seminar on MRI safety and include in orientation for new staff
- Have MRI safe equipment such as a special wheelchair
- Cases where oxygen tank brought in room and killed child, Guard came in and bullets came out of gun,
- TJC Sentinel Event Alert on MRI safety
- Careful about ED nurses carrying metal objects like scissors, and stethoscopes
- Patients have received burns from patches like nitro patch
- Nurse take metal IV cart to MRI door and flew across room into the MRI machine

# MRI Safety

- Make sure ED staff aware of P&P on MRI safety
- Recent case of sand bag as they may contain metal shots
- ACR has Updated 2013 white paper on MRI safety full of ideas and tips at [www.acr.org](http://www.acr.org) and make sure incorporated into your P&P
- Generally no patients with implanted pacemakers, ICD, vagus nerve stimulator, permanent eyeliner, cochlear implants, deep brain stimulators, insulin pumps, surgical pins and screws, aneurism clips, piercings, prosthetics, etc.
- Ice pack to skin staples during exam, problem with tattoos use same ice pack

# ACR Safe MRI Position Statement

JOURNAL OF MAGNETIC RESONANCE IMAGING 37:501-530 (2013)

## Special Communication

### ACR Guidance Document on MR Safe Practices: 2013

Expert Panel on MR Safety: Emanuel Kanal, MD,<sup>1\*</sup> A. James Barkovich, MD,<sup>2</sup> Charlotte Bell, MD,<sup>3</sup> James P. Borgstede, MD,<sup>4</sup> William G. Bradley Jr, MD, PhD,<sup>5</sup> Jerry W. Froelich, MD,<sup>6</sup> J. Rod Gimbel, MD,<sup>7</sup> John W. Gosbee, MD,<sup>8</sup> Ellisa Kuhni-Kaminski, RT,<sup>1</sup> Paul A. Larson, MD,<sup>9</sup> James W. Lester Jr, MD,<sup>10</sup> John Nyenhuis, PhD,<sup>11</sup> Daniel Joe Schaefer, PhD,<sup>12</sup> Elizabeth A. Sebek, RN, BSN,<sup>1</sup> Jeffrey Weinreb, MD,<sup>13</sup> Bruce L. Wilkoff, MD,<sup>14</sup> Terry O. Woods, PhD,<sup>15</sup> Leonard Lucey, JD,<sup>16</sup> and Dina Hernandez, BSRT<sup>16</sup>

Because there are many potential risks in the MR environment and reports of adverse incidents involving patients, equipment and personnel, the need for a guidance document on MR safe practices emerged. Initially published in 2002, the ACR MR Safe Practices Guidelines established de facto industry standards for safe and responsible practices in clinical and research MR environments. As the MR industry changes the document is reviewed, modified and updated. The most recent version will reflect these changes.

**Key Words:** MR safety; MR; MR safe practices  
*J. Magn. Reson. Imaging* 2013;37:501-530.  
© 2013 Wiley Periodicals, Inc.

THERE ARE POTENTIAL risks in the MR environment, not only for the patient (1,2) but also for the accompanying family members, attending health care professionals, and others who find themselves only occasionally or rarely in the magnetic fields of MR scanners, such as security or housekeeping personnel, firefighters, police, etc. (3-6). There have been reports in the medical literature and print-media detailing Magnetic Resonance Imaging (MRI) adverse incidents involving patients, equipment and personnel that spotlighted the need for a safety review by an expert panel. To this end, the American College of Radiology originally formed the Blue Ribbon Panel on MR Safety. First constituted in 2001, the panel was charged with reviewing existing MR safe practices and guidelines (5-8) and issuing new ones as appropriate for MR examinations. Published initially in 2002 (4), the ACR MR Safe Practice Guidelines established de facto industry standards for safe and responsible

<sup>1</sup>Department of Radiology, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania, USA.

<sup>2</sup>Department of Radiology and Biomedical Imaging, University of California, San Francisco, California, USA.

<sup>3</sup>Midford Anesthesia Associates, Milford, Connecticut, USA.

# MRI Safety

- Purchase only MRI compatible sandbags that are labeled for MRI Use
- Confirm they are ferromagnetic before allowing in MRI room
- Revise MRI screening checklist to include this
- Make sure magnetic objects are not hidden under blankets or sheets by patients
- May need to transfer to MRI compatible transport equipment including MRI safe cart
- Make sure ED staff are educated and include knowledge of policy and procedure

# Hospital Fined \$50,000

Published: Jan. 22, 2010

Updated: 7:13 p.m.

## Hoag fined in MRI accident

By COURTNEY PERKES  
THE ORANGE COUNTY REGISTER  
[cperkes@ocregister.com](mailto:cperkes@ocregister.com)

COMMENTS 13 | RECOMMEND  5 | PRINT | EMAIL |  SHARE

### ARTICLE

Hoag Hospital has been fined \$50,000 by the state Department of Public Health after an MRI patient on a metal gurney was magnetically pulled into the imaging machine, the hospital said Friday.

In a memo to staff, Dr. Richard Afable, chief executive officer of Hoag Memorial Hospital Presbyterian, described the scenario and policy changes to prevent future incidents. He was in Los Angeles on Friday and could not be reached for comment.



Afable said that last January a woman was taken into an MRI room on a metal gurney that was not compatible with the machine. The powerful magnet in the MRI pulled the gurney into the machine and the patient's leg was trapped for about three minutes. She was taken to the emergency room and spent three days in the hospital for treatment of fractures in her lower leg and foot.

Hoag failed to follow its policy of not allowing gurneys that are not MRI safe in the hallways outside the testing room, Afable said. The hospital has adopted new procedures including a checklist that must be done before entering the MRI room and installation of a camera for

**Story I**  
A patient  
after an  
machine

# Hospital Fined \$50,000 Jan 2010

- Hoag Hospital in California fined by state Dept of Public Health after patient was taken to MRI on a metal gurney
- Patient was pulled into the imaging machine breaking her lower leg
- Leg was trapped for three minutes
- Spent 3 days in the hospital
- Had adopted new procedure and checklist before entering MRI room
- Has installed cameras for monitoring

# Protocols

- Advanced triage protocols or triage based protocols are one approach to optimize ED front end operations
- Make sure approved by MS, order entered into the medical record, and consistent with scope of practice and state law
- Decreases patient length of stay
- Standardized pathways for specific conditions or complaints
  - Ordering x-rays for things like ankle injury, oral analgesic for pain or fever, institute elopement precautions for suicidal patients, EKG for chest pain patient, rapid strep protocol, urine for dysuria etc.

# ACEP Position Nurse Implemented Orders

## Clinical & Practice Management

### Clinical & Practice Management

Clinical Policies

Policy Statements

Resources

EMS & Disaster Preparedness

Find a Physician Group

## Use of Nurse Implemented Order Sets

Approved by the ACEP Board of Directors June 2010

The American College of Emergency Physicians (ACEP) recognizes the practice of utilizing nurse implemented **order sets**. These sets are predetermined collections of departmental orders initiated based upon nursing assessment of the patient and are consistent with high-quality emergency care, enhanced patient safety and satisfaction.

It is the position of the College that the use of such **order sets** does not, in and of itself, create a physician-patient relationship.

[www.acep.org/Content.aspx?id=48946&terms=order%20sets](http://www.acep.org/Content.aspx?id=48946&terms=order%20sets)

# Standing Orders

- CMS issued standing orders
  - Includes order sets, preprinted orders, electronic orders, and protocols
- Primarily located in tag 457 but also in 405, 406, and 450
- Make sure all standing orders approved by the Medical Staff (MEC)
- If medications then must be approved by nursing and pharmacy leadership
- Must educate staff on all standing orders

# Standing Orders 457

- Must make sure P&P reflects these requirements
- Must be consistent with national recognize standards and standards of care
- Must be well-defined clinical situations with evidence to support standardized treatments
- Can be initiated as emergency response
- Document in order sheet and practitioner must then sign, date and time the standing order
  - if electronic make sure entire order is present
- Must be medically appropriate

# Standing Orders 457

- Make sure there is periodic and regular review of the orders and protocols to determine the continued usefulness and safety
- P&P must address how it is developed, approved, monitored, initiated by staff and signed off or authenticated
- Make sure new ED physicians and staff are trained on existing protocols
- Audit to make sure they are dated, timed, and authenticated both by the person taking the order and the practitioner

# EMPSF Patient Safety Brief



Patient Safety Brief  
Emergency Medicine Patient Safety Foundation

## **CMS Requirements on Order Sets, Protocols, Preprinted Orders, and Standing Orders**

**Sue Dill Calloway RN MSN JD**

There are three separate tag numbers that hospitals must review in order to understand the Center for Medicare and Medicaid Services (CMS) requirements for standing orders, protocols, and order sets. Additionally, CMS included information on this topic in the changes to the hospital CoPs which was published in the Federal Register and which became effective July 16, 2012. Any hospital that accepts Medicare or Medicaid reimbursement must follow the conditions of participation (CoPs) and they must be followed for all patients seen in the hospital.

## Patients Who Leave Without Being Seen (LWBS)

- ED should track these for QI
- More recently refer to them as left before or after medical screening and AMA (2.8% in 2010 data)
- Good indicator of the quality of your ED
- If large number then look for opportunities for improvement including how to decrease wait times
- Document on the chart when it is first discovered that the patient left before screening
- Call patient three times and document times

# Left Before Medical Screening Examine

- TJC and CMS ( EMTALA ) requires the medical record be maintained on these patients
  - Even if just a patient name or if LBMS before being triaged
- Exponential rise in lawsuits after 2 hour waits
  - How does rate compare with the average rate of LWBS at 2% and AMA at 1.3% in 2009
  - Left before 1.7% or 1,928 and left after medical screen is 1.1% or 1,289 patient and Left AMA rate is 1.2% or 1,381 patients in 2010
  - AMA recommendations addressed in the EMTALA interpretive guidelines

# Refusal of Treatment

- Both CMS and TJC in the patient rights section allows a competent patient to refuse treatment
- However, they must be informed of the risks and benefits
- The risks and benefits should be clearly documented and the patient should sign the form
- The patient must be competent to make an informed decision to refuse care and not under the influence of drugs or alcohol

# Refusal of Treatment

- Patients can refuse part of care without being made to sign out AMA
  - Example is patient having a heart attack and will allow all tests except ABG's but pulse ox is allowed
- If patient wants to refuse a part of something then an informed signed refusal is done and patient is given treatment
- High number of patients return if sign out AMA
- CMS does not want to see ED with high AMA rate

# Patients Leaving AMA

- EMTALA requires that a medical screening exam be done on any patient who comes to the ED
  - Too many AMA may be EMTALA violation
- If the patient is in an emergency medical condition, then the patient must be stabilized
- There must be documentation of the exam that was done
- Documentation of the treatment refused

# Patients Leaving AMA

- An attempt to obtain written AMA form signed if the patient refuses all treatment
- Patient can not be intoxicated or mentally incompetent
  - only competent patients are eligible to sign out AMA
- CMS says hospitals should be very concerned about patients leaving AMA
- Can still give prescription or other call or call to check on patient

# Know How to Fill Out Your AMA Form

## AGAINST MEDICAL ADVICE/REFUSED TREATMENT/ EXAM/MEDICAL SCREENING CONSENT

### *Select One Option*

**Against Medical Advice**

I am leaving Bellin at my own insistence and against the advice of the health care organization's providers and the attending physician.

1. Risks and potential complications of leaving may include but are not limited to: \_\_\_\_\_  
\_\_\_\_\_
2. I accept risks/consequences of my decision to leave and release all health care providers from any adverse medical condition caused by my refusal of medical care.
3. Benefits of continuing care include: \_\_\_\_\_
4. Family/other involved in discussions and decision to dissuade leaving. If no, explain: \_\_\_\_\_  
\_\_\_\_\_
5. I have received discharge instructions and understand that I may return at any time for care.

**Against Medical Advice – Pediatric Patients Only**

I have been provided information on the risks associated with sleeping in the same bed as my child and have been advised to have my child sleep alone in the bed or crib provided. Even though I fully understand these risks, I intend to sleep in the same bed as my child while in the hospital.

**Refused Treatment/Examination**

I have been offered, and refuse to consent to \_\_\_\_\_

# Patients Leaving AMA EMTALA

- First, offer the patient further medical exam and treatment as needed to stabilize their condition
- Second, inform the patient of the risks of withdrawal prior to receiving such exam and treatment (be specific such as you could die, infection, death, etc.)
- Third, takes all reasonable steps to ensure written informed consent. This should contain a description of the risks discussed and that it was refused

# Patients Leaving AMA

- If the patient leaves without notifying the staff, document that the person has been there, and what time the hospital discovered the patient had left
- Retain all triage or other records
- The burden is on the hospital to show that it has taken all the appropriate steps to discourage the patient from leaving

## **AGAINST MEDICAL ADVICE (AMA FORM)**

This is to certify that I, \_\_\_\_\_,  
a patient at \_\_\_\_\_ (fill in name  
of your hospital), am refusing at my own insistence and without the authority  
of and against the advice of my attending physician(s)  
\_\_\_\_\_, request to leave against  
medical advice.

The medical risks/benefits have been explained to me by a member of the  
medical staff and I understand those risks.

I hereby release the medical center, its administration, personnel, and my  
attending and/or resident physician(s) from any responsibility for all  
consequences, which may result by my leaving under these circumstances.

### MEDICAL RISKS

\_\_\_\_\_ Death

\_\_\_\_\_ Additional pain and/or suffering

\_\_\_\_\_ Risks to unborn fetus

\_\_\_\_\_ Permanent disability/disfigurement

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# 5 Level Triage System ESI

- ACEP and ENA recommend five level triage system ESI or emergency severity index
- Can get copy of DVD and handbook on this at no cost by emailing [ahrqpubs@ahrq.hhs.gov](mailto:ahrqpubs@ahrq.hhs.gov)
- Called Emergency Severity Index, Version 4: Everything You Need To Know, (AHRQ Publication No. 05-0046-DVD)\
- Discusses evolution of triage
- Can print it off at [www.ahrq.gov/research/esi/esi1.htm](http://www.ahrq.gov/research/esi/esi1.htm)

# 5 Level Triage System



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Menu



Agency for Healthcare Research and Quality  
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www.ahrq.gov/research/esi/esi1.htm

## Emergency Severity Index (ESI): A Triage Tool for Emergency Department

Publication # 12-0014

[Go to Online Store](#)



Implementation Handbook, 2012 Edition  
A Triage Tool for Emergency Department Care  
Version 4

The 2012 edition of the *Emergency Severity Index Implementation Handbook* provides the necessary background and information for establishing ESI—a five-level emergency department triage algorithm that provides clinically relevant stratification of patients into five groups from least to most urgent based on patient acuity and resource needs. This edition includes updates throughout plus a new section on using the ESI algorithm with pediatric populations.

Select to download print version  PDF file ([PDF File, 1.3 MB](#)).

Select for [information](#) on how to request print copies of the handbook or DVDs.

# Emergency Severity Index, Version 4

## Implementation Handbook

---

The Emergency Severity Index (ESI) is a five-level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. The Agency for Healthcare Research and Quality (AHRQ) funded initial work on the ESI.

A well-implemented ESI program will help hospital emergency departments rapidly identify patients in need of immediate attention, better identify patients who could safely and more efficiently be seen in a fast-track or urgent care center rather than the main ED, and more accurately determine thresholds for diversion of ambulance patients from the ED.

Select for [information](#) on how to request print copies of the handbook or DVDs.

---

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**Appendixes**

[Appendix A: Frequently Asked Questions and Post-Test Materials for Chapters 3-8](#)

[Appendix B: ESI Triage Algorithm, v. 4](#)

[www.ahrq.gov/research/esi/esi1.htm](http://www.ahrq.gov/research/esi/esi1.htm)

# ACEP and ENA Position on Triage Scale

## Triage Scale Standardization

**Revised and approved by the ACEP Board of Directors June 2010**

**Originally approved by the ACEP Board of Directors September 2003**

*Joint Statement by the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA)*

The American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) believe that the quality of patient care benefits from implementing a standardized emergency department (ED) triage scale and acuity categorization process. Based on expert consensus of currently available evidence, ACEP and ENA support the adoption of a reliable, valid five-level triage scale such as the Emergency Severity Index (ESI).

# ENA Triage Documentation

- Time seen by triage nurse
- Chief complaint,
- Medications and allergies
- Vital signs (weight, LMP, immunization status)
- Subjective and objective based on chief complaint
- Acuity category (ESI emergency severity index **five** level)
- Past medical/surgical history

# ENA Triage Documentation

- Diagnostic tests initiated and care rendered
- Proper assessment
- Disposition
- Reevaluation
- Changes in condition
- Actions taken to comply with legal, institutional, and insurance company requirements

# Triage Competency Validation Form

## Competency Validation Form

<b>NAME:</b>	<b>UNIT: EMERGENCY DEPARTMENT</b>
<b>SOCIAL SECURITY #:</b>	<b>DATE:</b>

*Instructions:* Date/Initial each box as performance criteria is observed. If performance criteria not met, the comment/plan section must be completed with date of expected completion. An asterisk (\*) in front of performance criteria indicates the behavior is a critical behavior and is required to successfully complete this competency. When form is complete, it becomes part of the employee's permanent record.

<b>Competency Title: Triage</b>							
<b>Outcome:</b> Utilizes an effective triage system to rapidly assess and prioritize patient conditions and to regulate the flow of patients through the Emergency Department				<i>Key for Competency Validation Method</i> 1= Learning skill, 2=Requires observation 3= Able to perform independently 4= Acts as resource for others			
<b>Performance Criteria</b>				<b>Competency Validation</b>			
				(Please sign off each line)			
				Initial	Date	Circle Key	
<b>Preparation</b>							
Distinguishes criteria for triage acuity levels.				1	2	3	4
Identifies abnormal vital signs for adult & pediatric populations.				1	2	3	4
<b>Interview process</b>							
Assesses educational needs of patients/families entering the emergency care system.				1	2	3	4
Determines factors (i.e. age, developmental level, culture, language, anxiety) that may influence the interviewing process.				1	2	3	4
Respects the emergency patient's privacy.				1	2	3	4
Demonstrates empathetic understanding when caring for emergency patients & their families.				1	2	3	4

# So What's in your Triage Policy?

**MEMORIAL HOSPITAL**

**POLICY NUMBER: 1044-330**

---

**TITLE:** EMERGENCY DEPARTMENT TRIAGE

**CATEGORY:** EMERGENCY DEPARTMENT

---

**POLICY:** To provide a standardized system whereby patients presenting to the Emergency Department are treated in order of priority based upon acuity utilizing the Emergency Severity Index Five-Level triage system (Gilboy, Tanabe, Travers, Eitel and Wuerz, 2009).

1. An RN will triage all patients arriving to the Emergency Department to identify life-threatening conditions and prioritize patients according to acuity.
2. The following steps should occur when making the triage decision (ENA, 1999, p. 37):

Determine chief complaint; vital signs are not required during the initial triage unless the information is necessary to determine acuity category. The patient is prioritized into one of five acuity categories; (ESI, 2003) LMH ED approved resources are as follows: (please note that each bullet point is considered an individual resource)

- Labs
- ABG's
- Respiratory treatments
- EKG
- X-rays

# Triage

- Follow standard of care
- Hot spot of liability risk so get the best and the brightest RN with positive attitude
- Document recommendations made by ENA
- Have system in case triage gets backed up
- Have system to reassess patients if delay in getting them in a room
- Triage: Meeting the Challenge, Making the Right Decision: A Triage Curriculum

# Triage

- Nurse should have specialty training (ACEP)
- Protocols should be in effect so nurse can order EKG, X-ray, U/A, etc
- Remember reassessment is important if beds are full
- Patients should never be registered first as matter of policy (EMTALA)
  - Can not delay medical screening exam to inquire about insurance or form of payment
  - Never call an HMO for authorization after triage (EMTALA)
- Flexible staffing as may need to increase staff temporarily with float nurse, MD, or charge nurse

# Triage Policy

[http://ena.org/document\\_share/documents/pp-10triage.pdf](http://ena.org/document_share/documents/pp-10triage.pdf)

**TITLE:** EMERGENCY DEPARTMENT TRIAGE

**CATEGORY:** EMERGENCY DEPARTMENT

---

**POLICY:** To provide a standardized system whereby patients presenting to the Emergency Department are treated in order of priority based upon acuity utilizing the Emergency Severity Index Five-Level triage system (Gilboy, Tansbe, Travers, Estel and Wuerz, 2003).

1. An RN will triage all patients arriving to the Emergency Department to identify life-threatening conditions and prioritize patients according to acuity.
2. The following steps should occur when making the triage decision (ENA, 1995, p. 17):

Determine chief complaint; vital signs are not required during the initial triage unless the information is necessary to determine acuity category. The patient is prioritized into one of five acuity categories; (ESI, 2003) LMH ED approved resources are as follows: (please note that each bullet point is considered an individual resource)

- Labs
- ABG's
- Respiratory treatments
- EKG
- X-rays
- CT/MRI/Ultrasound/angiography
- IV fluids
- IV/IM medications
- Specialty consultations
- Sample procedures ex.
- Laceration repairs, Foley caths – 1 resource
- Complex procedures ex: (conscious sedation) – 2 resources

Level 1 Presentation

# ED Pharmacist in the ED

- Some of larger EDs are placing a pharmacist in the ED
  - Pharmacist in the ED is not there to dispense pills
  - There to work as troubleshooters and consultants to ED physicians and staff
- Help with medications during code, review medication orders, and watch for patient allergies
- Help prevent IV errors which are common in the ED
- 1 to 3% of hospitals have a pharmacist in the ED in 2007 when pharmacy residency program was started
- Rochester Democrat and Chronicle, Oct. 16, 2007

# ED Pharmacist

- American Society of Health System Pharmacist (ASHP) started the Emergency Department Pharmacy Mentorship Program in 2007
- Initially, 50 hospitals applied for the 10 slots so expanded to 20
- Supported by a grant from AHRQ
- AHRQ has many resources on the use of the pharmacist in the ED
  - <http://www.emergencypharmacist.org/index.html>
- Many articles show a reduction in medication errors

Principal Investigator/Program Director (Last, First, Middle): Fairbanks, Rollin Jonathan

## **The ED Pharmacist as a safety measure in Emergency Medicine**

AHRQ U18 HS15818 "Partnerships in Implementing Patient Safety"

*Principal Investigator:*

Rollin J. (Terry) Fairbanks, MD, MS

Department of Emergency Medicine

University of Rochester School of Medicine and Dentistry

*Co-Principal Investigator:*

Manish N. Shah, MD, FACEP

Department of Emergency Medicine

*Co-Investigators:*

Colleen Davis, MD, MPH; Erik Rueckmann, MD; Sandra Schneider, MD; Department of Emergency Medicine

Robert J. Panzer, MD, Chief Quality Officer; J. Edward Bell, PharmD, Associate Chief Quality Officer

University of Rochester Medical Center

*Advisory Board:*

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Robert L. Wears, MD, MS, Professor, University of Florida Dept of Emergency Medicine

Research Coordinator: Karen E. Kolstee, BSN, MPA

Research Nurses: Karen Dewar, RN; Heather Martin, MS, RN

Research Assistant: Lindsey Clark, BS

### **ABSTRACT**

**BACKGROUND:** The Emergency Department (ED) is a unique environment in medicine, and many safety mechanisms used in other hospital settings cannot be applied in the ED. For example, clinical pharmacists have traditionally provided extra layers of protection to hospital inpatients by cross-checking provider orders for appropriate dosing, contraindications, and interactions. Because medications in the ED must be accessed immediately and are often one-time doses, the use of central pharmacy services would introduce an unacceptable delay to the administration of medication. Although some hospitals have programs in place in which a pharmacist responds to the ED for cardiac arrests or trauma team activations, few have reported programs which involve a clinical pharmacist assigned exclusively to the emergency department. Nonetheless, published reports have asserted that ED-based pharmacists can increase patient safety. Although this concept appears logical, no study has attempted to show that these programs reduce potential adverse drug events in the ED.

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**PROJECT SUMMARY:** We propose to implement and optimize an ED Pharmacist (EDP) program as a safe practice intervention in a large ED. The hospital has provided funding for two permanent full-time positions

# ED Pharmacist Research Center AHRQ



U.S. Department of Health & Human Services

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**AHRQ** Agency for Healthcare Research and Quality

Advancing Evidence-Based Healthcare

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**QualityTool:**

## The Emergency Pharmacist Research Center: A Safety Measure in Emergency Medicine

Print E-mail Link

### Description

These slide presentations and other related tools can assist hospitals, pharmacists, and emergency departments in their efforts to describe, justify, and implement new emergency pharmacist programs.

The slide presentations, which are accompanied by associated tools, include the following sections:

- **Justification**
  - Provides a review of the literature that helps justify the need for an emergency pharmacist program
- **Role of the emergency pharmacist**

### Related Profile:

Emergency Department-Based Clinical Pharmacist Improves Quality of Care



## The Emergency Pharmacist Research Center

This research is supported by The Agency for Healthcare Research and Quality Partnerships in Patient Safety, Grant no. 1 U18 HS015818

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### Welcome

This website provides the resources and results associated with the [AHRQ](#)-funded research program aimed at increasing the use of clinical pharmacists in emergency medicine. The project goals include providing a body of evidence to demonstrate the value of using emergency pharmacists in the emergency department.

<http://www.emergencypharmacist.org/index.html>

### New Items

**New!!!** The [American Society of Health-System Pharmacists](#) is providing a **FIFTH year of the ASHP Patient-Care Impact Program for 2011**, [\[CLICK HERE FOR MORE INFORMATION\]](#) a 6-month, practice-based mentorship program for new or current emergency pharmacists or those (administrators or pharmacists) starting new clinical pharmacy programs in an emergency department. The 2011 kickoff will occur at the June ASHP meeting in Denver, with a newly expanded session, and will culminate at the midyear meeting with a poster session in New Orleans. Over 50 Emergency Pharmacist programs have been initiated through the PCIP mentorship program. Click [\[here\]](#) to download a recently published paper describes the first program.

**New.** Dr. Fairbanks has taken a new position as Director of the National Center for Human Factors Engineering in Healthcare, in Washington DC. The Center, part of the [MedStar Institute for Innovation](#), focuses on applying system safety engineering methods to healthcare. More information is available at [www.MedicalHumanFactors.net](http://www.MedicalHumanFactors.net).

In related news, we have recently co-authored a paper describing the first year of the PCIP Emergency Pharmacist program, in the American Journal of Health System Pharmacy. [\[link to article\]](#) (access required) or [email us](#) to request reprint.

# Pa Patient Safety Authority ED Medications



Commonwealth of Pennsylvania

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ADDRESS:  
Patient Safety Authority  
333 Market Street  
Lobby Level  
Harrisburg, PA 17120

Phone: 717-346-0469  
Fax: 717-346-1090

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## Pennsylvania Patient Safety Advisory

Produced by ECRI Institute and ISMP under contract to the Pennsylvania Patient Safety Authority

### Medication Errors in the Emergency Department: Need for Pharmacy Involvement?

Pa Patient Saf Advis 2011 Mar;8(1):1-7.

[www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2011/mar8\(1\)/Pages/01.aspx](http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2011/mar8(1)/Pages/01.aspx)

**ABSTRACT**

*Of all care areas mentioned in medication error reports submitted from August 1, 2009, through July 31, 2010, to the Pennsylvania Patient Safety Authority, the emergency department (ED) is the third most commonly mentioned, appearing in 6% of all medication error reports. The predominant medication error event types in the ED include wrong dose/overdosage, drug omission, and wrong drug. The predominant classes of drugs mentioned in wrong-dose/overdosage error reports include antibiotics, steroids, anticoagulants/antithrombotics, opioids, and nonsteroidal anti-inflammatory agents. Possible risk reduction strategies include expanding the role of the pharmacy department in the ED's medication-use process, limiting the number and variety of medications and concentrations available in the ED, and incorporating redundancies (e.g., order read-back) throughout the medication-use process.*

**Introduction**

Between 1996 and 2006, visits to U.S. emergency departments (EDs) increased by 32%, from 90.3 million to 119.2 million.<sup>1</sup> During the same period, the number of EDs decreased approximately 5%. The disparity has contributed to crowding of EDs and boarding of patients waiting for admission or transfer. These quality issues, combined with a high volume of patients seeking episodic care for a wide range of acute and chronic illnesses and injuries, shortages of healthcare workers, and a complex healthcare environment, increase the potential for compromised patient safety in the ED.<sup>2</sup> In addition, an inadequate information infrastructure across

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# Confusion About Epinephrine Dosing Leading to Iatrogenic Overdose: A Life-Threatening Problem With a Potential Solution

Manreet Kanwar, MD

Charlene B. Irvin, MD

John J. Frank, MD

Kathryn Weber, PharmD

Howard Rosman, MD

From the Division of Cardiology, Department of Medicine (Kanwar, Frank, Rosman), Department of Emergency Medicine (Irvin), and Department of Pharmacy (Weber), St. John Hospital and Medical Center, Detroit, MI.

Epinephrine is indicated for various medical emergencies, including cardiac arrest and anaphylaxis, but the dose and route of administration are different for each indication. For anaphylaxis, it is given intramuscularly at a low dose, whereas for cardiac arrest a higher dose is required intravenously. We encountered a patient with suspected anaphylaxis who developed transient severe systolic dysfunction because of inappropriately received cardiac arrest dose, ie, larger dose given as an intravenous push. Three additional patients who experienced potentially lethal cardiac complications after receiving inappropriately higher doses intravenously were also identified. These iatrogenic errors resulted from underlying confusion by physicians about proper dosing of epinephrine for anaphylaxis. The risk of error was amplified by the need for rapid decisionmaking in critically ill anaphylactic patients. An e-mail survey of local hospitals in southeast Michigan revealed that 6 of 7 hospitals did not stock prefilled intramuscular dose syringes for emergency use in anaphylaxis. At our institution, we have introduced prefilled and appropriately labeled intramuscularly dosed epinephrine syringes in crash carts, which are easily distinguished from intravenously dosed epinephrine syringes. In this Concepts article, we describe the clinical problem of inadvertent epinephrine overdose and propose a potential solution. Epinephrine must be clearly packaged and labeled to avoid inappropriate usage and unnecessary, potentially lethal complications in patients with anaphylaxis. [Ann Emerg Med. 2010;55:341-344.]



**Figure.** Clearly labeled prefilled syringes containing (upper box) 0.3 mg of 1:10,000 concentration IM dose in an autoinjector labeled “for anaphylaxis use only.” Lower box contains 1 mg of 1:10,000 concentration IV dose labeled “for cardiac arrest use only.”

# 10 Reasons Your ED May Not Be as Safe

- Article called “Ten Reasons Your ED May Not Be As Safe As You Think It Is” at <http://www.thesullivangroup.com/>
- The ED is send patients home with abnormal vital signs
  - Be sure to repeat any abnormal vital signs and reassess patient
  - Studies show association between discharging patients with abnormal vital signs and morbidity and mortality
- Risk Factor Analysis
  - John Ritter came the ED with chest pain

# 10 Reasons Your ED May Not Be as Safe

- No one asked about a family history
- If they had he would have told them that his father died of a thoracic aortic dissection and likely doctor would have ordered a CT scan and discovered it (clinical decision support system can help)
- Patients in severe pain are not getting their pain meds within one hour
- ED is not taking full advantage of the power of discharge instructions
  - Patient riding his motorcycle gets something in his eye
  - ED doctor diagnosis as corneal abrasion and applied eye patch

# 10 Reasons Your ED May Not Be as Safe

- Patient gets back on the motorcycle to drive home
- Hits and kills a mother and three children
- No warning about impaired vision
- Analysis of immunization status of febrile children is inadequate
- Also has new emerging patient safety and risk issues
- Evaluation of the immunization status is a critical part of the history
  - Some children are poorly immunized
  - Could fail to recognize a life threatening infection



## Ten Reasons Your Emergency Department May Not Be As Safe As You Think It Is

The Emergency Medicine Risk Initiative (EMRI) is a proven System Solution designed to reduce risk and improve patient safety in the emergency department. The Sullivan Group's work with over 600 hospitals in the United States and extensive research have disclosed a number of critical risk and safety issues of which you may not be aware.

The issues and comments below represent observations based upon an analysis of thousands of emergency medicine medical malpractice cases and TSG published research on over 170,000 high-risk patients in several hundred U.S. emergency departments.

The data is powerful and compelling, and probably represents the profile of care in your facility. Unless you have implemented a System Solution in the following areas, then this is your department!



# 1

**The ED Is Sending Patients Home With Very Abnormal Vital Signs**

# New Emerging Patient Safety and Risk

- Septic patients are severely under treated
- Patient are bleeding into the perispinal space
  - Hospitals are trying to reduce PE and DVT in post operative patients
  - Patients are increasingly being put on anticoagulants
  - Consider if severe back pain and no injury and look at medication list
- There is an increased incidence of perispinal abscesses
  - Use to be from drug addicts but now from community MRSA

# Infection Control

- Infection control is very important now
- CMS had 12 pages of infection control standards in the CMS Hospital CoP manual and has IC final Worksheet
- TJC has 12 pages of standards in the IC or Infection Prevention and Control Chapter
- Hand hygiene is big issue and compliance is still an issue in many EDs
  - Must follow CDC guidelines or WHO guidelines

# Infection Control



- The CDC says there are 1.7 million healthcare infection (HAI) in America every year
- There are 99,000 deaths in American hospitals every year
- Leadership need to make sure there is adequate staffing and resources to prevent and manage infections
- Healthcare-Associated Infections (HAIs) are one of the top ten leading causes of death in the US<sup>1</sup>

■ 1 [www.cdc.gov/ncidod/dhqp/hai.html](http://www.cdc.gov/ncidod/dhqp/hai.html)

# Infection Control

- Need policies and protocols to prevent catheter associated urinary tract infections
- Need to use the central line bundle to reduce catheter associated infections
- Clean glucometers between use
- Clean carts off between use
- Hospital needs a good infection control plan and program including safe injection practices
- Infection preventionist needs to have frequent contact with nursing

# SEA 52 Safe Injection Practices

## Sentinel Event Alert Issue 52: Preventing infection from the misuse of vials

Use safe injection practices for multiple-dose vials



Apply Aseptic Technique with MDVs <28 Days Open

- 1 Scrub the rubber septum with an approved antiseptic swab.
- 2 Allow to dry.
- 3 Insert a new needle attached to a new syringe for each entry.

Thousands of patients have been adversely affected by the misuse of single-dose/single-use and multiple-dose vials.

[Learn More](#)



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# Video on Preventing HAI

U.S. Department of Health & Human Services  
**HHS.gov**

[www.hhs.gov/ash/initiatives/hai/training](http://www.hhs.gov/ash/initiatives/hai/training) Email Updates Font Size

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## Partnering to Heal:

TEAMING UP AGAINST HEALTHCARE-ASSOCIATED INFECTIONS

*Partnering to Heal* is a computer-based, video-simulation training program on infection control practices for clinicians, health professional students, and patient advocates.

The training highlights effective communication about infection control practices and ideas for creating a "culture of safety" in healthcare institutions to keep patients from getting sicker. Users assume the identity of the following five main characters and make decisions about preventing healthcare-associated infections (HAIs):

 **A Physician, Nathan Green, Director of a Hospital Post-op Unit, ready to start new prevention efforts in the unit;**

 **A Registered Nurse, Dena Gray, working to learn effective communications skills that could make the difference for her patients;**

# Safe Injection Practices in the ED



EMERGENCY  
MEDICINE  
PATIENT SAFETY  
FOUNDATION

## **Safe Injection Practices Patient Safety Brief** Emergency Medicine Patient Safety Foundation

By: Sue Dill Calloway RN MSN JD CPHRM  
Ruth Carrico PhD RN FSHEA CIC

July 2012



The Centers for Disease Control and Prevention (CDC) says there are 1.7 million healthcare-associated infections in the US every year. Of these, it is estimated that about 99,000 deaths occur as a result. Infection prevention and control is an important issue in today's healthcare environment. It is important to accreditation organizations like the Joint Commission (TJC). The Joint Commission has eight pages of standards in the chapter on

# Nursing Linked to Safety

- AHRQ has published 3 volume, 51 chapter handbook for nurses and available at no charge
- Has chapter on staffing levels and outcomes and effect of fatigue on patient safety
  - Discusses **staff nurse fatigue** and patient safety study
- Patient Safety and Quality: An Evidence-Based Handbook for Nurses, 2008
  - AHRQ website at [www.ahrq.gov/qual/nursesfdbk](http://www.ahrq.gov/qual/nursesfdbk)
- Also important IOM study and AHRQ did comprehensive evidence based report

# Chapter 40. The Effects of Fatigue and Sleepiness on Nurse Performance and Patient Safety

Ann E. Rogers

## Background

Although the words “fatigue” and “sleepiness” are often used interchangeably, they are distinct phenomena. Sleepiness refers to a tendency to fall asleep, whereas fatigue refers to an overwhelming sense of tiredness, lack of energy, and a feeling of exhaustion associated with impaired physical and/or cognitive functioning.<sup>1</sup> Sleepiness and fatigue often coexist as a consequence of sleep deprivation.

Even though fatigue can be due to a variety of causes (e.g., illness, a vigorous workout, or a period of prolonged concentration), this chapter will focus on the effects of fatigue associated with insufficient sleep (see Key Terms and Definitions). The impact of extended work shifts and the relationship of these work schedules to nurse and patient safety will also be explored. Several practices that show demonstrable potential for reducing the adverse effects of fatigue on patient safety will be reviewed at the end of the chapter.

## Insufficient Sleep

Studies suggest that average sleep durations have decreased from 9 hours in 1910 to as little as 6.9 hours on workdays in 2002.<sup>2-6</sup> Objective measurements, however, suggest that mean sleep times may actually be somewhat lower than are typically reported in surveys. For example, 273 randomly selected middle-aged residents of San Diego (40 to 64 years) reported sleeping approximately 7 hours, an amount that appeared to correspond to their time in bed. Mean sleep times obtained from wrist actigraphy, however, revealed that participants slept on average 6.22 hours, approximately 43 minutes less than their subjective reports.<sup>7</sup>

Sleeping longer on weekends and nonworkdays is also common,<sup>4,6</sup> suggesting that individuals are obtaining insufficient sleep on workdays, then attempting to “catch up” on weekends. Americans slept on average 36 minutes more on weekends in 2002,<sup>4</sup> which is somewhat longer than the 23 minutes reported by British adults.<sup>6</sup> American nurses who participated in a recent survey, however, obtained on average 84 minutes more sleep on nonworkdays than work days (8.2 hours on nonworkdays compared to 6.8 hours on workdays),<sup>8</sup>

# Fatigue

- Nurses working nights and rotating shifts rarely obtain optimal amounts of sleep
- Insufficient sleep has variety of adverse effects
- Associated with cognitive problems, mood alterations, reduced job performance, increased safety risks and physiological changes
- Reviewed several hundred studies and none showed any positive effects from insufficient sleep
- Growing body of evidence linked to metabolism and can contribute to obesity

# Nursing Linked to Safety & Fatigue

- Limits to number of hours worked to prevent fatigue
- No mandatory overtime and don't let a nurse do a double and then double back
- Never work over **12 hours** or **60 hours** in one week (or will have 3 times the error)
- Also showed medication error rate linked to staffing
- Redesigning the work force
  - See Keeping Patients Safe: Transforming the Work Environment of Nurses 2004 by IOM
  - [www.nap.edu/openbook/0309090679/html/23/html](http://www.nap.edu/openbook/0309090679/html/23/html)

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The link between health care worker fatigue and adverse events is well documented, with a substantial number of studies indicating that the practice of extended work hours contributes to high levels of worker fatigue and reduced productivity. These studies and others show that fatigue increases the risk of adverse events, compromises patient safety, and increases risk to personal safety and well-being. While it is acknowledged that many factors contribute to fatigue, including but not limited to insufficient staffing and excessive workloads, the purpose of



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# The End!

# Questions?



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