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Vol. 40, No. 6; p. 61-72

→ INSIDE

Four hazards that did not make the ECRI list . . . 63

Designed to help, can cause harm 64

SEA 54: Watch out for Health IT 65

Feeling put upon by RACs? 65

Auditing the RAC audits: Sheehy's study 67

Near misses, harm from devices regular occurrence. 67

Beware the weekend . 68

Hospitals stepping up for pediatric readiness. . . 70

AHC Media

Hear that alarm ringing?

Alarm issues top ECRI Institute's annual watch list...again

Cindy Wallace, CPHRM, Senior Risk Management Analyst and chief author of the annual ECRI Top 10 Patient Safety Concerns for Healthcare Organizations, wants to emphasize: Every hospital will have its own top 10 list. Yet she and her colleagues know that most of these concerns will resonate with most readers.

The 10 chosen safety concerns are:

1. Alarm hazards: inadequate alarm configuration policies and practices.
2. Data integrity: incorrect or missing data in EHRs and other health IT systems.
3. Managing patient violence.
4. Mix-up of IV lines, leading to misadministration of drugs and solutions.
5. Care coordination events related

to medication reconciliation.

6. Failure to conduct independent double checks independently.

7. Opioid-related events.

8. Inadequate reprocessing of endoscopes and surgical instruments

9. Inadequate patient handoffs related to patient transport.

10. Medication errors related to pounds and kilograms.

Half of the list are new concerns, or at least are a new iteration.

(For a look at a handful that did not make it, see story on page 63.)

The primary concern, alarm hazards, has been a topic of interest for well over a year in healthcare. Alarm hazards are listed in The Joint Commission's requirements for certification starting in 2016, and have appeared on ECRI Institute's

"THEY WEREN'T CLOSELY MONITORING THE PATIENT AND THERE WAS A SERIOUS EVENT AS A RESULT."

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EDITORIAL QUESTIONS

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technology watch list every year since it began.

What is different about this particular note of concern, **William Marella** MBA, Executive Director of the patient safety, risk and quality group notes, is that it relates to problems that are related to alarm fatigue — although that remains a problem. Rather, this is about alarms not working properly or going off as they should or when they should. One problem might be a tendency to use factory default settings regardless of where the patient is being cared for, while a patient in the NICU is certainly different than a patient in an observation unit.

Still, do not discount alarm fatigue in your search for proper configuration. Marella relates the story of one accident investigation where “everyone was ready to point the finger at the nurse. The alarms sounded, the messages were relayed to her pager, the pager went off, and she acknowledged them,” he says. But when they investigated further they found her pager had been pinged 400 times in a single shift.

Managing patient violence is not technically a new addition, and doesn't have the requisite asterisk in the ECRI Institute report. However, says Wallace, last year the focus was on behavioral health patients. Now, they have removed that distinction.

The second completely new item on the list is the mix up of intravenous lines, or “spaghetti syndrome,” says Wallace. “This is particularly a problem in the ICU, where you might have patients on multiple drips.” Imagine a patient who is on a saline drip and a heparin drip, she says. One goes in at a higher rate than the other, and one is much more dangerous than the other. Making sure the right line is attached to the right back can be a

life or death issue. Recommendations include to trace back lines, to put different drugs on different sides of patients, or more clearly label the lines.

Failure to conduct independent double checks independently sounds more like a mouthful of too many words than a problem hospitals need to conquer, but it is a real safety issue, Marella says. “If you are doing a double check and say to someone, ‘Can you double check this heparin line for me?’ you are biasing that person to find it is, indeed a heparin line.”

The Institute for Safe Medication Practices says that 95% of medication errors can be detected with independent double checks. Marella says you should figure out which medications require them, then make sure the staff is available to ensure they are done, or they will find workarounds that can compromise safety.

Inadequate patient handoffs related to transport, particularly between units, is something that *Hospital Peer Review* looked at in the January 2015 issue with the Ticket To Ride program in Pittsburgh.

(For more information, see “Improving transitions within the hospital” in the January 2015 issue of Hospital Peer Review, page 7.)

Those who transport patients are not often read into special needs that some of them may have. Take a patient with oxygen needs, add to that the labyrinthine nature of hospitals, some of which extend across multiple buildings, and a request for a patient to appear somewhere else for a test. You could end up with a patient decompensating over a long ride simply because you did not tell the aide that the patient might need oxygen, says Marella. “People,

including transport aides, need to have situational awareness,” he adds.

Wallace mentions the case of a baby transported to the NICU with a fluctuating temperature, but was not relayed to either the transporter or the NICU. “They weren’t closely monitoring the patient and there was a serious event as a result.” Happily, she reports, the patient survived, but the event did not need to occur. Even if the NICU hadn’t known, if the transporter had, it would have been a safety net of information transfer.

Last on the new list is medication errors related to converting pounds to kilograms. (*For more on this topic, see story on pediatric emergency room readiness, page 70*) “Pediatricians actually are pretty good about this, and oncologists,” says Marella. But what if a hospitalist or resident is taking care of that patient? “This is completely solvable,” he says. “If we could convert to the metric system, even just in hospitals, that would help.”

Many EHRs still allow documentation either way, leaving it open to enter pounds into a

kilogram field. The best have computer logic that catching these errors, he says. “If you have a two-year-old child and you enter 30 pounds into the kilogram field, the EHR should be able to recognize that weight as off-the-charts high and prompt you to correct it.”

Wallace says the other option is to remove scales recording in pounds or if they have a toggle that lets you switch between, make sure they are as permanently put on kilograms as possible.

The list is a quick look at what has appeared on the desks of investigators and consultants at ECRI Institute, Marella says. “Our intent is that hospitals take this as an opportunity to take stock and see which of these apply to you and your patient populations. Ask probing questions about if you have good processes in place for identifying and preventing problems.”

If you lack resources to adequately address these issues, and you have identified them as problems, Wallace says this report is good to put in front of leadership, since it is based on a nationally

compiled database of information — some 1 million events from about 40 states. “Maybe it will help you get resources and support.”

All of these are common enough that most hospitals should be looking to see if they exist. Not all will apply to every hospital, Marella says. Nor is it likely that any hospital has dealt with them uniformly. “Some may have good processes in place for some, but I bet if you looked at your malpractice claims, you find something here to work on. That should help you gain support to deal with these problems, too.”

A complete copy of the report is available on the ECRI Institute website at <http://bit.ly/1F1zcXk>.

For more information on this topic contact:

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Four hazards that did not make the ECRI Institute list

Developing the top 10 patient safety list every year comes down to a group of ECRI Institute experts culling through submitted event reports, conducting accident investigations, and looking at the consulting projects they do. Every year, the consensus distributes a list of the top 10 concerns. **Cindy Wallace**, CPHRM, senior risk management analyst at the institute, shares some concerns that did not make this year’s list:

- Dealing with disruptive clinicians:
- managing anticoagulation medications, specifically older ones like Coumadin:
- ineffective suicide assessment:
- infant/newborn falls: instances where a very tired new mother might be holding the newborn and falls with the infant;
- pressure ulcers from devices: nasal cannulae come to mind, where if not moved or checked, or

if placed too tightly, can cause skin deterioration in a relatively short period of time.

Although these items did not make the top 10 list, Wallace reminds us to remember they are also important safety issues to consider — but, if you have to stratify what is most important, start with the top 10. If you have the bandwidth to delve further, these are certainly items worthy of consideration. ■

Designed to help, can cause harm

Health IT harms on TJC radar

The Joint Commission released a health IT-related Sentinel Event Alert this spring. There was another one in 2008 related to the convergence of technology regarding electronic health records and devices. (For more information, see the story on page 65.) Since then, organizations have been informing stakeholders of the concerns they should have and care they should take related to technology that, when used properly, can make the lives of frontline staff easier and the care of patients safer and of higher quality.

This time, the Commission focused on some workflow issues surrounding the various technologies, says **Gerry Castro**, PhD, project director for patient safety initiatives. “We know that a lot of people are worried about this, but we have the added benefit of the root cause analyses in our database, so we can see how these events transpire, not just the reports of them happening.”

They are finding that harm happens at one end, but the event beginnings are often much further upstream, Castro says. “Someone clicks the wrong thing on the screen, and somewhere further down the road, something bad happens to the patient. The things we have in place to protect patients from that fail, too. There are multiple failures involved.”

These mistakes yield most commonly to medication errors, wrong site surgeries, and delays in treatment. “And in each one of these cases, there has been significant injury, permanent harm, or death, which is another way our information is different. We aren’t dealing in close calls here. These are

the things that actually kill people, hurt people.”

In terms of wrong site surgery, which is one of those events that the general public may not understand, Castro provides an example: A computer terminal is down the hall from the operating theater. There is no way to double check the right place is being operated on because there has never been an effort to place the new technology that has all the patient information on it in a place where the surgeon can have immediate access for a last check.

“BUT WHAT WE HAVE SEEN WITH MANY IS THAT THEY ARE DOING A GOOD JOB CONNECTING THE IDEA OF HEALTH I.T. WITH THE IDEA OF SAFETY.”

Another situation leading to harm Castro relates to is drop-down lists. “How many times have you clicked on the wrong thing in your own life? Or if a scheduler is trying to select something and there is nothing in the list that drops down that fits, you make a decision to pick this next best thing and then write something in the comments. But what if the comments do not get read? What if the provider system does not copy the comments over from the scheduler’s system?”

The goal of these alerts is

for hospitals to look at their environments and assess their risks. “You do not necessarily make a connection between this technology that is supposed to make your life easier and a safety issue. And sometimes, these issues just end up on the IT department’s help desk.” That department may not be keyed into patient safety the way others in the hospital are.

“Everyone needs to make the connection between the IT issue and patient safety,” says Castro. He recommends the government SAFER guides, available for a variety of issues related to technology at www.healthit.gov/safer, which offer well-developed checklists and tools that the Office of the National Coordinator for Health Information Technology (ONC) created with a great deal of input from end users and robust research from peer-reviewed literature. “These are a great risk assessment tool, and not just for user issues, but also for organizational and leadership issues, too,” he says.

Those who worked on the alert did learning site visits with organizations to discover which technology they used and how they calculated and moderated the risks related to it, Castro says. This is an issue that will continue to evolve. He mentions smartphones that are used to pull up vital signs for patients, and patient access to Wi-Fi. Both of those offer the potential for data integrity issues at the very least, so chances are there will be another technology-related SEA in the future. “What do you do if all your patients want to stream movies and that makes the hospital bandwidth slow down to

the point that it slows down critical information?” he says.

“But what we have seen with many is that they are doing a good job connecting the idea of health IT with the idea of safety,” he says. He can’t name names, but he mentioned the hospital with the smartphones. They keep a bank of them on the

unit for use on the unit only. And if they leave the unit, they are programmed to stop working. That means they can’t be removed and used with patients who are not on the unit, nor can the information on the phones be used outside of it. “But I think it will be tough for everyone to keep up.”

The complete alert can be found at http://www.jointcommission.org/assets/1/18/SEA_54.pdf.

For more information on this topic, contact Gerry Castro, Ph.D., Project Director, Patient Safety Issues, Joint Commission, Oakbrook Terrace, IL. Email: gcastro@jointcommission.org. ■

SEA 54: Watch out for Health IT

Hospital highlights from The Joint Commission SEA 54

The Joint Commission studied 120 Sentinel Events, a third of which were related to human-computer interface. Think of a case where you chose the wrong item from a drop-down menu, or if you had two files open and clicked the wrong one. Clinical content was nearly a quarter of them. That relates to design issues related to clinical content, like the ability to have two EHRs open at once. Another quarter were workflow and communication issues. Three issues each had 6%: policies/procedures/culture, people (training or failure to follow the procedures in place), and software or hardware issues.

The Commission recommends three actions related to this alert. First, create a good safety culture

in which the issues related to technology are well-known, and when adverse events happen they are reported and investigated. The issue is not about assigning blame, but sharing responsibility.

Second, develop a good process improvement program related to health IT. They recommend the SAFER guides which can be found at <http://www.healthit.gov/safer>.

Third, have a good leadership culture on this topic, while also engaging people from the frontline staff to help identify risks and come up with solutions and rewarding vendors that have safety in mind when creating their products.

Several requirements from the survey manual relate to this topic. Those related to hospitals are:

Requirements

Human Resources

HR.01.04.01

HR.01.05.03

Information Management

IM.01.01.01 (IM.1.10 for some programs)

IM.01.01.03 (IM.2.30 for some programs)

IM.02.01.03 (IM.2.20 for some programs)

Leadership

LD.03.01.01

LD.03.02.01

LD.04.04.03 (LD.4.20 for some programs)

Medication Management

MM.08.01.01 EP4

The complete alert can be found at http://www.jointcommission.org/assets/1/18/SEA_54.pdf. ■

Feeling put upon by RACs? There is a reason

Study finds 25x audit rate as CMS says, long appeals delays

No one would say that modern medicine is perfect or that it is free of bad actors. Yet, most of those involved in dealing with the repercussions of Recovery Audit Contractor (RAC) audits have probably sighed in exasperation over the length of time an appeal takes.

You weren’t imagining things. A study in the April issue of the *Journal of Hospital Medicine*¹ found that three hospitals, representing three of the four RAC regions, experienced audit rates related to observational care of an average of 8%. The Centers for Medicare &

Medicaid Services (CMS) says it should be 0.3%. Audit appeals will take years before adjudication.

These were just two of the findings **Ann Sheehy**, MD, MS, a hospitalist at the University of Wisconsin’s medical center, and her colleagues, from Johns Hopkins

Hospital and University of Utah Hospital made. (*For a complete list of findings, see page 67.*)

“We thought we would find a lot of hospital wins,” Sheehy says of her feelings going into the study. “There has been nothing in the literature on it, and there has been a lot of pressure in its use due to the RAC program.”

She was surprised by the length of time appeals take. “Two years? That is a failure of due process. And the number of cases settled in discussion is large.”

CMS rules say that appeals should be heard in two months for level 1 or 2 appeals, and three for a level 3 appeal. Sheehy and her coauthors are unsure that the delays in the process will not accumulate again, particularly in a system where so many more cases are being audited than the system was designed for.

All three hospitals had the same experience in the pre-appeals discussion phase. And all three experienced the huge burden of audits, far higher than CMS says anyone should be. That this uniformity existed was also a shock, she says. “We felt we were three clean hospitals being audited at a high rate.”

What a shock

That was surprising. The other thing was sheer volume of audits: 8%, rather than 0.3%, with a range of 20% at University of Utah, and a tenth that rate at Johns Hopkins. All are still over the 0.3% CMS espousal. “That is a huge burden,” she says, “and it was across three of four RAC regions.”

Right now, RAC does not have to publish what happens in

discussion, the time in appeals, or the number of cases they are auditing. Sheehy says if that happened, there would be a bigger push for reform. “This is not good governance, and transparency does not cost anything.” However, the way RACs are managing the process now is costing hospitals money and taking up resources that would be better spent on patient care or some other quality-improving method.

Sheehy is keen to mention that none of the audits ever question patient care, just the place it is given. “None of the audits are uncovering unnecessary care for patients.”

Also the contingency fee payment plan, under which RACs operate, needs to change. At a time when the entire healthcare system is being weaned off of fee-for-service and onto a quality-based payment system, Sheehy says it is ironic that the auditing function is being paid based on how much work they can muster up. It makes sense then that they would do 25 times the work that CMS thinks they should be doing.

What would it take?

These changes require congressional action, and this is one case when Sheehy thinks a good action for hospital stakeholders to take is to actually write to their congressional representatives and senators. They have heard from stakeholder groups, she says. But hearing from the front line staff who have to deal with it? That might be more powerful.

She would like to see a time when there are not five full-time staff devoted to handling audit issues, “and that does not include

the case management staff who have to get involved,” Sheehy says. She would like to see high-risk programs and providers targeted, and bad actors weeded out. “This does not do that. This is about status and billing and is a huge waste of time and energy. Out of 8,000 encounters, they found nothing wrong with the care we delivered, and the bulk of the cases were found in favor of the hospitals. They would be better off looking for medical fraud, for care that was billed but not delivered, not this.”

Completely clean hospitals will be audited, and the only advice Sheehy can give based on her findings is to meet the deadlines. Other than that, take up your pen and paper, and settle in for a long wait for your money if you appeal. “If you have access to this data, it is a good idea to keep it and track it, too. If you write a letter, include it with the letter. That could be a powerful tool.”

Is she afraid her vocal criticism will lead to more attention from the RACs? No, Sheehy says. “If they come after us harder, we’ll just publish again. If there are more flaws, we want people to see them.”

For more information on this topic, contact Ann Sheehy, MD, MS, Department of Hospital Medicine, University of Wisconsin School of Medicine and Public Health, Madison, WI. Email: asr@medicine.wisc.edu.

REFERENCE

1. Sheehy AM, Locke C, Engel JZ, Weissburg DJ, et al. Recovery Audit Contractor audits and appeals at three academic medical centers. *J Hosp Med*. 2015 Apr;10(4):212-9. doi: 10.1002/jhm.2332. ■

Auditing the RAC audits: Data from Sheehy study

RAC audits are good at ferreting out information on what hospitals are doing “wrong”, but the study that Sheehy et al (see story above) published on the actual impact of RAC audits and their outcomes is eye opening. Below are some of the highlights from their work:

- RACs alleged non-compliance — all overpayments — for 31% of the cases they requested.
- Hospitals disputed just about all the cases — 91%.
- Hospitals employ more than five full-time staff to deal with the audit process
- The care provided was never disputed, just the fact that it was

provided in an inpatient rather than outpatient or other setting.

- More than 16% of cases are still pending, more than 555 days after their appeal.
- Some from 2010 and 2011 spent more than 900 days in appeal.
- Hospitals won an increasing number of cases as the years progressed, going from 36% in 2010 to 68% in 2013.
- Half the time, hospitals withdrew appeals or rebilled during the discussion phase of the case.
- Half the cases have been won in discussion or appeal over the four year period of the study.
- A third of cases are decided in

favor of the hospital in the discussion period.

- A two-fold increase in audits and 300% increase in overpayment determinations during the last two calendar years of the study at all three hospitals.
- Just 18 cases were conceded by hospitals due to missing a filing deadline.

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1. Sheehy AM, Locke C, Engel JZ, Weissburg DJ, et al. Recovery Audit Contractor audits and appeals at three academic medical centers. *J Hosp Med.* 2015 Apr;10(4):212-9. doi: 10.1002/jhm.2332. ■

Near misses, harm from devices regular occurrence, say nurses

Lack of interoperability an issue

If there is a Sentinel Event and you do a root cause investigation, you may start by looking at what time something occurred. But if you look at an infusion pump, it might give you a completely different time than the heart monitor. Why? Because there is no central device that synchronizes time for devices. This is one of the examples of the lack of interoperability between devices and the potential problems it can cause hospitals.

“If you want to learn from big data, at the very least, they [devices] should share the same time,” says **Joseph Smith**, MD, chief medical and science officer for West Health Institute.

The word interoperability has been bandied about the healthcare world for several years. It is usually associated

with electronic health records (EHRs) and their frustrating inability to talk to one another if they aren’t made by the same vendor, or often made by the same vendor in the same decade. But there is another problem of interoperability that is worrying frontline staff: the ability for medical devices to talk to one another.

A survey of nurses conducted by Harris Poll for the West Health Institute found that just about every one of the nearly 500 respondents thought that medical devices should be able to talk to each other and to the electronic health record, and just about every one of them worked with these devices on a daily basis. Half of them had witnessed a medical error related to a device and its lack of interoperability with another device or the health record.

Almost half said they felt that a medical error was likely due to the necessity to hand transcribe data that these devices should be able to report to one another automatically. If these devices did talk to each other, most of the respondents — 96% — thought healthcare could be safer.

As it stands, three-fourths of respondents felt that a lot of devices ended up creating work for them that takes them away from patient care. The nurses answer alarms, troubleshoot technical issues, transcribe data, and teach patients and family members about the devices, they reported — all things that take them away from other, more important tasks.

An example of the potential safety improvement, says Smith, might be an infusion device and an oxygen monitor. If the infusion pump, dispensing an

opioid, was set wrong or the patient somehow decompensated, the oxygen monitor would note a decline in blood oxygenation, sound an alarm, and alert the nurse. Would it not be better, though, if the two were paired and the oxygen monitor could alert the infusion pump, and the infusion would suspend operation pending a nurse or physician arriving on scene?

Another example of the potential of interoperability, Smith says, is if you need to change the programming of one device because of something observed by another. For instance, if the blood pressure of a patient is very high, and the medications aren't doing what they should, then you would want the rate of medication delivery to increase. "It is closing the feedback loop," he says. "We want these devices to make sure things are happening the way they should be."

In the near term, the best hospitals can do is ensure that equipment is uniform so that staff does not have to learn new interfaces. "That does tend to drive us to a single vendor, and reward a business model that does not share," he says. "I do not like this."

There are some manufacturers who are integrating across product lines. Another option is middleware vendors, who create software to hang off the back of the devices to make sure they talk to each other or send data seamlessly to the EHR.

He also wants to see more user-centered design for devices. "Right now, we have to pick our EHRs from ONC-certified lines, rather than picking something that is easy for us to use or that meets our needs. Let's not go that route with devices. Let's make sure that manufacturers start creating the devices that provide what we need."

The problem is solvable — we did it with the Internet, he says, which can talk to any device we own. But healthcare lags. "We have to get 21st century information flow," he says.

The Center for Medical Interoperability, associated with the West Health Institute, is working on the topic, with some 500 hospitals involved in it at the board level. "We can't be burdening bedside care and clinicians like this. We have to amass our buying power and sentiment to let vendors

know that we will only buy what talks to each other."

That is the long-term approach. For now, the more complicated medical world means it is more dangerous. The best a hospital can do is to keep its finger on the pulse of what is going on within its own doors. Ask frontline staff what problems they have, the workarounds they are having to create, and what worries them most.

Sometimes, a hospital is big enough that its own IT staff can help with some solutions. Other times, he says, vendors may be willing to help.

More information on the Center for Medical Interoperability is available at <http://www.medicalinteroperability.org>. A conference video on the topic can be viewed at <http://www.westhealth.org/igniteinterop>. And the entire nurse survey can be found at <http://www.westhealth.org/sites/default/files/Nurses-Survey-Issue-Brief.pdf>.

For more information, please contact Joseph Smith, MD, Chief Medical and Science Officer, West Health Institute, San Diego, CA. Telephone: (858) 535-7000. ■

Beware the weekend

Falls, other harm more likely

You can get a lot of data from more than 350 million hospital admissions. What you hope to find is that the care is equivalent from day to day, patient to patient. But that is not the case. According to a study published in April in *BMJ*, patients who are admitted on the weekend are more likely to fall or experience some other adverse event.¹

Frank Attenello, the lead author of the study, said that while looking at data from a neuroscience outcomes research

group — data that comes from 20% of the hospitals in the US each year — they wanted to see what was happening related to preventable outcomes that the Centers for Medicare & Medicaid Services (CMS) and other payers said they would no longer cover. "No one had looked at this data from such a large group of people, or what caused them," he says. "There had been some previous press on weekends and that mortality was higher, but not other forms of harm."

The data came from 2002-

2010, and the authors found that just over 4% of patients had some hospital-acquired condition (HAC). Of the 20% of patients admitted on weekends, 5.7% ended up with a HAC, while the weekday patients had a rate of 3.7%. Even correcting for variables, the difference continued, Attenello says, and the risk for getting at least one HAC was 25% greater on the weekend. Patients with neurological conditions were at a 35% greater risk of developing a HAC, and the teaching status or size of the hospital

also mattered, with smaller hospitals faring better. Older white men were more likely to have problems than minorities, women, and young people.¹

The most common HACs were falls, pressure ulcers, and catheter-associated urinary tract infections (CAUTI). Interestingly, the rate of HACs increased “notably,” the study says, from 2002 to 2010. This could be due to increased surveillance, reporting, and attention to those issues.¹

Hypothetical reasons

There are a lot of potential reasons behind these observations, says Attenello. At the time of these patient admissions, many hospitals did not have equivalent services available seven days a week, and there have been numerous studies that show not getting diagnostic testing done in a timely manner can impact outcomes. A patient who needs an endoscopy who is admitted on a Saturday night but has to wait until Monday for care could deteriorate, he notes. There is a lot more understanding that patients need to have access to equivalent care regardless of when they come in, and more effort by hospitals to ensure that it is available. Need a neuro consult on a holiday weekend? You’ll get it.

Secondly, there are often itinerant staff — particularly nursing — working on weekends. These are people who may be covering a shift for a friend for some extra money, or locums who make their living floating from facility to facility. Attenello says that these people may not know the intricacies of a particular facility — related to layout, policies and procedures, or

even where medications are kept. That can lead to delays in care, or situations that lead to HACs. Imagine a nurse who does not know he or she has the power to suggest to a physician that a catheter is not needed? A patient who develops CAUTI as a result has a HAC he or she did not need to have.

Lastly, there are issues that you just can’t do anything about, he says. Ask a doctor who works in a hospital when the sickest patients come through the doors, and they

“IF YOU GET TO THE POINT WHERE YOU HAVE PLUCKED ALL THE LOW HANGING FRUIT, THEN YOU CAN LOOK AT THE VARIABILITY OF TIME.”

will almost unanimously say, “the weekend.” “Most people do not plan when they come to the hospital,” he says. “But there are people who come in only when they finally have time, after they have gotten sicker and sicker.”

One finding that was crystal clear in the study was that the sickest patients were the most likely to fall, the most likely to get a pressure ulcer or infection — about twice as likely, he says.

There has been an increased focus on HACs since the people who make up this data were admitted to the hospital. CMS reported last year that there was a 17% reduction in some of the kinds of harm that Attenello and his peers looked at in this study. Does that mean the outcome of this study might be different in a few

years’ time? Perhaps, he says. What is important is that you keep focusing on the overall infection and harm problem.

“Focus on the complications and avoiding them altogether,” he says. “If you get to the point where you have plucked all the low hanging fruit, then you can look at the variability of time.”

Resolutions

One thing you can be sure to do is to help people who are working on different units or are new to your hospital know the ropes and the rules. “Standardize things as much as possible everywhere. That way, if you are having nurses covering different areas, working with sicker patients, they all know what to do with everyone every time,” he says.

Attenello is a huge proponent of checklists for the most basic things, down to hand-washing. “Every hospital will have different risk factors, but every hospital will have something they can do to ensure that patients get the best care every day. It may be something very simple that helps you improve care and save money.”

For more information on this topic, contact Frank Attenello, MD, Department of Neurosurgery, Keck School of Medicine, University of Southern California, Los Angeles, CA. Email: attenell@usc.edu.

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Getting ready for baby

Hospitals stepping up for pediatric readiness

It's been nearly 10 years since the Institute of Medicine (IOM) issued a report stating that hospitals needed to be better prepared for the smallest and youngest patients when they came into their emergency departments (available at <http://www.iom.edu/Reports/2006/Emergency-Medical-Services-At-the-Crossroads.aspx>).

Initial studies found that as few as 12% of hospitals had the recommended physician coordinators trained to deal with emergent cases. But a new study in the April issue of *JAMA Pediatrics* shows that hospitals are increasingly getting on board with this and other recommendations.

The IOM report included recommendations to appoint two pediatric emergency care coordinators (PECCs), at least one of whom was a physician. This and later guidelines for emergency preparedness for pediatric patients led to the National Pediatric Readiness Project (pediatricreadiness.org), suggesting hospitals have adequate pediatric-sized equipment, that staff be adequately trained in its location and use, and that quality improvement and patient safety efforts include thinking about pediatric patients.

Where are the stats?

The lead author of the current study, **Marianne Gausche-Hill, MD, FACEP, FAAP**, a professor of clinical medicine and pediatrics at UCLA's David Geffen School of

Medicine and the vice chair of the division of pediatric emergency medicine and director of that department at Harbor-UCLA Medical Center, looked at uptake of the recommendations in 2007 and found that only 18% had physician PECCs, and 12% had a nurse PECC. Other studies that included data from about 5% of US hospitals responding had similar results.

"THE MOST IMPORTANT FINDING WAS THAT THE MOST ADVANCED HOSPITALS IN TERMS OF PEDIATRIC READINESS WERE THE ONES THAT HAD PECCS."

Yet there is hope

Things are improving, though, says Gausche-Hill. The results of the current survey on emergency readiness for pediatric patients, which came from an astounding 83% of US hospitals, found that 47% had a physician PECC, and almost 60% had a nurse. Just over 40% had both. Higher volume hospitals had emergency trained physicians while smaller facilities tended to have family physicians caring for children.

Findings

Other key findings from the study:

- Most respondents reported that staff knew where pediatric equipment was kept and had a cheat sheet, software, or another tool to help ensure they were using the proper size or giving the proper dose to these young patients.

- However, some important pediatric-sized equipment was missing in 15% of hospitals, according to the study: laryngeal mask airways, umbilical vein catheters, central venous catheters, tracheostomy tubes, size 00 laryngoscope blades, continuous end-tidal carbon dioxide monitoring equipment, pediatric Magill forceps, and infant and child nasopharyngeal airways.

- One issue that continues to be a problem with pediatric patients – and which was highlighted in the cover story on patient safety hazards – is the tendency for many physicians to weigh patients in pounds and thus have to convert to kilograms for pediatric medications that are weight-based. A third of the respondents reported they do not routinely weigh pediatric patients in kilograms, and thus have to do conversions.

- Pediatric patients aren't usually considered in QI projects for the ED, the survey found, with just 45% of respondents noting they have a plan that focuses on children at all. Of those, 58% have child quality indicators, 88% collect and evaluate data, 79% have a plan for addressing non-standard care,

and 73% look at outcomes based measures like pain relief.

• More than half of the EDs report they do not consider children in their disaster plan, with even the highest volume hospitals faltering in this area. Just over two-thirds of those consider the special needs that pediatric patients might have in the event of a disaster. About 70% have pediatric transfer guidelines, and just under 90% have a child maltreatment policy.

The most important finding was that the most advanced hospitals in terms of pediatric readiness were the ones that had PECCs, says Gausche-Hill. If they did not have a PECC, there was little chance a facility was going to show readiness for pediatric emergencies, regardless of pediatric patient volume.

Barriers

The biggest barriers to implementing the guidelines reported by respondents were lack of awareness of them, as well as the cost of training. Just about everyone who responded expressed interest in implementing them fully.

Gausche-Hill says that while she did not look at outcomes as they related to complying with these guidelines, there is evidence that without them, there is a lack of quality. “The highest prepared hospitals have great quality,” she says.

And these recommendations aren’t reaches for hospitals, she continues. “These are minimal standards. It does not cost anything to weigh children in kilograms. No one should be doing conversions. If you weigh only in kilos, there will be no problem.”

Including children in your quality improvement indicators also does not add cost, and can potentially improve care and reduce risk. Ask your risk manager what patients bring the most litigation and see where pediatric patients fall on that list. Gausche-Hill says that bringing the best quality, safest care to those patients makes sense.

“THESE ARE MINIMAL STANDARDS. IT DOES NOT COST ANYTHING TO WEIGH CHILDREN IN KILOGRAMS. NO ONE SHOULD BE DOING CONVERSIONS. IF YOU WEIGH ONLY IN KILOS, THERE WILL BE NO PROBLEM.”

Gausche-Hill says the fact that they had such a large respondent base makes her confident in her findings, and hopeful that even

the hospitals that are not currently ready are willing to get ready now. “They are very engaged in the ideas behind this,” she says. She knows that is true because there are many organizations that have made changes since first taking the survey and want to retake it. She is considering ways to keep the web portal where she asked for responses open.

She suggests that those with a desire to improve their pediatric readiness start at the National Pediatric Readiness Project website.

Editor’s Note: For more information on this topic, contact Marianne Gausche-Hill, MD, FACP, FAAP, Director Pediatric Emergency Medicine and EMS Fellowships Harbor-UCLA Medical Center, Department of Emergency Medicine, Torrance, CA. Telephone: (310) 222-6740.

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COMING IN FUTURE MONTHS

- Dealing with patient violence
- Inviting patients to participate in care
- News from the survey trenches

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

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CNE QUESTIONS

- 1. How many potential medication errors can be captured by true independent double checks, according to the ISMP?**
 - a. 28
 - b. 56
 - c. 95
 - d. 77
- 2. What is one potential concern about Wi-Fi in hospitals?**
 - a. Hacking data
 - b. Stealing signal
 - c. Slower speeds due to high use
 - d. Access to pornography or "dark net" sites
- 3. How many hospitals failed to file RAC appeals in time?**
 - a. 25
 - b. 8
 - c. 5
 - d. 18
- 4. What is one of the things nurses do related to devices that they say take away from patient care?**
 - a. Medication reconciliation
 - b. Answer alarms
 - c. Patient education
 - d. Answer call buttons

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the health care industry in general.
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.