HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

RELIAS MEDIA

JULY 2019 Vol. 27, No. 7; p. 73-84

Hospitals Can Do More to Prevent Maternal Deaths

U.S. maternal death rate is higher than other nations

By Melinda Young

About 700 women die each year of childbirth complications in the United States, and most of these deaths could have been prevented. The death rate is double the United Kingdom's rate and higher than nearly 40 other developed nations. *(For more information, visit: http://bit.ly/2QiNVpA and: http://bit.ly/2JxleVk.)*

Health officials point to a variety of contributing factors, including healthcare professionals overlooking early danger signs. Researchers, obstetric experts, and professional organizations are working to fix this problem.

> "A HUGE PIECE FOR CASE MANAGEMENT IS TO GET THE PATIENT TO THE RIGHT LEVEL OF CARE TO MEET THE WOMAN'S NEEDS — AND IT'S NOT JUST ABOUT NEONATAL NEEDS ANYMORE."

For example, The Joint Commission (TJC) published its new Proposed Standards for Perinatal Safety in April to provide evidence-based procedures that hospitals can use to identify and treat maternal hemorrhage and pre-eclampsia. *(The standards can be found online at: http://bit.ly/2Hv7CaA.)*

"Hemorrhage and severe hypertension — pre-eclampsia — are leading causes of preventable maternal death or harm," says **Jennifer Hurlburt**,

Financial Disclosure: Author **Melinda Young**, Author **Jeanie Davis**, Editor **Jill Drachenberg**, Editor **Jesse Saffron**, Editorial Group Manager **Leslie Coplin,** and Nurse Planner **Toni Cesta**, PhD, RN, FAAN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

HOSPITAL CASE MANAGEMENT

***Hospital Case Management™*, ISSN 1087-0652, is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Hospital Case Management*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.**
GST Registration Number: R128870672.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
ReliasMediaSupport@relias.com
ReliasMedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours or CMCC clock hours, $469.

Outside U.S., add $30 per year, total prepaid in U.S. funds.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at groups@reliasmedia.com or 866-213-0844.

Back issues: $78. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

ACCREDITATION: Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hour(s).

The target audience for *Hospital Case Management*™ is hospital-based case managers.

This activity is valid 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

AUTHOR: Melinda Young
AUTHOR: Jeanie Davis
EDITOR: Jill Drachenberg
EDITOR: Jesse Saffron
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson, MSN, RN, CPN

Copyright© 2019 by Relias LLC.

PHOTOCOPYING: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner.

EDITORIAL QUESTIONS
For questions or comments, call Jill Drachenberg at (404) 262-5508.

MSN, RN, APN/CNS, associate director of TJC's department of standards and survey methods in Oakbrook Terrace, IL.

TJC's requirements to address these complications could make a significant difference in maternal morbidity and mortality, she adds. *(See Q&A about The Joint Commission's perinatal safety standards, page 75.)*

Public health officials first observed a bump in maternal deaths when states changed their reporting structure to include information about whether a death was pregnancy-related, says **Michael R. Foley**, MD, chair of the department of obstetrics and gynecology at the University of Arizona College of Medicine - Phoenix. Foley also is chair of obstetrics and gynecology at Banner-University Medical Center in Phoenix.

Compared to other industrialized nations, the U.S. rate of maternal mortality within a year of giving birth is very high, Foley adds.

This problem is comprehensive and requires a multidisciplinary approach to understand it, which is why a group of obstetric experts — including Foley — and organizations wrote a recent paper about a collaborative effort to address maternal morbidity and mortality in the United States.[1]

"We recognized a number of things we could do to reduce mortality for the future," Foley says.

Also, the Alliance for Innovation on Maternal Health (AIM) has partnered with professional societies and industries to improve maternal health and reduce morbidity and mortality, he says.

"They're bringing in bundles, a representation of existing guidelines that provide a template for what's needed and how to educate, prevent, and prepare," Foley adds. "It's a cookbook of guidelines that all hospitals should be moving toward and endorsing, and it's not expensive."

It does require hospitals to collect and share data, but they benefit from a report card to see how they are performing.

Nurses, including RN case managers, are very important to these collaborative efforts, Foley notes.

"Nurses are frontline people and the most important," he says. "All of these Alliance bundles include nursing assistance, teamwork, multidisciplinary care. It's about the entire team."

One evidence-based bundle has nurses administer medication for a hypertensive crisis if they are unable to contact the doctor to reduce risk to the patient, Foley explains.

EXECUTIVE SUMMARY

Women in the United States have a higher rate of childbirth-related morbidity and mortality than women in most other wealthy nations. Often, these complications can be prevented.

- One solution involves The Joint Commission's Proposed Standards for Perinatal Safety, which provides evidence-based solutions to addressing pregnancy complications.
- A comprehensive, multidisciplinary approach can help solve the problem.
- Maternal health education should be provided to hospital staff, including nurses and physicians.

"In this one example, we make it an emergency order so the nurse could administer this medication to save lives," Foley says. "If the nurse has 30 minutes to get the order from the doctor and the order doesn't arrive on time, she can do it."

One of the issues related to inpatient cases of pregnant women identified as critically ill is that there has been no plan in hospitals on how to manage these cases, says **Suzanne McMurtry Baird**, DNP, RN, co-owner and nursing director of Clinical Concepts in Obstetrics in Brentwood, TN.

When it comes to neonatal care, there are established processes for handling challenging cases. If a baby meets certain criteria, he or she is transferred to another neonatal center that is able to handle a higher level of care.

But there has not been a regionalized program for transporting pregnant women who are critically ill to a higher level of care, Baird explains.

This deficit is being addressed. Now, hospitals will be rated according to the level of maternal care that they can provide for obstetric patients. The level will be designated by the state's department of health, she says.

"Lots of work will go on within states to do that and determine how each hospital will level out," Baird adds. "The main objective is getting obstetrics patients to the right level of care so they can be managed by a team that has training in high-risk, critical obstetrics."

For example, a hospital might have a level 4 neonatal unit and a level 4 maternal care unit, meaning the hospital can handle the highest-risk births.

"Hospitals are going to be leveled and will have some idea of where to transport patients when they become high-risk or critically ill," Baird says. "A huge piece for case management is to get the patient to the right level of care to meet the woman's needs — and it's not just about neonatal needs anymore."

All hospitals can do a better job of diagnosing serious illness among pregnant women and new mothers — and the place for hospitals to start is in educating staff, Baird says.

"One of the biggest mistakes hospitals make is thinking they just

THE JOINT COMMISSION'S NEW PERINATAL SAFETY STANDARDS EXPLAINED

Hospital Case Management asked **Jennifer Hurlburt**, MSN, RN, APN/CNS, associate director of The Joint Commission's (TJC) department of standards and survey methods, to answer a few questions about TJC's Proposed Standards for Perinatal Safety, published April 17, 2019. *(The standards are available online at: http://bit.ly/2Hv7CaA.)*

HCM: The element related to developing evidence-based procedures for identifying and treating maternal hemorrhage includes items related to creating a blood bank plan and using emergency response medications. Are these procedures that The Joint Commission has found to be lacking in some hospitals? And why is it important that hospitals have written plans for such procedures?

Hurlburt: Having written response plans ensures that all team members are educated about the organization's response, which increases the team's readiness to respond. Ensuring that key elements, such as emergency response medications and blood bank procedures, are in place decreases the time it takes for the team to respond to an emergency. This level of preparedness may increase the patient's chance of survival because interventions are able to occur much sooner.

HCM: How new is the idea of having a dedicated hemorrhage supply kit in the maternity area?

Hurlburt: Having a dedicated supply kit for hemorrhage has been around since the AIM [Alliance for Innovation on Maternal Health] bundles were created in 2014.

HCM: Hospitals often create other types of drills, such as disaster drills. Why is it a good idea also to have a drill related to maternal hemorrhage and pre-eclampsia emergencies?

Hurlburt: Drills allow the team to practice their skills and identify system issues. When these issues are discovered during a drill, this allows the organization to make improvements before an emergency actually happens. It is also an opportunity to determine what the team does well, and highlight successes, too.

HCM: How might hospitals employ case management procedures to improve management of high-risk pregnant women on the obstetrics floor? How helpful might it be to have RN case managers involved in the guidance or team decision-making process and in educating staff, providers, and patients?

Hurlburt: Each organization may determine whether an RN case manager's role is employed in the management of high-risk pregnant women. ■

need to educate their nurses," she says. "In other words, they will send nurses to a conference and when they come back, they say, 'We'll be fine.'"

But everyone needs to be educated on maternal health, Baird adds. *(See story on how hospitals can improve diagnosis and case management of pregnant women and new mothers, page 77.)*

One area of maternal mortality that may be overlooked involves trauma, such as automobile collisions and domestic partner violence, says **Christy Pearce**, MD, MS, director of maternal fetal medicine at Centura Health and Southern Colorado Maternal Fetal Medicine in Colorado Springs.

Healthcare providers and public health officials are putting systems in place to reduce maternal morbidity and mortality with hemorrhage, and states are adopting these guidelines. But less attention is paid to maternal deaths connected to trauma, as these are less common, Pearce says. *(See story on maternal morbidity and trauma, page 78.)*

Public discourse about maternal deaths also overlooks a systemic problem related to shortages of obstetricians, Pearce notes.

"Why don't we have enough people taking care of pregnant women?" Pearce says. "So many centers don't do OB/GYN care because it loses money for that hospital."

Unless doctors are trained to provide obstetrics care, they cannot provide such care optimally.

"It's a hard specialty because people want a perfect outcome, and that's not how life works. And it's a high-litigation specialty, which goes into the risk-benefit analysis of whether an obstetrician continues to deliver babies," Pearce adds.

This shortage of obstetricians and fetal medicine specialists places women at risk.

"We did notice that in areas where there were a lot of maternal fetal medicine specialists, within those geographical locations the maternal mortality rate was lower." Foley says.

This suggests that healthcare providers need additional training and education.

"We convened a huge group of people with expertise in this area from across the country, and we identified a couple of areas we could launch into," Foley explains.

First, training programs should be developed for maternal-fetal medicine specialists. Educational sessions could focus on the maternal side of the equation, increasing physicians' comfort levels, he says.

"The American Board of Obstetrics and Gynecology was interested and acted nicely in changing the training model for a fellowship to include mandatory intensive care training," he says.

The plan was to get hospital providers confident in taking care of people who are critically ill and to spend more time on labor and delivery, Foley adds.

The second step was to create an international training program in critical care and obstetrics that would provide experiential learning. In Phoenix, Foley was involved in developing the simulation program. The program used pregnant mannequins that were realistic enough to blink eyes and bleed.

"We worked with a national team, many experts from across the country, to create the facility," he says. "Also, there are 22 online lectures, including testing simulation, and we followed it up with an online simulation course at Phoenix."

Close to 2,000 OB/GYN doctors have rotated through the program over the past five years. They learn new skills, such as airway management and handling cardiac arrest when new mothers are bleeding, he says.

"They go through an actual simulation," Foley explains. "Many hospitals bring in their teams and we train them, giving them materials to take back to their hospitals where they can use them." ■

REFERENCE

1. D'Alton ME, Friedman AM, Bernstein PS, et al. Putting the "M" back in maternal-fetal medicine: a 5-year report card on a collaborative effort to address maternal morbidity and mortality in the United States. *Am J Obstet Gynecol*. 2019;Epub ahead of print.

Assess...
Manage...
Reduce...
Healthcare RISK

Listen to our free podcast!

Episode 4: Reflections of a Nurse: What Made Me Stay or Leave?

ROUNDS WITH RELIAS

www.reliasmedia.com/podcasts

Hospitals Sometimes Diagnose Critical Obstetric Illness Too Late

Develop plans of care at the outset

The key to setting up a program for recognizing and managing maternal compromise is to create a team and train staff on how to recognize early warning signs.

"We know that when people learn together, they work better together," says **Suzanne McMurtry Baird**, DNP, RN, co-owner and nursing director of Clinical Concepts in Obstetrics in Brentwood, TN.

One of the key issues that comes up when hospital staff debrief after an obstetric emergency is role designation, she notes.

"The majority of teams we work with have absolutely no role designation," Baird says. "When there's an obstetric emergency, everyone needs to know what their role is and that they've been trained for that role."

Staff should know their roles, what medications to provide, how to communicate, and who the team leader is.

"You should have a designated leader that was predetermined, and so you know there is one provider leading the team during the obstetric emergency," Baird says. "You want to be able to work as efficiently as possible and have systems and processes in the hospital that are as efficient as possible."

> CASE MANAGERS AND NURSES MUST COMMUNICATE THEIR ASSESSMENTS AND OBSERVATIONS TO PROVIDERS AND CONVINCE THEM TO VISIT THE PATIENT AT BEDSIDE. THIS PART IS CRUCIAL.

Hospitals can achieve this efficiency with team training.

"It's similar to airlines, where pilots and flight attendants and everyone are training for these emergencies and know what to do if a problem occurs," she says. "We haven't done that [training] as well in healthcare yet."

A first step in training might include teaching frontline staff how to recognize warning signs when a pregnant woman is in medical distress. Baird offers these suggestions for how to recognize and react to early maternal compromise:

• **Assessment.** Follow the nursing process of conducting a full nursing assessment, based on the patient's complaint and scenario, Baird says.

• **Recognition.** "Recognize any assessment parameters outside the normal," she says.

These might include the following:

- A high heart rate;
- Respiratory rate over 24;
- Shortness of breath;
- High blood pressure;
- Low blood pressure.

"One of the things I teach is vital signs are vital," Baird says. "These work. These assessment parameters are defined ahead of time and it forces not just recognition, but management."

Nurses and case managers can use recommendations by the Alliance for Innovation in Maternal Health (AIM) in the AIM bundle and provide staff training with the AIM eModules. *(More information is available at: http://bit.ly/2YF6LKk.)*

For instance, AIM provides free access to 10 patient safety bundles, including prevention of maternal venous thromboembolism. The bundle uses evidence-based recommendations under readiness,

EXECUTIVE SUMMARY

Hospitals can establish programs to educate staff on how to recognize and manage maternal compromise as part of a plan to reduce maternal illness and death.

- Designating roles is a key element of any maternal health program.
- Hospital case managers and others need to assess pregnant patients' health concerns.
- Nurses and case managers must communicate health problems to providers and work with providers at the bedside to develop a plan of care.

recognition and prevention, response, and reporting/systems learned.

One sample response item is to "use standardized recommendations for appropriate timing of pharmacologic prophylaxis with neuraxial anesthesia." *(Available online at: http://bit.ly/30BFv10.)*

• **Communication.** Case managers and nurses must communicate their assessments and observations to providers and convince them to visit the patient at bedside. This part is crucial, she notes.

"That's a real key piece that has been missing in the care of these patients," Baird says. "Often times, nurses will recognize abnormal assessments and communicate them, and there might not be a provider that comes to the bedside for further assessment."

When providers visit the patients' bedside, there is greater potential for interprofessional critical thinking about the cause of an abnormal assessment, Baird says.

"For example, let's say the mom has pre-eclampsia and her urine output drops," Baird says. "The nurse notes that and communicates it to the provider, who then comes to the bedside and does an assessment with the nurse."

Then, they discuss reasons why the urine output has dropped for this patient: First, the patient could have low intravascular volume status that decreases renal profusion; secondly, she could have problems with blood flow to the kidneys; thirdly, the patient could have increased vascular resistance, which also decreases blood flow to the kidneys, she explains.

"Through your assessment, you critically think about what the cause is," Baird says. "It's through key assessment that you're trying to determine what's going on."

But determining the cause and pinpointing the optimal treatment to include in a plan of care depend on interdisciplinary assessment and communication.

"This is a new way of thinking about how we provide care for these moms," Baird says. "We recognize that these patients are sick, and how we manage their symptoms is really important."

• **Plan of care.** Developing a plan of care is part of a continuous nursing process that includes case managers and the entire team, Baird says.

"Part of the plan might be to get the patient to the right level of care," she says. "In the past, it was provider-ordered: notify the provider if a heart rate was larger than 120; then the nurse would notify, and they say, 'Thank you,' and that's it."

There has been a normalization of some of the abnormal components of the assessment, she notes.

"For example, I see a lot of normalization of heart rate abnormalities," Baird says. "The heart rate is too high, and there may be some who think her heart rate is high because she's in pain or she's anxious about her labor and those types of things."

But this is not true critical thinking about what is causing the high heart rate, Baird adds.

"Now, we have a heightened awareness that we need to appreciate these early warning signs of maternal compromise and do critical thinking about why they're abnormal." ■

Maternal Mortality Risks Include Accidents and Domestic Violence

Case managers need to be alert to risk factors

Hospitals should be prepared to deal with pregnant trauma patients, and some may not have best practices in place due to the low incidence.

"When a pregnant trauma patient comes into the hospital, you need to have an obstetrician, EMS team, a trauma team, a multidisciplinary team, and have everyone working together," says **Christy Pearce**, MD, MS, director of maternal fetal medicine at Centura Health and Southern Colorado Maternal Fetal Medicine in Colorado Springs.

The major causes of maternal trauma are motor vehicle accidents and domestic partner violence. Even when the cause appears to be an accident, such as a woman falling down the stairs, it could be related to domestic violence, Pearce notes.

"If a woman has fallen down three times in pregnancy, then maybe she's not falling," she explains. "Domestic violence is so difficult and a tricky situation."

One in four women experience intimate partner violence, and this does not stop during pregnancy, she adds.

Hospital nursing staff and case managers should be alert to risk

factors of maternal trauma. They can give women a screening questionnaire and ask them if they feel safe at home, she says.

Domestic partner violence often escalates in pregnancy. The intimate partner feels less in control and increases violent behavior, she explains.

"And these women don't have control over their lives or pregnancy," Pearce says. "So you have to be careful how you screen for it."

For instance, one strategy is to place domestic violence literature in the women's restroom. Also, healthcare providers can give women a small card with numbers and helpful information that they can place in their shoes, she adds.

"I try to screen pregnant women when I'm alone with them," Pearce says. "You educate women that violence might escalate during their pregnancy."

Clinicians also can educate pregnant women about how to position seatbelts. Some women may believe misinformation that says seatbelts could hurt their babies and will not wear one, which could cause major trauma in the event of a collision.

Case managers and nurses can teach pregnant women how to wear the seatbelt over their hip bones and over their breast and shoulder, keeping the lap belt beneath the abdomen.

"Data show you have an 84% reduction in morbidity and mortality if you are in a car wreck and are wearing a seatbelt," Pearce says. "People forget to address the basic things."

Other traumas that pregnant women may face include opioid addiction, overdosing, and mood disorders, she says.

"You have less control over those as a clinician," she says. "You can screen for them, but people might not listen to you."

People suffering from addiction, including pregnant women, may not have the necessary coping skills to handle abstinence and stay clean, Pearce says.

"You can counsel them on how to stay safe, but there are many things you cannot affect from a case management perspective," she adds.

The same is true when it relates to domestic partner violence. A case manager can provide a woman with resources and information.

Clinicians can counsel women on how the violence is not normal or their fault, but they cannot make decisions for women, who might be experiencing psychological manipulation by their partners and living in fear.

"There is so much programming by these partners to make them believe it truly is their fault that they're in that situation," Pearce says. "It takes a long time for people to realize they are worth more than that." ■

EXECUTIVE SUMMARY

Some maternal injuries are caused by accidents and intimate partner violence. Case managers should be alert to signs and symptoms and educate about prevention.

- The biggest causes of maternal trauma are motor vehicle accidents and domestic violence.
- Risk factors can be assessed with a screening questionnaire that asks whether the woman feels safe at home.
- Women sometimes avoid wearing seatbelts out of concern for the fetus, and case managers can show them how to wear seatbelts safely.

Age-Friendly Initiative: Is Your Hospital Ready?

By Jeanie Davis

Case managers see it all the time: an older adult who has difficulty navigating the healthcare system. And, too often, this difficulty can lead to 30-day readmissions because the patient did not receive optimal care.

Vision and hearing problems, confusion, emotional disorders, and other difficulties interfere — and the patient's care suffers, despite everyone's good intentions.

Solving that problem is the crux of the Age-Friendly Health Initiative, developed to improve the experience and outcomes of care for older adults and their families. In 2017, five health systems adopted the model, and more than 100,000 patients received age-friendly care at 26 sites.

In less than two years, the Age-Friendly initiative has gone global, adopted at 350 sites in 126 systems in 37 states, as well as sites in Australia, Brazil, Nigeria, and Canada. "Those are just the ones we know about," says **Terry Fulmer**, PhD, RN, FAAN, president of The John A. Hartford Foundation (JAHF). "It's just wonderful; I couldn't be happier."

The health systems are collecting data on improvements in patient outcomes, which are already evident, reports Fulmer. More than 70 articles on the initiative have appeared in peer-reviewed journals and industry publications.

The core of the program is the 4Ms, based on a careful analysis performed by the Institute for Healthcare Improvement (IHI). This expert team studied the best practices and care models in the literature, then distilled the best concepts into these points:

- **What Matters:** Understanding and aligning care with what is most important to each patient;
- **Medication:** Using appropriate prescriptions that do not interfere with What Matters, stopping medications where needed;
- **Mentation:** Preventing, identifying, treating, and managing delirium, dementia, and depression;
- **Mobility:** Promoting safe and regular movement to preserve function, and implementing falls prevention strategies.

Case managers are prime "champions" for ushering this program into their hospitals, Fulmer emphasizes. "They're the critical link to the transition of care from hospital to home. If they look at the discharge sheet, they will see the 4Ms in it."

Case managers will be thrilled to see what the program can achieve, she adds. "The 4Ms empower the case manager to do their job effectively."

Are you ready to carry the torch in your institution? In the following case studies, two hospitals describe their processes for implementing the program. If your hospital already is involved in NICHE (Nurses Improving Care for Healthsystem Elders), you are making progress — and are ready to take those concepts hospitalwide.

If you are in the early stages of gaining buy-in from hospital leadership and staff, it is important to make your message personal. By telling patients' stories, you touch the hearts of everyone with an elderly family member or friend — and that sells the 4Ms initiative, Fulmer says.

Christiana Care System Launches 4Ms

Early last year, when Fulmer was looking for the first 100 sites to sign on, one hospital signed up immediately. "With it being evidence-based care, we knew it was the right thing to do," says **Denise L. Lyons**, DNP, APRN, AGCNS-BC, a clinical nurse specialist at Christiana Care Health System, based in Wilmington, DE.

Lyons also is manager of the hospital's NICHE program, a nursing program designed to improve geriatric care in healthcare organizations. Her team had already set up the Acute Care of Elderly (ACE) Unit at Christiana Care's Christiana Hospital.

"The Age-Friendly initiative challenged us to take the 4M concepts to both Christiana Hospital and Wilmington Hospital and our primary care centers," says Lyons.

Working directly with the section chief of geriatrics, they piloted the Age-Friendly 4Ms program within the ACE Unit and one primary care office. A whiteboard at the foot of each patient's bed became the primary tool. The patient's 4Ms were prominently listed on the board and updated daily based on the patient's evolving goals and medical status.

"We wanted to embed the 4Ms in the electronic health records system, and started working with our colleagues in information technology," says Lyons. "The whiteboard allowed us to move forward with the program in the interim."

When that pilot program proved successful, Lyons' team approached the Professional Nursing Practice Council to implement the 4Ms on a larger scale throughout the hospital. The council would determine how the 4Ms program and bedside shift reports would be integrated into daily workflow.

The senior nursing leaders were in "full support of the 4Ms," Lyons says. The team currently is testing the program on a second nursing unit, then will roll it out to the other service lines. The nursing informatics team is working to embed these elements into the electronic health records.

Wellness nurses in the primary care clinics reported that the program is well-received by patients. "It's all very positive," says Lyons. "And there's really not one extra thing for nurses to do. Really, it's the focus on what matters most — that's the big M that matters most to our patients."

Anne Arundel Medical Center Rolls Out 4Ms

Anne Arundel Medical Center (AAMC) was also in the first wave to launch the Age-Friendly initiative. The hospital's chief operating officer was on board from the start, as the hospital was already participating in the NICHE program.

Barbara Jacobs, RN, AAMC's chief nursing officer, and **Lil Banchero**, MSN, RN, senior director of AAMC's Institute for Healthy Aging, championed the 4Ms launch throughout the medical center.

The ACE Unit served as their pilot program and the organizing

team made good use of all available training modules, podcasts, and webinars from JAHF and IHI websites, says Jacobs.

This core group of nursing supervisors led the program initially, then the ACE Unit nurses spread the message to the other service lines to "educate the educators on the units," Jacobs explains. "These became the 'superusers' — each leading their own teams in the training and conducting full-day seminars."

Physicians also received training in the 4Ms and other Age-Friendly concepts, as did social workers, physical therapists, occupational therapists, and other team members who work with the elderly.

Jacobs and Banchero have advice to get staff and the C-suite on board: "If you can tell the stories of these older patients, you can win them over," says Jacobs.

"Everyone has an older person in their family, in their life," she explains. "That will resonate to get others involved. We were very good about telling patient stories in every presentation. You need to touch their hearts."

One patient story proved to be especially powerful. The team decided a patient needed to go to rehab. But the patient kept declining to go.

"We finally learned that for him, getting home to his dogs was much more important," Banchero explains. "He didn't want to spend that precious time in a rehab center. So we had to rethink the plan so he could go home and live there safely."

This happens frequently, she says. "We assume the patient should go to rehab, but we don't think to ask if that's what the patient wants. The 4Ms show it's not about us, the providers — it's about the patients and what they want."

The first M — "What Matters" — is the guiding force, Jacobs and Banchero say. "If we don't get to the heart of what our patient wants, we won't serve that patient well," says Jacobs.

They also suggest tapping the hospital's patient/family advisory group. These are current or former patients or family members who can become advocates for the 4Ms program.

> "RIGHT NOW, EVERY SINGLE PATIENT IN THE HOSPITAL IS ASKED WHAT MATTERS MOST TO THEM. THE GOAL IS THAT EVERY DAY, WE WILL LOOK AT WHAT MATTERS TO THEM: THE RIGHT MEDS, MOBILITY, MENTATION."

The patient's motivation will affect end-of-life discussions, adds Jacobs. "A patient might need dialysis, but if you ask that patient — such as a 96-year-old who is relatively disabled — they might decline. They don't want their last months spent in dialysis. They want to go home. They want to go to a grandson's graduation. They just want a bag of popcorn. Whatever they want, that's the driver for their care."

"Just imagine how powerful the 4Ms can be," she adds. "Especially if they are documented so everyone can see what they are. These are the things most important to me, the patient — my three grandchildren. We will make sure you get home to see them."

There is power in viewing the patient "as a person outside this illness," says Banchero. "It's extremely powerful to see that patient as a human. This sickness is just a little piece of them. Whatever it is they love, that becomes the focus we take."

The AAMC team has hundreds of stories to tell, says Jacobs. "Right now, every single patient in the hospital is asked what matters most to them. The goal is that every patient, every day, will be touched by the 4Ms. The goal is that every day, we will look at what matters to them: the right meds, mobility, mentation. We're doing dementia and depression screenings in our ambulatory care clinics today, for the first time."

Enhancing care of the elderly is a movement, says Banchero. "We will provide safe care, the right care, so patients feel what matters to them is part of their care. This improves outcomes — reduces falls and infections. Patients are getting up and moving earlier, so they are less likely to fall and break a hip. They're better hydrated, so there's less likelihood of infections."

Implementing the Age-Friendly 4Ms was "relatively easy," says Jacobs. "We didn't have to bring in extra resources. We've just redesigned some of our workflow. Any organization can do this."

The initiative dovetails perfectly with AAMC's mission "to enhance the health of people we serve," she adds. "This program is a perfect example of that. We're touching hundreds and hundreds of people. Not just patients; family feels it, too. The positives are great. It strikes a very powerful note with everyone." ■

Privately Paid Care Management: Emerging Service Provides Advocacy and More

An elderly patient has arrived at the ED. She fell and possibly broke a hip. She is alone, or with a neighbor. But no family or close friend is with her, and she is confused.

It is a common but difficult situation. "The providers will be making decisions without any sense of the patient's preferences," says **Liz Barlowe**, MA, CMC, president-elect of the Aging Life Care Association (ALCA), formerly the National Association of Professional Geriatric Care Managers.

At this point, it is imperative to contact the family — who may live in another city some distance away. As the case manager, you feel empathy for this patient, wishing you could do more to help.

One solution is to contact a privately paid care manager/health advocate. This is a service that has emerged to fill a need of the "sandwich generation" — adult children trying to coordinate care for elderly parents who live far away.

The ALCA serves to connect consumers with paid care managers in every region of the country. This position has several labels; the ALCA refers to this position as Aging Life Care Professional, but the titles "care manager" and "nurse advocate" also are used.

The care manager/health advocate often is a nurse, social worker, gerontologist, physical therapist, occupational therapist, or other health-related professional. A bachelor's degree is required; certification also is recommended. "We have standards of practice and a pledge of ethics members must adhere to," Barlowe explains.

While the majority of clients are geriatric adults, some are younger adults with physical or developmental disabilities, brain injury, mental health problems, or chronic illness.

Barlowe describes the relationship between care manager/health advocate and the patient/client.

"Just as everyone ages differently, everyone views their future — and their health challenges — differently," she notes. "Some clients want as little intervention as possible, while others want to see the doctor immediately if something minor comes up, and they want us with them."

> "SOME ISSUES THEY WON'T EVEN TELL THEIR FAMILIES, BUT THEY SHARE WITH US. TOO OFTEN, OLDER PEOPLE DON'T FEEL PEOPLE ARE LISTENING. WE CAN ADVOCATE FOR THEM AND EMPOWER THEM, GIVE THEM THEIR VOICE AGAIN."

The care manager will spend time with the patient to really understand his or her values and goals. "Some issues they won't even tell their families, but they share with us," says Barlowe. "Too often, older people don't feel people are listening. We can advocate for them and empower them, give them their voice again."

Michael Newell, MSN, RN, is founder-president of LifeSpan Care Management LLC, a firm that offers health coordination and advocacy services.

"We believe a good nurse is able to see a problem before other people see it, address that problem before most people know there is a problem," says Newell. LifeSpan Care Management is based on a rehabilitation nurse model.

"The health advocate helps the patient to function and live as independently as possible," he explains. "That includes suggesting adaptations in lifestyle, adaptive equipment, and other support that helps people remain safe in their own homes. That's what most people want and what we try to do."

Adult children appreciate the assessment that a care manager can provide: identifying their parent's problems and goals, and finding solutions.

Care managers attend doctor appointments and take notes. "A lot of times, the patient can't articulate the problem," says Newell. "A health advocate will have a plan going in — what needs to be addressed, what the doctor should know, medication issues."

The advocate can raise a red flag if a new medication has contraindications with another medication the patient is taking. "Doctors tend to spend more time with the patient if someone is with them who is recognized as an advocate and has some medical training," Newell says.

When it is time to transition the patient to a care facility, the care manager can be an invaluable

resource to families. "The healthcare system is so complex, that's where families really rely on us," Newell explains.

"We act in a fiduciary capacity to help them sort through all the options — rehabilitation and assisted living facilities, nursing home care, or hospice," Newell adds. "We help them figure out how to pay for it — what insurance, Medicare, and Medicaid will cover."

The care manager also can recommend local facilities based on their direct experience, adds Barlowe. "We are inside these local facilities all the time, and we know their strengths and weaknesses. We don't get any kind of kickback for recommending a facility; we are hyperfocused on that patient and getting them the very best care."

After discharge arrangements are made, the care manager will smooth the transfer process. He or she will be there to organize a care conference to ensure the patient's needs are addressed. The care manager also will check on the patient regularly to ensure optimal care.

Both Newell and Barlowe encourage hospital case managers to refer patients and families to the ALCA website. "We know the hospital case manager has limited time and resources to help families make these very difficult decisions," Newell says. "We can work with the family to get the best care for mom or dad, and avoid paying out-of-pocket as much as possible. It's to the benefit of all concerned."

The cost for this service varies across the country, and is rarely an issue for family members. "They want what's best for mom, but can't quit their jobs. When they hire a care manager, they get an advocate who is available 24/7, including middle of the night or Sundays. When there's an emergency, we are there right away to make sure our client is safe and getting what's needed," says Barlowe.

She encourages healthcare professionals to consider this role as a career opportunity. "It's very satisfying," Barlowe says. "You really build an intimate relationship with the client and their family. We get to know our clients very well, help them with healthcare coordination and decisions, and promote their optimal aging journey. I always say we are the experts at aging, we may not know everything, but we can find an expert who does." ■

AHA: Hold Off on Star Ratings Until CMS Can Fix Problems

Problems with the structure and execution of the Centers for Medicare & Medicaid Services (CMS) star ratings are so serious that CMS should halt their use until repairs can be made, according to a letter sent by the American Hospital Association (AHA) to the government agency.

The AHA was responding to a request for comment on 12 potential changes to the star ratings methodology. It argued that only these three proposals should be pursued further: empirical criteria for measure groups, peer grouping star ratings among similar hospitals, and "explicit" scoring.

"The remaining proposals either fail to address important shortcomings with star ratings, or simply do not have enough information for us to judge their impact," the AHA letter says. "We believe it is important that these steps be taken prior to considering implementation of any other changes to the star ratings."

The AHA suggests that CMS should convene a small group of experts on latent variable models, study how to mitigate the impact of outliers in readmission rates, and develop an alternative to hospital ratings that instead provides ratings on specific clinical conditions.

"Lastly, we continue to urge CMS to remove the existing star ratings from Hospital Compare while its important work of improving the methodology continues," the AHA letter says. "We appreciate the desire for the ratings to reflect the most current quality data. Yet CMS's public comment underscores the many problems with the current methodology. Unless and until the ratings methodology is improved, it will be difficult for hospitals and the public to have confidence that star ratings portray hospital performance accurately."

The full letter is available online at: https://bit.ly/2vqNxLX. ■

COMING IN FUTURE MONTHS

- Study suggests that not all capitation models work
- Diabetic patients do better with health coaching
- Better communication improves home health transfers
- Case managers can have say in discharges against medical advice

HOSPITAL CASE MANAGEMENT

EDITORIAL ADVISORY BOARD

CONSULTING EDITOR:

Toni G. Cesta, PhD, RN, FAAN
Partner and Consultant
Case Management Concepts, LLC
North Bellmore, New York

Kay Ball, RN, PhD, CNOR, FAAN
Professor of Nursing
Otterbein University
Westerville, OH

Beverly Cunningham, RN, MS
Partner and Consultant
Case Management Concepts, LLC
Dallas, TX

Teresa C. Fugate, RN, CCM, CPHQ
Case Management Consultant
Knoxville TN

Deborah K. Hale, CCS
President
Administrative Consultant Services Inc.
Shawnee, OK

Patrice Spath, RHIT
Consultant
Health Care Quality
Brown-Spath & Associates
Forest Grove, OR

Donna Zazworsky, RN, MS, CCM, FAAN
Consultant
Zazworsky Consulting
Tucson, AZ

Interested in reprints or posting an article to your company's site? There are numerous opportunities for you to leverage editorial recognition for the benefit of your brand. Call us: (800) 688-2421. Email us: reprints@reliasmedia.com.

Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at groups@reliasmedia.com or (866) 213-0844.

To reproduce any part of Relias Media newsletters for educational purposes, please contact The Copyright Clearance Center for permission: Email: info@copyright.com. Web: www.copyright.com. Phone: (978) 750-8400

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log onto ReliasMedia.com and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you.

CE QUESTIONS

1. **What are the leading causes of preventable maternal death or harm?**

   a. Intimate partner violence and pre-eclampsia
   b. Hemorrhage and motor vehicle accidents
   c. Suicide and falls
   d. Hemorrhage and pre-eclampsia

2. **RN case managers and other healthcare professionals should look for signs of maternal distress by checking vital signs that are outside normal parameters. Which of the following is an important vital sign to measure and assess?**

   a. Body temperature
   b. Blood pressure
   c. Pupil dilation
   d. Reported pain

3. **Which of the following is not one of the 4Ms of the Age-Friendly Health Initiative?**

   a. Medication
   b. Mentation
   c. Malaise
   d. Mobility

4. **Which of the following is a good way to gain buy-in from hospital leadership to implement the 4Ms initiative, according to Terry Fulmer, PhD, RN, FAAN?**

   a. Create a PowerPoint presentation about the benefits.
   b. Make the message personal by telling patient stories.
   c. Present a cost-benefit analysis.
   d. Ask staff to help petition leadership for the change.

CE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Interdisciplinary Care Rounds: A Key Strategy for Improving Case Management Outcomes, Part 4

By Toni Cesta, PhD, RN, FAAN

Introduction

This month, we conclude our four-part series on the topic of interdisciplinary care rounds. We have focused on why interdisciplinary walking rounds are so important for care coordination, patient throughput, patient satisfaction, and many other outcomes. We discussed the roles of each team member when conducting interdisciplinary rounds, particularly walking bedside rounds. We also reviewed how team members can prepare for rounds, how they should conduct themselves during rounds, and what tasks may need to be completed following rounds.

In this issue, we will focus on talking points for rounds, documentation related to rounds, measuring the success of rounds, and how to manage your rounding process in the future.

ROUNDS THAT ARE TOO LONG OR DO NOT STAY ON TOPIC WILL RESULT IN POORER OUTCOMES AND MAY ULTIMATELY FAIL AS MEMBERS STOP ATTENDING.

Talking Points for Walking Bedside Rounds

Bedside rounds must be carefully managed and choreographed. The management of rounds is critical to success. Rounds that are too long or do not stay on topic will result in poorer outcomes and may ultimately fail as members stop attending. To ensure a greater measure of success, the team planning for implementation of new rounds or revision of existing rounds must spend time developing talking points for each team member.

First, there should be general rules of the road for team members. These rules should be hardwired and adhered to at all times. These rules should include the following:

- Rounds must take place at a consistent time daily;
- All key members of the interdisciplinary team are expected to attend and to be on time;
- Rounds begin when the facilitator or team lead is in attendance;
- Each team member must come prepared to present at rounds and stay true to his or her talking points;
- Each team member should spend no more than two minutes on any one patient. If additional time is needed, that patient should be discussed after rounds.

Talking Points for the Physician

The physician attending rounds often is the leader of rounds. The physician leader sets the tone and the timing for rounds. He or she should discuss the following talking points:

- The reason for hospitalization;
- The plan of care;
- Expected length of stay;
- Expected outcomes for the day and for the hospital stay;
- The discharge plan;
- Any delays or barriers.

Talking Points for the Staff Nurse

The staff nurse is expected to present his or her assignment of patients, and leave the rounds to return to direct patient care.

The nurse brings a different perspective from that of the physician. The staff nurse should discuss the following

topics related to his or her role as the direct care provider:

• The patient's progress as it relates to the plan of care;

• Any barriers to the patient's progression, such as pain or inability to walk or eat;

• Any issues related to the family;

• Any transition points, such as discontinuing IV meds, removing drains or other devices, or diet progression.

Talking Points for the Case Manager

Case managers play an important role in walking rounds. They bring knowledge about the patient's discharge planning progress, any insurance issues that may impede that discharge plan, any family issues, and any barriers to care or throughput. As a case manager, you also should discuss the patient's actual against expected length of stay and ensure that the white board in the patient's room reflects this information.

As you prepare to speak on rounds, consider organizing your talking points in categories that relate to your roles and functions. Examples of these include:

Category: Coordination of Care

• The actual against expected length of stay;

• Any care progression delays;

• Any barriers to care;

• Achievement of any outcomes of care.

Category: Discharge Planning

• Status of the discharge plan;

• Any insurance barriers related to the plan for discharge;

• Any family and/or patient dynamics affecting the discharge plan.

Category: Utilization Management

• Any insurance issues that may affect the discharge plan in a negative way (uninsured or underinsured);

• Status of any pending insurance approvals.

By organizing your talking points in this way, you will be more organized in your thinking and less likely to leave out any important information.

Talking Points for the Social Worker

Depending on your hospital's case management model, the social worker may or may not be available to attend rounds. If the social worker is the sole discharge planner, then he or she may be able to attend rounds. If the social worker is following cases on a referral basis from the case manager or other members of the team, he or she will not be able to attend rounds. In the second example, the social worker is likely to be covering more than one unit, but only a handful of patients on each of these units. In this case, the social worker should provide any pertinent psychosocial or discharge planning information to the case manager who will present it in rounds.

> THE SOCIAL WORKER BRINGS UNIQUE INFORMATION TO THE INTERDISCIPLINARY TEAM AS TO THE PATIENT'S FAMILY DYNAMICS, LIVING SITUATION, FINANCIAL SITUATION, AND OTHER PSYCHOSOCIAL ISSUES.

The talking points listed below should be presented by either the social worker or the case manager:

• Psychosocial issues affecting the hospital stay and/or discharge plan;

• Concerns that may warrant a behavioral health intervention;

• Any necessary community referrals;

• The status of the discharge plan.

The social worker brings unique information to the interdisciplinary team as to the patient's family dynamics, living situation, financial situation, and other psychosocial issues.

It is important that the social worker have a voice in the walking rounds process.

Talking Points for Ancillary Providers (Respiratory Therapist, Physical Therapist, Nutritionist)

Ancillary providers should participate in rounds on the units where their specialty is of importance.

As previously discussed, each specialty should be included on units where their discipline's care plan and discharge plan are most relevant. For example, physical therapy should be present on orthopedic unit rounds and where their knowledge is critical to the patient. The nutritionist might attend rounds on a geriatric or oncology unit. Below are the specific talking points for one of these specialties.

• Interventions;

• Goals of care;

• Status of interventions;

• Barriers to care;
• Any barriers affecting the discharge plan.

Walking Rounds Checklist

Another useful tool for conducting rounds is a checklist. The list can be used as a way to remind each team of their talking points. It also can be used as a tool to streamline each interdisciplinary team member's documentation. Some electronic medical records have similar tools readily available.

The advantage of using an electronic tool is that it is easier to edit the content and not have to start from the beginning each day. If this is not the case in your hospital, you can have such a tool added to the system or use a paper tool.

When developing your own version of the checklist, consider which team members are participating in the walking rounds process and be sure each of these members is represented. Discuss their talking points with them to ensure that all relevant information is included on the checklist. You may also consider creating a separate list for each team member that they can carry and use. Think creatively as you implement your own checklist.

Below are sample elements of a checklist/documentation tool:

• Patient name;
• Date and day of week;
• Attending in charge and team;
• Identified surrogate/caregiver (if needed);
• Goals of care (aggressive/palliative/unknown/other);
• Expected discharge destination;
• Has the patient been out of bed in prior 24 hours?
• Walking? If not, why?
• Catheters/IVs/Pressure;
• Injuries/Nutritional status;
•Presumptive diagnosis;
• Expected length of stay;
• Day of hospitalization;
• Expected discharge date;
• What happened in last 24 hours;
• What can be expedited?
• What can be done as outpatient?
• Pending results of tests and consults;
• How will test results affect the care plan?
• Medication review:
- All current meds;
- Convert to oral medication?
- Discontinue?
- Home infusion?
• Barriers to next level of care/discharge:
- Clinical;
- Functional;
- Social;
- Economic.

Measuring the Impact of Interdisciplinary Care Rounds

The Institute for Healthcare Improvement has identified some standard outcomes that you should be able to achieve with an effective walking rounds process:

• Improved teamwork and communication between providers;
• Reduced duplication and redundancy;
• Reduced length of stay;
• Improved patient flow;
• Reduced errors;
• Expedited discharge planning;
• Increased collaboration and satisfaction among the team.

During the implementation and testing phase of your rounding process, ensure that you are holding the gains that you are making. It is very important that you measure these process steps regularly as you roll out the nursing units to the new way of conducting rounds.

Measures Needed to Hold the Gain

It is important that you keep track of how the rounds are performing as you move through the implementation process. Rather than looking at the outcomes achieved through the rounding, these measures are focused on the rounding process itself. It is easy for the team to fall back into bad habits if the rounds are not monitored and measured. The following are examples of how you can best keep track of the progress of your walking rounds process.

1. Measure the numbers of days a week that the rounds occur.

If rounds are frequently canceled, you will need to find out the cause or causes of the cancellations. It may be that the leader is absent or specific team members are not participating. Patterns like this can lead to a failure of the rounding process.

2. Keep track of how often rounds begin on time.

If rounds frequently start late, a root cause analysis may be needed to determine why.

3. Track the number of disciplines represented on rounds and, specifically, that the core members are present.

You may find that rounds occur as scheduled but that certain members often are absent. This may require a corrective action to get absent members back on board or it may only require speaking to the individuals.

4. Measure the percentage of patients with a documented daily goal in their record.

Since one of the core elements of effective rounds is that each patient has at least one documented daily

goal, this measure should be conducted routinely on an adequate sample size of charts. A typical sample size is approximately 30 medical records.

5. Observe how well the team adheres to scripting and talking points.

Someone will need to objectively observe the rounds and take notice of each discipline's talking points to ensure that they are being followed. If not, the rounds can lose focus and take more time than allotted. If this happens with your team members, re-education of the scripts may be needed.

6. Observe the time spent on each patient during the rounds, including at the bedside.

The rounds should be designed to allow for an average of 60 seconds per patient. New admissions may need more time, and longer-stay patients less time. You should observe rounds and measure the time spent with each patient to ensure that the time intervals are not too long.

Outcome Measures

In addition to measuring the processes of rounds, you will also want to measure the outcomes achieved. The following represent those that you may consider including in your outcomes measures.

• **Reduction in length of stay.** The team discusses the care plan and any changes that can be made in a timely manner. Barriers also can be identified and addressed in real time.

• **Reduction in ICU patient days.** Review clinical picture, treatment goals, and test results of ICU patients. Patients ready for transfer can be identified in a timely manner and expedited quickly.

• **Reduction in morbidity and mortality.** Team member collaboration and use of best-practice care bundles can have a positive effect on these measures.

• **Quick assessments.** The team can get a sense of patients' progress by observing and communicating with the patients.

• **Environmental check.** Reinforce the importance of a clean patient environment and removing unnecessary supplies and linens to the nurses and patient assistants.

THROUGH IMPROVED COORDINATION, COMMUNICATION, AND A TIMELY ASSESSMENT BY THE CASE MANAGER AND SOCIAL WORKER, AN INITIAL DISCHARGE PLAN CAN BE IDENTIFIED EARLY IN THE STAY.

• **Safety check.** Rounds present an opportunity to check the safety of patients at high risk for falls or who may pull their lifesaving devices or lines.

• **Regulatory check.** For this step, make note of any regulatory compliance check issues in the patient's room; for example, the number of side rails on the bed.

• **Patient satisfaction.** Patients and families are happy to see members of the care team and appreciate being included in the care processes. Be sure to include the day and date of discharge on the white board in the patient's room.

• **Staff satisfaction and education.** Staff members note and report any instances where education may be lacking and improvements can be made. They also promote a culture of safety and quality.

• **Ventilator days.** Team members identify stable patients who can wean off ventilator or be removed from ventilator by reviewing their clinical picture, vital signs, treatment goals, and diagnostic test results. The staff nurse collaborates with the respiratory specialist to ensure patients are ready for ventilator changes.

• **Number of pharmacy changes such as discontinuing antibiotics.** Measure whether changes occurred in a timely manner and when clinically appropriate.

• **Number of discharge delays.** Measure delays associated with communication, physician practice, or care coordination.

• **Number of discharges before noon**. Better coordination among the team members will improve discharge times.

• **Number of patients with a discharge plan within 24 hours of admission.** Through improved coordination, communication, and a timely assessment by the case manager and social worker, an initial discharge plan can be identified early in the stay.

Summary

Walking bedside rounds can make a difference as you place the patient and family in the center of all patient care activities. In 30 minutes, the team can achieve a patient interaction, focused quick assessment, plan of care discussion, safety check, environmental check, regulatory check, and patient and staff education. Within the current demands of healthcare, this culture of safety, transparency, efficiency, collaboration, and autonomy makes a big difference in the quality of care patients receive. ■