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INSIDE

RELIAS MEDIA

Hospitals Work to Improve Procedures Designed to Protect Staff and Patients From Harm

Experts urge healthcare leaders to try creative solutions to address workplace violence

In November, an emergency physician and a pharmacist were among four people shot and killed by an active assailant at Mercy Hospital & Medical Center in Chicago. On Dec. 1, deputies shot and killed a patient who was exhibiting threatening behavior at University Hospital in Tamarac, FL. Two days later, at the University of Kansas Medical Center in Kansas City, KS, a gunman injured at least two people before turning the gun on himself.

With incidents like these occurring on a more frequent basis, frontline providers have ample cause for concern. In fact, it is already quite clear that violence is hardly a rare occurrence in healthcare. In October, the American College of Emergency Physicians (ACEP) released the results of a survey showing that nearly half of more than 3,500 emergency physicians polled indicated that they had been physically attacked while on the job, and more than two-thirds of respondents agreed that violence in the ED has increased over the past five years. *(Editor's Note: Read much more about this ACEP poll at: https://bit.ly/2EOQYTi.)*

Hospitals are responding to the problem with tactics that include everything from de-escalation training to active shooter drills. While experts note there is no one-size-fits-all solution to keeping frontline providers safe, they concur that protective measures need to evolve continuously to meet the challenges posed by new threats and societal trends.

Test Your Processes

Mission Health, a system that includes several hospitals in western North Carolina, has instituted a multifaceted approach to safety that encompasses many different departments and layers of protective steps.

"We have teams on de-escalation, local law enforcement engagement,

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AUTHOR: Dorothy Brooks
EDITOR: Jonathan Springston
EXECUTIVE EDITOR: Shelly Morrow Mark
EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

systems safety, and we have teams on assault data," explains **Robert Whiteside**, CHPA, executive director of security for Mission Health. "It is a large elephant, and we look at it piece by piece."

Like many systems, Mission Health keeps its procedures for responding to an active assailant largely under wraps so as not to tip off people with ill intent. Whiteside notes that staff members regularly engage in active shooter drills so they will be prepared in the event an attack occurs.

"We stay on top of every white paper, every new bit of literature that comes out, and every new bit of research that is available on the subject of active assailants," he says.

Further, Whiteside emphasizes that while he oversees security, the work is very interdisciplinary, involving risk management, legal, and facility services. Likewise, given the vulnerability of hospital EDs to violent intruders, leaders from emergency services work alongside Whiteside to develop and implement security procedures and to ensure staff and patients are protected.

"The staff [members] are very engaged in education and training," explains **Richard Lee**, MSN, RN, CEN, NE-BC, executive director of emergency services, who oversees operations at six EDs for Mission Health. "We invest in our teams."

For example, Lee notes that the health system provides staff with training in crisis intervention techniques, which helps employees recognize when the behavior of a patient or family member starts to become agitated. Further, staff members learn how to de-escalate these situations.

"We have care process models for agitation, anxiety, and how to manage patients who may be out of control," says Lee, noting that such training also includes equipping physicians and advanced practice providers with education on medications that may be clinically appropriate in some circumstances. "We drill constantly, whether it is a code blue drill or it's a mass casualty drill or an active assailant drill ... the more you drill staff, the more comfortable you get with your processes, and the more comfortable [staff members] get with whatever the routine is for when we go on any type of lockdown or restricted access."

Lee says this training is essential for staffers who have to continue operating the ED and keep patient flow moving when there is some type of emergency or threat.

"A lot of health systems drill when it is convenient, and they try to drill without disrupting their operational flow of the hospital. If you are truly going test your system, it may be uncomfortable, but you have got to test your processes to the point where they start to break," Lee advises. "Understand where your risk points are, and where you can put processes in place to really make a stronger defense and a more reliable process."

Prioritize Reporting

Such processes are constantly tweaked and improved with the assistance of a reporting system that invites staff to comment on any processes or situations with patients that did not go well or as intended. Staff can input what the experience was and what they believed the problem was. Then, a risk and safety team will review the situation, Lee explains. For example, he notes that if there is an event during

which a patient comes into the ED and a staff member finds a knife or a firearm on the patient that was missed at a safety check, that event will be entered into the system. "The team will put a root cause analysis around it, and then put a process in place that will prevent that from ever happening again," Lee says.

The improvement process is built around what Lee refers to as an ED joint practice model. Under this model, stakeholders meet every month and learn from each other about what is working and what is not. This also is an opportunity to anticipate any ED challenges that may be coming down the road.

"We also have what is called an ED psychiatric operations meeting," Lee adds. "The ED team, security, and behavioral health meet. We talk about what trends we are seeing in our processes for patients who may be coming to the ED for a mental health crisis or mental health illness."

In addition, there is a system-wide behavioral health safety committee that focuses on everything from education and processes to even the physical layout of the EDs, with an eye on making sure the health system is using the safest equipment and innovations, Lee shares.

Employ Emergency Response Teams

One approach that has helped Mission Health ED staff feel more safe and secure is the distribution of wearable devices that essentially act as personal alarms that staff can use if they feel threatened or need assistance. "Security officers will respond immediately ... and it is connected to the computer system throughout the department so even our leadership team knows if a staff member has hit that button and needs help," Lee notes.

Staff members throughout the system also have at their disposal the option of calling a Code BERT, which triggers a behavioral emergency response team. "The BERT team is called whenever there is an aggressive or escalating patient. Ideally, it is called well in advance of anything becoming physical," Whiteside shares. "The team shows up, they implement de-escalation tactics and any other nursing protocols [deemed appropriate] such as medication management ... to try to get a handle on things."

Whiteside is a big believer in de-escalation techniques, and he has security personnel certified to train hospital staff in multiple de-escalation programs such as Verbal Judo and Surviving Verbal Conflict. "I have permeated our department with that de-escalatory, nonescalatory philosophy and practice, and it has had a visible effect and a trackable effect on how we are able to de-escalate patients," he reports.

Recently, Whiteside says a person was smoking in the parking lot of a Mission Health hospital, which is a tobacco-free campus. A team leader saw the smoker and another person engaging in a quickly escalating conversation. First, the team leader tried using de-escalation techniques to defuse the situation and convince the man to leave the campus. When this initial effort did not work, the team leader used more advanced de-escalation techniques designed to mitigate the chances that a conflict will become physical. "We successfully got the individual to leave the campus without leading to any hands-on [conflict], without having to call law enforcement, and without the kind of escalation tactics that could easily have turned the issue into something that would either have gotten physical or ended up attracting cell phone or camera usage," Whiteside relates.

Beyond Mission Health's strong emphasis on violence prevention,

EXECUTIVE SUMMARY

Hospitals are looking for new and better ways to protect staff and patients, both from intruders who mean harm, and patients or family members who become aggressive and agitated. However, defending against active assailants presents the greatest challenge, as hospitals and EDs strive to remain open and welcoming to the communities they serve.

- Asheville, NC-based Mission Health has created a multidisciplinary approach to violence prevention, with staff at all levels involved in de-escalation training and active assailant drills. The health system also equips emergency staff with wearable devices that act as personal alarms if a staff member feels threatened.
- Staff members throughout Mission Health also can call a Code BERT, which triggers a behavioral emergency response team.
- To prepare staff for the potential of an active shooter, the Medical University of South Carolina stages regular live-action drills that include the participation of actors and local law enforcement.
- State hospital associations can help smaller, rural facilities gain access to training and other resources to help them keep staff members safe.

there also are resources available to support the needs of any healthcare worker who has been assaulted or attacked. Through a "care for the caregiver" program, the staff member will receive emotional support and any other type of assistance that might be needed to reduce stress or anxiety, Lee notes.

"We have a strong critical incident stress management [CISM] program within our health system. If a team member or a department were to encounter a disruptive patient, we could call that team, and they would bring in resources that have CISM training to help provide therapy and support for an individual, a few team members, or a whole department," he explains. "If we have an event where a patient was out of control and hurt someone ... we can put a CISM team around a department and have several debriefings throughout the day to make sure staff [members] get what they need emotionally."

Manage the Response

Whiteside acknowledges the constant challenge to stay ahead of the trends in society that fuel or change the nature of violent events. For instance, he notes the opioid epidemic and increases in gun violence events have affected healthcare. He observes that it is particularly difficult to protect hospitals from active assailants because such attacks tend to be random. "When it comes to prevention and mitigation of an active assailant, that is extremely hard," he says. "You are really managing the response part."

Like many hospitals, Mission Health trains staff in the Department of Homeland Security's "Run, Hide, Fight" active shooter protocol so healthcare workers will know what to do if an assailant enters their facility. *(Editor's Note: Learn more about this program at: https://bit.ly/2EV8Ziv.)* Whiteside adds that any proper active assailant response plan should address preparation, mitigation, response, and recovery.

While internal preparedness is important, Whiteside emphasizes that it is also vital to engage with community partners. "Our hospital participates in a local threat assessment team that is a multijurisdictional, multidisciplinary committee that includes [representatives from] the local sheriff's department, police department, leadership from Mission Health, [and] some other professionals from the local community," he says, noting that social workers and representatives from probation and parole also participate.

The threat assessment teams meet regularly, either in person or virtually, to review any perceived threats in the community and to discuss mitigation tactics. "I can't emphasize enough how important it is to do everything we can do alongside all of our colleagues right here in the health system, but also all of our non-healthcare colleagues in the community," Whiteside says. "It makes all the difference because you are able to pull from all the different resources."

Does such a comprehensive approach to violence make frontline clinicians at Mission Health feel more secure? Data from the National Database of Nursing Quality Indicators (NDNQI) suggest that it does make a difference, Lee says.

"It asks a lot of questions about how staff perceive their environment ... one of the actual questions on the NDNQI survey is do they feel safe," he explains. "We try to compare ourselves to the magnet hospitals across the United States, which probably consists of the top 10%. We exceed the magnet mean for our staffing satisfaction and [whether] staff members feel safe." *(Editor's Note: For even more data on the connection between physical and emotional safety at work for nurses and the ability to deliver high-value care, visit: https://bit.ly/2EPTZC8.)*

Test Training Protocols

Erik Modrzynski, CHSP, CEDP, is an emergency manager at the Medical University of South Carolina (MUSC), an academic medical center in Charleston. He has worked for 15 years on fire and EMS matters, experience that has influenced his approach to ensuring MUSC staff members are optimally prepared for active assailants through scenario-based training.

The training involves two phases. First, staff members learn the government-recommended "Run, Hide, Fight" technique. Then, participants go through the motions of actually putting these lessons into practice. "We teach them how to barricade themselves, and we teach them how to escape and use other techniques that might help them if there was an active shooter," Modrzynski explains. "After that, they are able to go through our live, active shooter drills that we go through."

To make the drills as authentic as possible, Modrzynski uses actors who play various roles, including assailants and police officers. Drills even include firing blank rounds. "We have observers that are there ... taking copious notes," he says. "The actors who play patients and bystanders — they take notes for

us, too, so we can see what is going on." These observations inform the kind of training that staff will receive going forward. For example, in one of these drills, whenever a staff member goes into a building, he or she needs to know the way out.

"It is important to know your escape routes and where you can hide or barricade yourself, so that got added into the training," observes Modrzynski, noting that this is particularly important for staff members who tend to float between different buildings on campus.

Local law enforcement gets a good experience out of these live-action drills, too, Modrzynski observes. In August 2018, he says police, fire, and EMS personnel practiced rapid-entry procedures that help remove patients from facilities and away from danger.

Engage Leadership

In surveys, MUSC staff members have voiced strong support for the active shooter training. For example, following the first such drill a few years ago, most said it was very helpful and that they wanted to do it again, Modrzynski shares.

"I get requests from local law enforcement to do it for us. Even our community partners are [asking] us to do this," he says. Also, it is clear from these live-action events that even the phase one training makes a difference. "During our second [live-action drill], we had some folks [participate] that didn't go through the training beforehand ... and you could tell," Modrzynski recalls. "They didn't really know what they were doing. People were hiding under desks and doing things that we tell them not to do if they can get out."

These same individuals completed the phase one training and performed much differently during subsequent live-action drills. "It was completely different for them," Modrzynski says.

Staging such a drill takes time and effort, Modrzynski acknowledges. Typically, he begins preparations roughly three months prior to the actual drill. Also, he notes it is important to respect the time that will be required for staff to participate.

"For the second active shooter drill, we made a movie for that. It was a longer process, and we actually didn't have as many people show up," he explains. "But for the [drill] we just did [in August 2018], we did it in two hours, and 130 people showed up."

One step that has helped offset the staff time required to participate in the drills is a move by the hospital administration to enable employees to leave work a couple of hours early one day as compensation for the time required to participate in the drills, which take place on Saturday. "Even with that, we have people who come in on their day off just to be part of the training," Modrzynski adds.

Another sweetener involves providing lunch along with the training.

"Especially coming from the fire service myself, food does a lot," Modrzynski adds.

However, he notes that perhaps the most powerful incentive is to secure leadership support and participation. "When the COO shows up on his day off or the CEO shows up on his day off to do this training, that speaks volumes," he says.

Work With Local Partners

What works for one organization is not necessarily going to be a perfect fit for another, particularly given variations in the size and staffing of different healthcare organizations, Modrzynski stresses. Consequently, he encourages colleagues to be creative in using the resources available to customize a training solution that works best.

Modrzynski obtained a proper certification to develop this live-

action, scenario-based program through the Alert, Lockdown, Inform, Counter, Evacuate (ALICE) Training Institute. However, he notes there is plenty of good information available online through the Department of Homeland Security and other sources.

"Working with your community partners is huge," he says. "All the surrounding police departments [here] will come out and do the training for little or no charge at all ... you just have to reach out and ask." ■

ACEP, AMA Announce Steps Aimed at Curbing Gun Violence

New educational tools, more research, and comprehensive regulatory updates on the table

Following the shooting deaths of four individuals at Chicago's Mercy Hospital & Medical Center on Nov. 19, the American College of Emergency Physicians (ACEP) President **Vidor Friedman**, MD, FACEP, issued a statement expressing exasperation about gun violence but also pledging to redouble the organization's efforts "at what is unfortunately becoming a regular occurrence in our nation."

Friedman said ACEP would continue to work with others across the emergency response continuum to reduce potentially preventable deaths and disability from violent incidents. To that end, he said the organization supports research regarding the effectiveness of extreme risk protection orders and gun violence restraining orders as well as related legislation aimed at preventing gun violence. In fact, Friedman said ACEP will convene public health and injury prevention experts "to review the current state of research and legislation regarding firearm violence to make recommendations to our board of directors."

New Resource for Providers

Also, the American Medical Association (AMA) is acting to address gun violence. On Dec. 12, the group unveiled a new continuing medical education online module aimed at providing physicians with the knowledge and preparation to effectively counsel patients on firearm safety.

Specifically, the module is targeted to emergency and primary care providers to help them recognize the risk factors that increase the potential for firearm injuries and deaths and understand how to communicate with patients to reduce such risks.

"Injury and death from firearms is a major public health crisis. Yet, while we know there is a very real need for firearm injury prevention among patients, the majority of physicians are not taught how to screen and counsel their patients on

ACEP RECOMMENDATIONS

Recently, ACEP indicated that it supports legislative, regulatory, and public health efforts focused on:

- changing norms that promote "a culture of violence" to those that encourage social civility;
- promoting public and private funding of firearm safety and injury prevention research;
- funding firearm safety and injury prevention research;
- creating a confidential national firearm injury research registry;
- promoting access to effective and affordable mental health services;
- developing technology to improve gun safety;
- establishing universal background checks for firearm purchases;
- enforcing current laws that prevent high-risk people from obtaining firearms;
- restricting the sale of high-capacity firearms intended to be used solely by military or law enforcement personnel.

"Every day, many people and families are harmed by firearms and those who wield them," ACEP President **Vidor Friedman**, MD, FACEP, said. "Can we find the will collectively to say 'enough already' and do something other than watch, holding our breath for the next devastating event?" ■

firearm safety," noted AMA President **Barbara L. McAneny**, MD, in a statement released by the group. "The AMA developed this education module to ensure more physicians are prepared to confidently and effectively communicate with their patients about firearm safety. We encourage all physicians to openly talk with high-risk patients about firearm safety. Doing so will go a long way toward addressing this public health crisis, helping prevent unnecessary firearm-related injuries and saving lives."

The AMA reports that the module presents three scenarios to help physicians determine the best approach for interacting with patients: a patient at risk of suicide, a patient dealing with domestic violence, and parents in pediatric settings.

To access the module at no charge, visit: https://bit.ly/2AqIePD. For more information about this subject, including how ACEP and other organizations reacted to the recent ban on gun bump stocks, visit: https://bit.ly/2BJwF60. ■

State Hospital Association Tackles Workplace Violence With De-Escalation Training, Evolving Toolkit for Member Institutions

While hospitals across the country are acting to protect staff and patients from violence, state hospital associations are getting involved, too. For example, the Washington State Hospital Association (WSHA) is updating its "Preventing Healthcare Workplace Violence Toolkit" that it developed in 2017 in conjunction with the Alaska State Hospital & Nursing Home Association. *(Read more about the toolkit at: https://bit.ly/2ETooj5.)* The toolkit includes best practices, steps, and resources to help member institutions address the problem, but it also is part of a larger effort to assess the effectiveness of the various recommended approaches.

"To date, we have 85 member hospitals that are actively participating with us on this work," explains **Ian Corbridge**, MPH, RN, a director at the WSHA who works on the safety and quality team as well as government affairs. "They are actively integrating the interventions within their systems, and they are providing quality metrics back to us at WSHA so that we can monitor progress and change over time."

Corbridge adds that WSHA's intention is to make meaningful modifications to the toolkit to ensure the resources and recommendations remain relevant and applicable to new issues and emerging trends facing hospital leaders and workers.

In addition to the toolkit, WSHA has created a new position of safety officer. This person is charged with working with member hospitals on reducing worker harm and ensuring employees are aware of the workplace violence toolkit and best practices for keeping healthcare workers safe. This work is targeted to smaller, critical access hospitals in the state, according to Corbridge.

"It is a great opportunity for us to make sure we are out in communities working closely with our members on behalf of the association," he says.

One of the messages that the association has received from some of the smaller, rural hospitals is that they lack the tools and resources to provide de-escalation training to all the staff who could benefit from this type of instruction. Consequently, WSHA in the process of making such training available to member institutions at a lower cost.

"Members will be able to come here to WSHA to get the training, and some of it will involve the train-the-trainer model," Corbridge explains. "The new safety officer will also be going out to our member hospitals and offering the training as well."

Corbridge notes that roughly half of the 108 member institutions in WSHA are in rural areas.

"We have a very high number of smaller, critical access hospitals in the state ... so we are talking about a large number of member institutions that will directly benefit from this work," he observes.

How to address the issue of active assailants is vexing for hospitals, Corbridge acknowledges. "Unlike other institutions where you may be able to have very strict policies or physical barriers, hospitals need to take pains to be an open place for community members to come," he says. "We need to make sure we are there for our communities and have that open presence."

However, some member institutions, especially in urban areas, have established a strong security presence, with some facilities using metal detectors at hospital access points, such as the ED. Typically, such measures are informed by data and events that have occurred at these facilities, Corbridge says.

"Member hospitals do have codes in place to make sure staff members know if an event is taking place, who needs to respond, and what type of response needs to take place," he says. "Members are training staff per their individual policies and plans at their institutions for those codes."

To assist hospitals and their employees in this work, the WSHA is partnering with an IT vendor to develop an electronic platform capable of providing notifications to providers if a patient has shown aggression in the past. "We are trying to make sure we are sharing information that may be relevant to the care team and their actions going forward," Corbridge explains. "That is an opportunity for us to de-escalate situations before they lead to potentially an aggressive event." ■

Sarasota Memorial Hospital Implements Sweeping Initiative, Raising HCAHPS Scores

Administrators note that many processes and protocols are designed with older patients in mind

Sarasota Memorial Hospital serves one of the oldest populations of any hospital in the country, with patients aged 80 years and older making up about 25% of all hospital admissions in 2017. However, while the hospital always has performed well on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, analysts combing through the data in 2012 found that the scores were not uniform across all age groups.[1]

In particular, satisfaction seemed to be lagging among patients 80 years of age and older. For example, among patients aged 18-49 years, the hospital was at least meeting national average satisfaction scores in nine out of 10 publicly reported satisfaction measures. However, among those aged 80 years and older, the hospital was achieving average patient satisfaction in only two of 10 measures.

To correct the problem, the hospital focused new energy on improving the patient experience among older patients with the creation of a project dubbed PEACE (patient experience for acute care elders). Developers first piloted the effort on the nursing units that treated the highest concentration of patients aged 80 years and older.

"For us, it was three cardiac units and our orthopedic unit," explains **Shawn Halls**, MA, manager of consumer and competitive strategy in the Sarasota Memorial Health Care System, and the person who first discovered the discrepancy in satisfaction scores in the older patient group. "Orthopedics didn't have the highest percentage, but it had the highest volume of patients aged 80 and older. [The PEACE project] moved to a house-wide initiative after we became a NICHE [Nurses Improving Care for Healthsystem Elders] organization in the summer of 2017."

The NICHE program, offered through New York University's Rory Meyers College of Nursing, provides resources and expertise to teams seeking to improve the care of older adults. *(Learn more about the program at: https://bit.ly/2QaOaRX.)*

EXECUTIVE SUMMARY

Discovering that there was a decline in patient experience scores among patients aged 80 years and older, Sarasota Memorial Hospital in Florida initiated a multidisciplinary effort, dubbed PEACE (patient experience for acute care elders), to address the gap. With continual input from senior advisors from the community, the effort focused on engaging frontline caregivers and improving communications with patients and caregivers at multiple levels.

- Each hospital unit identified a geriatric resource nurse (GRN) to be the primary contact person for PEACE project goals. The GRNs are staff nurses who have volunteered to go through additional training to understand some of the specific needs of older adults.
- In addition, in the ED, where most of the patients are older adults, nurse leaders are Geriatric Emergency Nursing Education (GENE) certified and play a key role in training ED staff in how to communicate with and assess special needs in older adults.
- The PEACE project, which began as a pilot in the hospital units with the highest number of patients aged 80 years and older, moved to a house-wide initiative after the hospital became a Nurses Improving Care for Healthsystem Elders (NICHE) organization in the summer of 2017.
- Despite a steep hike in volume, the PEACE and NICHE initiatives have delivered impressive gains, with improvements in nine of 11 Hospital Consumer Assessment of Healthcare Providers and Systems domains among patients aged 80 years and older.

From the start of the PEACE initiative, developers focused on securing support from frontline staff members who would be critical to achieving project goals. As part of this effort, each pilot unit identified a geriatric resource nurse (GRN) to serve as the primary contact for the project.

"The GRNs are staff nurses who have volunteered to go through additional training to understand some of the specific needs of older adults," explains **Jackie Garabito**, MSN, RN-BC, manager of clinical specialty programs at Sarasota Memorial. "Staff nurses can call on GRNs when treating patients who exhibit conditions that indicate they are at risk of developing additional challenges, using the Fulmer SPICES assessment tool for older adults."

The SPICES tool prompts clinicians to consider several common syndromes affecting older adults, including sleep disorders, problems with eating, incontinence, confusion, evidence of falls, and skin breakdown. *(Learn more about it at: https://bit.ly/2GJ7vtL.)*

In the early days of the PEACE project, the GRNs followed the hospital's own informal program of training, Garabito explains. However, the NICHE program has formalized training for the GRNs, including tools offered through the program.

In addition, in the ED, nurse leaders are GENE (Geriatric Emergency Nursing Education) certified, explains **Lisa Collins-Brown**, MSN, RN, the director of emergency care at Sarasota Memorial. "[They] play an integral role in training ED staff in how to communicate with and assess special needs in older adults and coordinate care that will help improve the patient experience and outcomes," she says. "The majority of our ED patients are elderly, and so many of our processes and protocols are designed with the older adult in mind."

Both the PEACE and NICHE initiatives have enhanced staff understanding of the challenges in older adults and reinforced their commitment to serving the needs of that population, Collins-Brown adds. "We have designed our nursing stations so that clinicians have a clear line of sight of patients in our ED waiting area and private rooms," she says. "Our team includes case managers, social workers, and sitters who aid in the care of and communication with patients and ensure they or family members/caregivers understand their plan of care, which ensures a safe discharge."

To ensure they were on the right track, developers of the PEACE approach note that they received continual feedback and support for the project from a senior advisory council consisting of members from the community and representatives for local organizations that serve seniors. With input from this group, the PEACE project team decided to focus their efforts on improving communications, particularly in three areas: the interface between nursing staff and patients or family members, directions regarding the correct use of medications, and ensuring that both patients and caregivers fully understand discharge instructions.

Staff spent time learning and practicing the "teach back" approach, in which patients or caregivers are

asked to repeat back to the clinician important instructions to ensure that they are understood completely. Further, the PEACE project team used empathy training to help healthcare workers understand the challenges that seniors face when they are in the hospital. This included the use of glasses designed to simulate several age-related vision problems and special gloves to simulate the effects of arthritis. Staff members were asked to perform common tasks, such as opening a pill bottle, while wearing restrictive gloves to understand what seniors sometimes face when trying to carry out routine self-care tasks.

With patients older than age 80 years in mind, PEACE project developers decided to add "transport chairs" to the supply of wheelchairs on hand on the hospital's first floor to help older patients or visitors navigate the hospital. Experts note the transport chairs serve a similar function as wheelchairs, but are designed to be less clinical-looking so users do not feel as though they are disabled. A team is on hand to direct patients where they need to go in the facility and to provide assistance when there are mobility constraints.

The efforts to improve patient experience scores among patients aged 80 years and older have occurred at the same time as steep volume increases at Sarasota Memorial. For instance, from 2013 through 2017, inpatient volume increased by 30%, representing 8,000 additional patients.

"We focused our efforts on managing capacity and adding resources to handle such a large increase in such a short period," Halls explains.

However, despite the added capacity challenges, the PEACE-driven changes have delivered promising results.

"During the same timeframe, we saw improved scores in nine of 11 HCAHPS domains for patients aged 80 and older," Halls notes. "Importantly, we've seen a five-point increase in responsiveness of staff, a six-point improvement in communication about medicines, and a four-point improvement in care transitions and overall rating."

Meanwhile, HCAHPS scores among other age groups have remained robust. "Our biggest opportunity and focus has been in our 80 and older age group," Halls says. "When we segment our HCAHPS scores by age, our patients under age 65 are largely satisfied, and the younger the patient, the more satisfied they tend to be. Even our patients aged 65 to 79 are overwhelmingly satisfied with their experience."

For instance, in 2017, Halls notes that in the 65-79 age group, the hospital finished above national averages in eight of 11 HCAHPS domains, although Halls anticipates seeing some upward movement from this age group, too, as a result of the PEACE and NICHE initiatives.

"Because of the complexity of many patients aged 80 and older, we don't expect their experience to be the same as their younger counterparts, but we're focused on narrowing the gap between groups," he says. "As we continue with our NICHE protocols and roll the tactics out to more of our units, we expect to see improvements in our 65- to 79-year-old patients, but we're not at that point yet."

After working on the original PEACE project team, Halls has some advice for other hospitals that struggle with their patient experience scores in the ED or elsewhere.

"Each hospital has its own unique challenges. For us, it is that such a high percentage of our patients are over the age of 65. Of those, 25% are aged 80 and older," he says. "In the PEACE project, we started by segmenting by individual age rather than age group and determined that our experience drop-off point was age 80. [Another] facility's drop-off age may be younger or older, which is important because it

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
2. Discuss how developments in the regulatory arena apply to the ED setting; and
3. Implement managerial procedures suggested by your peers in the publication.

COMING IN FUTURE MONTHS

- A roadmap for improving pain assessment and management
- The crucial role paramedics can play in relieving pressure on EDs caring for psychiatric patients
- A strong case for regionalizing care for heart attack patients
- Using telemedicine to preserve emergency care in critical access hospitals

will dictate strategy and tactics for improvement."

Halls also recommends that leaders of similar initiatives first take the time to review programs or services that are in place already to see what enhancements could be helpful and look for enthusiastic staff to help drive improvement efforts.

David Verinder, MBA, president and CEO of Sarasota Memorial Health Care System, adds that the PEACE/NICHE initiatives are not just about improving satisfaction.

"Older patients face greater challenges today than previous generations, [with] higher incidences of chronic disease, more complicated medical conditions, and increasingly complex technologies, therapies, and treatments," he says. "That's why investing time and resources into these initiatives are so important. They not only enhance communication, but also promote the best health outcomes and experience." ■

REFERENCE

1. Reynolds K, Halls S, Jones M. The PEACE Project. *NEJM Catalyst.* Available at: https://bit.ly/2Q89Hul. Accessed Dec. 28, 2018.

Joint Commission Revises National Patient Safety Goal Regarding Suicide Risk

Noting little improvement in the number of in-hospital suicides reported as sentinel events over the past seven years, The Joint Commission (TJC) has revised its National Patient Safety Goal (NPSG) regarding suicide prevention.

The move follows a re-evaluation of the NPSG covering this issue that began in 2016, and included research, public field review, and analysis with experts in suicide prevention as well as representatives from healthcare organizations and other key stakeholders.

TJC notes that suicide remains the 10th leading cause of death in the United States, making this issue a significant concern to healthcare organizations.

The revised NPSG 15.01.01 (reduce the risk of suicide) includes seven elements of performance on which TJC will review hospitals and behavioral healthcare organizations during accreditation surveys, an increase from three such elements in the current NPSG, called "identify individuals at risk for suicide."

The revised requirements, which will go into effect on July 1, 2019, direct hospital surveyors to assess:

- environmental risk assessment and steps to minimize suicide risk;
- use of a validated screening tool to assess patients who may be at risk for suicide;
- use of an evidence-based process for assessing patients who screen positive for suicidal ideation;
- documentation on patients found to be at risk as well as plans for risk mitigation;
- documented policies and procedures that address the care of at-risk patients as well as evidence that these policies and procedures are followed;
- consistent monitoring of the implementation and effectiveness of suicide prevention procedures and actions taken to boost compliance.

TJC notes that the revised NPSG is designed to be more specific and instructional to healthcare organizations and that it is more in keeping with the latest research and expert panel recommendations. The goal is to improve the quality and safety of care for patients who are treated for behavioral health conditions as well as those found to be at risk for suicide.

More details about the revised NPSG are available in an R3 (requirement, rationale, reference) report published by TJC online at: https://bit.ly/2QZKHLi. ■

ED MANAGEMENT®

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CME/CE QUESTIONS

1. **While experts note there is no one-size-fits-all solution to keeping frontline providers safe from workplace violence, they do concur that protective measures need to:**

   a. evolve continuously.
   b. include the use of metal detectors.
   c. meet national standards.
   d. include arming staff.

2. **Whenever there is an aggressive or escalating patient, staff members throughout the Mission Health hospital system can call:**

   a. a supervisor.
   b. security.
   c. the police.
   d. a Code BERT.

3. **Erik Modrzynski, CHSP, CEDP, the emergency manager at the Medical University of South Carolina, an academic medical center in Charleston, suggests that the *most powerful* incentive for securing hospital staff participation in active-shooter training is:**

   a. providing food at the training classes.
   b. providing positive feedback.
   c. asking the hospital CEO or COO to join the training sessions.
   d. learning about other hospital shootings.

4. **To ensure they were on the right track, developers of the PEACE (patient experience for acute care elders) approach at Sarasota Memorial Hospital in Florida note that they received continual feedback and support for the project from:**

   a. frontline caregivers.
   b. a senior advisory council.
   c. former patients.
   d. nurses from other hospitals.