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'No secrets, no excuses' policy leads hospital to performance excellence

Employee initiatives have saved $2.5 million

In 1995, Baptist Hospital in Pensacola, FL, found itself sandwiched between two larger health systems and facing a stagnant market. Like other hospitals, it also was confronting diminishing reimbursement, increasing regulatory requirements, and staffing shortages. Since then, the hospital has made dramatic gains in all its performance criteria and has become recognized as a national leader in quality innovation. Most remarkably, it has steadily improved its market share.

In fact, overall market share has increased more than 3%, while employee turnover has been cut in half. Employee initiatives have resulted in more than $2.5 million in cost savings. And patient satisfaction, as measured by Indianapolis-based Press, Ganey Associates, has been sustained at the 99th percentile for the last 11 quarters.

Lucy Crouch, RN, MSN, director of patient care quality improvement at Baptist, says the dramatic improvements were brought about through an ambitious quality improvement effort centered on five key pillars — service, quality, cost, people, and growth.

"Pensacola is a little small for three major hospitals, and we were clearly the underdog," Crouch says. The hospital's competitors are the large system-based hospitals owned by Columbia/HCA and The Daughters of Charity hospital systems. In addition, Baptist is not easily accessible, she explains.

Against that backdrop, the Health Care Advisory

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- How to monitor the effectiveness of cardiopulmonary resuscitation
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Board had just released a study that concluded little if anything could be done to improve market share. Whenever one hospital added an MRI, a primary care clinic, or other new service, other hospitals in the same market simply mimicked those initiatives. Health care is a copycat business, and Pensacola was used as an example in the report, says Crouch.

In an effort to improve its competitive position, Baptist initially opted for staffing and organizational changes that proved very unpopular with staff internally. Employee morale dropped, and by September 1995, patient satisfaction had fallen from the average range to the 27th percentile.

The hospital's senior leaders went back to the drawing board. The result was a commitment to the board of directors that the hospital would refocus its efforts on patient satisfaction and customer service and achieve the 75th percentile for patient satisfaction within a year.

Baptist studied emerging techniques from hospitals that were faring well in this area and established seven patient satisfaction teams. "We were very confident that our results would improve in the next quarter," reports Crouch. Instead, Baptist plummeted to the ninth percentile.

The leaders went back to the drawing board once again. "Once we picked ourselves up off the floor, we realized that if we could be good in four key areas that we would thrive operationally," says Crouch. "What we talked about was best service, high quality, best people, and low cost." Eventually, Baptist added growth as a fifth key pillar.

In order to accomplish these objectives, Baptist discovered that it had to undergo a major transformation of its culture, beginning with the way it communicated internally. "We had to change the way we work, and central to that transformation was a philosophy of open communication," she explains.

According to Crouch, bringing that change about required the development of many new mechanisms. Baptist established a communication board in every unit as well as quarterly employee forums in which the hospital administrator holds hour-long sessions to update all employees on where the hospital stands in terms of its five key objectives. In addition, all departmental and meeting agendas are structured around the five pillars.

Another key to open communications was a

(Continued on page 64)

Baldrige Award program gains favor with hospitals

Hospitals seeking to improve their performance increasingly are turning to the ambitious criteria established by the Malcolm Baldrige National Quality Award. Two years ago, health care was added as a category in that quality improvement program, and last year, Baptist Hospital in Pensacola, FL, became only the second health care organization to reach the level of site visit — a significant accomplishment. **(For a profile of Baptist Hospital, see cover story.)**

Congress established the Gathersburg, MD-based Baldrige program in 1987 to raise awareness about the importance of quality and performance excellence. Many say the Baldrige criteria represent the most far-reaching quality improvement program now available. As many as three awards may be given each year in several categories — manufacturing, service, small business, education, and health care. But awards are not based on specific products or services. "There can be three awards given in each category, but we have never had a full complement in any of the categories," explains **Jan Kosco**, Baldrige public affairs specialist. She reports that in 1999, nine health care organizations applied for the award; last year, that number was eight. "We have been receiving numerous applicants in health care, but at this point, none of them have reached the final stage."

According to Kosco, it is not unusual for a relatively new category such as education or health care, both of which were added in 1999, not to receive an award. For example, she notes there was no award given in the service category until 1990, several years after it was added.

Applicants receive anywhere from 300 to 1,000 hours of review conducted by an independent board of examiners, and at the site visit stage, and go through as many as six rounds of reviews. "It is a very tough process," says Kosco. "When you apply for the award, you have to provide great detail showing improvement in all seven areas."

Baldrige assesses hospitals and schools in the same light as for-profit companies. "They all have to go through the same application process and show achievement in seven areas that range from leadership to process management," she explains. However, the criteria are tailored somewhat for each specific environment. The seven categories that make up the award criteria are:

1. Leadership. Examines how senior executives guide the organization and how the organization addresses its responsibilities to the public and practices good citizenship.

2. Strategic planning. Assesses how the organization sets strategic directions and how it determines key action plans.

3. Customer and market focus. Examines how the organization determines requirements and expectations of customers and markets.

4. Information and analysis. Assesses the management, effective use, and analysis of data and information to support key organization processes and the organization's performance management system.

5. Human resource focus. Examines how the organization enables its work force to develop its full potential and how the work force is aligned with the organization's objectives.

6. Process management. Assesses aspects of how key production/delivery and support processes are designed, managed, and improved.

7. Business results. Examines the organization's performance and improvement in its key business areas: customer satisfaction, financial and marketplace performance, human resources, supplier and partner performance, and operational performance. The category also examines how the organization performs relative to competitors.

While the basic purpose of Baldrige is similar to Japan's Deming award, there are also important differences. According to Kosco, Baldrige focuses more on results and service, relies upon the involvement of many different professional and trade groups, provides special credits for innovative approaches to quality, includes a strong customer and human resource focus, and stresses the importance of sharing information.

The purpose, content, and focus of Baldrige also differ markedly from ISO 9000, a series of five international standards published in 1987 by the International Organization for Standardization (ISO) in Geneva. While health care organizations can use the ISO standards to help determine what is needed to maintain an efficient quality conformance system, those standards do not look at the entire organization in nearly the same fashion that Baldrige does. In fact, ISO 9000 registration covers less than 10% of the Baldrige Award criteria.

"What we are looking for is outstanding improvement and achievement across the board," Kosco asserts. "When you submit an application for a Baldrige Award, you have looked at every nook and cranny of your organization." In addition, organizations that submit an application receive very detailed feedback that cites areas where improvement is possible. In fact, it is precisely that feedback that organizations are seeking when they apply, she says.

[For more information on the Baldrige National Quality Award, contact:

Baldrige National Quality Program, Gathersburg, MD. Telephone: (301) 975-2036. Web site: www.quality.nist.gov.] ■

policy of no secrets. "We literally have a 'no secrets' culture," Crouch explains. That means employees have access to the financial information given to the board of directors, and compensation issues are discussed openly.

Another key to facilitating change is a policy of no excuses. "We realized that once you can explain a less-than-optimal result, you quit looking for a solution," Crouch asserts. For example, Baptist had a 30% turnover rate in nursing, which is 5% above the average in the Florida panhandle, 10% above the Florida average, and 15% above the national average. But the hospital attributed that mainly to its location in a military town and the highly qualified but transient spouses it often hires.

Once the new policy was implemented, that explanation was no longer accepted. Instead, Baptist reviewed its selection process, instituted peer interviewing, and improved orientation and training. "We also worked feverishly on employee satisfaction," Crouch says. The new processes paid dividends. Baptist's turnover rate last year was 16% — 1% above the national average but 9% below the panhandle average and 4% below the Florida average. "The military base has not closed, and we still hire military spouses," she adds.

According to Crouch, another key ingredient to improving the hospital's culture was the implementation of performance standards developed by a team of frontline staff known as the Standards Team. Its job was to identify "expected behaviors" for all hospital employees. The categories for those standards are attitude, appearance, communication, call lights, commitment to co-workers, customer waiting, elevator etiquette, privacy, safety awareness, and sense of ownership.

For each of those categories, there are very specific behaviors. "Most of the performance standards are very straightforward but also very specific," says Crouch. For example, no call light is allowed to ring more than five times. Likewise, if a visitor approaches a staff member requesting directions, that staff member physically walks that person to the appropriate destination.

As the standards were implemented, every employee was required to read them and sign a commitment to abide by them. The standards also were built into the employee screening process. "We actually have had some people decide not to apply after reading them," notes Crouch. "But that is good, because if they can not make that commitment, they are not going to be successful here."

In order to maintain the standards as an active component of the hospital's daily life, Baptist celebrates a different standard each month using games, prizes, and activities. "Every month, we are thinking about one of our standards and how and why we live it," says Crouch.

In addition, employee evaluations now include how well they are complying with the standards. "Employees are not only evaluated on how they performed their job in terms of skill but also how compliant they are with the standards," she says.

To further reinforce the new performance standards, Baptist also implemented a process of reward and recognition. "Most people want to be successful, and they want to do a good job," says Crouch. But rewards and recognition are often overlooked in health care, she adds.

Champions and Legends

In order to break that trend, anytime an employee demonstrates performance above and beyond a certain standard, he or she becomes eligible for a Wow Award from any employee in the hospital. For example, one Spanish-speaking secretary received the award for assisting a Spanish-speaking patient in both his cognitive therapy as well as his personal care needs.

Once five Wow Awards are accumulated, employees receive a $15 gift certificate. In addition, when employees go well beyond the standards, they are designated as Champions and their stories are presented at a monthly meeting of department leaders where they receive a plaque. Their pictures also are placed in a designated area at the hospital.

Each year, several Champions are designated as Legends. Those employees are picked up by a limousine and taken to the hospital board retreat where they have dinner with the board of directors and their stories are repeated.

In addition to the performance standards, Baptist also implemented a range of quality improvement initiatives such as a program to reduce hospital-acquired pressure ulcers, Crouch says. Nursing units that achieve zero in a month receive a banner and a pizza party. A similar program is the hospital's medication error reduction program. Nursing units that have the highest return rate of discontinued medicated to the pharmacy receive a banner each month.

According to Crouch, the key to implementing these measures is consistency. "It can't be a 'flavor of the month,'" she asserts. "It was helpful to focus on five key areas because that makes the process very simple but also very specific."

Baptist also placed a new premium on leadership development — another area that Crouch says is often overlooked in health care. "If we are going to be the hospital that patients select, we have to be the hospital that employees select."

To bring that about, the Baptist leadership developed its own homegrown leadership development program, called Baptist University. The program offers established and elective courses that include quarterly sessions attended by all hospital leaders and built around the five key pillars. The hospital is now developing several other delivery modules, including computer-based and lecture-based training as well.

The program initially was established through a survey that asked each leader to identify the three individuals he or she considered to be the most highly qualified to help engender the new culture that was being sought. From there, a steering committee selected a final team.

To help keep leaders focused, every leader has a 90-day action plan. That plan includes a specific goal related to each of the five key pillars along with specific action steps for achieving that goal. At the end of 90 days, leaders report their results.

"The specific goal under each pillar may not change every 90 days, but what does change is the action plan," says Crouch. For example, the goal under service may be to reach the top 1% of patient satisfaction, but the means to achieve that goal may vary.

Teamwork is also essential, according to Crouch. "You can accomplish a lot more as a team than you can as an individual," she says. To improve its level of teamwork, Baptist established a multitude of teams under each of its five key pillars. For example, under the service pillar, the hospital has eight patient satisfaction teams. Under the quality pillar are a number of teams, such as Target Zero Team for hospital-acquired pressure ulcers, Medication Event Team, and Restraint/Seclusion Team.

To spur innovation, Baptist implemented its "Bright Idea" program, which requires every employee to submit at least one idea for improvement each year. "People doing the work know the best way to accomplish that work as well as the most cost-effective method," says Crouch.

The year the Bright Idea program was implemented, more than $1 million in savings were realized, along with many program improvements. "It is amazing what employees will come up with if you give them the opportunity," says Crouch.

Measurement is also critical, according to Crouch. Under each of the five key pillars, the hospital has established criteria. For example, the primary measure under service is patient satisfaction. Under people, employee satisfaction and turnover rates are gauged. Under quality, hospital-acquired pressure ulcers and use of restraint and seclusion are measured along with other indices. Under cost, operating expense is assessed along with net revenue. Under growth, admission rates are reviewed along with the development of new services.

Positive results from the initiatives continue to pour in. Baptist not only reached the 99th percentile in patient satisfaction, it has sustained that level. In addition, employee morale improved 30% over 18 months, an increase so dramatic that the firm performing the survey initially thought it was the result of a data sampling error. Eighteen months later, the same firm reported the highest level of morale among any of its clients, including its nonhealth care clients.

Finally, as patient satisfaction soared and employee turnover declined, Baptist's market share showed steady improvement at the expense of its competitors. At that point, the hospital's leaders seized on criteria provided by the Malcolm Baldrige National Quality Program in Gaithersburg, MD, to realize even further improvements. **(See related story, p. 63.)**

"This assessment was a very worthwhile process because it helped us identify our strengths as well as areas for continued improvement," says Crouch. "It is always about getting to the next level." The improvements recognized by the hospital were further validated last year when it became only the second hospital in the country to receive a site visit by the Malcolm Baldrige program. ■

JCAHO proposes staffing effectiveness standards

JCAHO: 'Shortage of qualified personnel'

The Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations has proposed a set of new standards aimed at assessing staffing effectiveness, which the Joint Commission defines as "the number, competency, and skill mix of staff respecting the provision of

(Continued on page 67)

Sensitivity of Screening Indicators Compared with 'Currently Collecting Data'

	Proposed Staffing-Related Screening Indicator Human Resources (HR) or Clinical/Service (C/S)	Expert Panel's Perception of Whether the Screening Indicator is Sensitive to Staffing	Organizations on the Expert Panel Who Are Currently Collecting this Screening Indicator Data
1	Overtime (HR)	77.0%	90.4%
2	Family Complaints (C/S)	75.3%	92/1%
3	Patient Complaints (C/S)	70.3%	96.0%
4	Staff Vacancy Rate (HR)	74.0%	91.1%
5	Staff Satisfaction (HR)	81.0%	79.2%
6	Patient Falls (C/S)	72.3%	87.1%
7	Adverse Drug Event (C/S)	68.3%	92.1%
8	Staff Turnover Rate (HR)	69.7%	90.0%
9	Understaffing as compared to organization's staffing plan (HR)	84.1%	73.3%
10	Nursing care hours per patient day (HR)	76.5%	77.2%
11	Staff injuries on the job (HR)	61.0%	92.0%
12	Injuries to Patients (C/S)	60.0%	87.0%
13	Skin Breakdown (C/S)	76.3%	61.0%
14	On-call or per diem use (HR)	60.6%	69.3%
15	Sick Time (HR	48.4%	81.2%
16	Pneumonia after major surgery (C/S)	69.0%	52.0%
17	Use of floating staff (any discipline) (HR)	59.6%	57.4%
18	IV Related Infections (C/S)	50.5%	61.4%
19	Wound infection after major surgery (C/S)	42.4%	65.0%
20	Closed Beds (HR)	51.5%	47.5%

Source: Staffing Effectiveness Expert Panel Survey Results, August 2000

Source: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

needed services." In a March 14 letter, **Dennis O'Leary**, MD, president of the Joint Commission, solicited feedback from providers on the proposed standards, noting that "the increasingly apparent national shortage of qualified professional personnel, coupled with the growing number of identified linkages between staffing effectiveness and patient safety, have created flashpoints of both concern and controversy in the health care field." O'Leary also criticized proposed legislation in some states that would mandate specific staff-to-patient ratios.

O'Leary acknowledged the difficulty of establishing measures of staffing effectiveness and said,"the screening measures that have been identified as part of this project can only be said to have a known potential association with staffing effectiveness." A panel of more than 100 performance measurement experts helped identify the screening indicators. **(See chart, p. 66.)** The indicators used by any given organization "would be selected in part from evidence-based measures identified by the Joint Commission, and in part by the organization itself to assure sensitivity of the screening indicators to its unique nature," he wrote.

O'Leary added that during on-site surveys, Joint Commission surveyors "would review the health care organization's staffing plan, the organization's actual staffing vs. the plan, the organization's rational for screening indicator selection, the data collected for the chosen indicators, and the organization's response to its analysis of the data." ■

URAC progressing with web site accreditation

Program to pacify skittish health care consumers

Polls suggest consumers continue to swarm the Internet in search of health care information, but the same surveys also show that people remain dubious about the information they receive. Worse yet, no health care accreditation standard currently exists to help boost consumer confidence.

URAC — the American Accreditation HealthCare Commission in Washington, DC — is seeking to change that. In fact, URAC's accreditation standards for health web sites now are in the final phases of development. A set of draft standards for its Health Web Site Accreditation program were released for public comment Feb. 26, 2001, and in March the association started accepting pre-applications. The projected launch date is Aug. 1, 2001.

According to a Harris-Interactive survey conducted in January 2001, 77% of those surveyed indicated that an accreditation "seal of approval" would increase their trust in a hospital web site. But industry experts complain that no mechanism currently exists for hospitals and other health care providers to accredit their web sites.

"Certain organizations have developed standards with regard to privacy and other issues, but as far as we know there is no organization performing the accreditation function," reports **Don Nielsen**, MD, senior vice president of quality leadership with the Chicago-based American Hospital Association (AHA).

According to Nielsen, nearly every hospital now has a web site that includes qualitative and clinical information. But he says the overwhelming number of health care web sites and the disparity in the quality of that information have led the general public to question the reliability of that information.

"The first question on their minds is the quality of that information and how to know whether it is reliable," asserts Nielsen, who plays an advisory role in URAC's effort. "Hospitals and others constructing web sites must ensure that the information they are providing is up-to-date and current."

There is currently a gulf between the rhetoric and what is actually happening with web-enabled technology, agrees **Gary Carneal**, JD, MA, president of URAC. He points out that URAC's core affiliation is preferred provider organizations, HMOs, and other managed care entities, and says the association has no current plans to enter the hospital accreditation market in general. Rather, Carneal says, the association is seeking to fill what it sees as a vacuum to give consumers confidence that a basic quality infrastructure underlies health care web sites.

To make that effort as broad-based as possible, URAC has assembled an advisory committee that includes representatives from the AHA, the American Medical Association (AMA), and numerous other health care organizations. Its effort to draft standards also enjoys the support of High Ethics, a coalition of organizations that has been active in developing a code of ethics for consumer web sites.

"One of the exciting things that we have been able to do is bring together all of the actual stakeholders that were developing ethics standards such as High Ethics, the Internet HealthCare Coalition, the AMA, Health on the Net, and others," explains Carneal. He says URAC is attempting to aggregate the efforts of all of these groups and generate a verifiable set of standards through a single accreditation program.

Carneal points out that URAC is the first nationally recognized health care organization to release a set of standards for public comment. Moreover, it is the only accreditation program under development that represents a third-party audit function with an on-site component in this area.

He says URAC's underlying aim is to provide expertise in how to launch an accreditation program in a cost-effective manner with reliable points of measurement in the auditing functions and ensure there is integrity in how reviews are performed. "We are trying to apply the best practices of the accreditation to the on-line web site community," he explains.

"It is too early to predict what will happen one way or the other," adds Carneal. "We hope we can offer consumers and other businesses a method to assess the practices that support health care web sites."

URAC currently is developing the accreditation process it will use to verify compliance with these standards by health web sites. However, it has tentatively made the following determinations:

❒ Health Web Site Accreditation will last for one year. (This is shorter than URAC's usual accreditation period of two years. The rapidity with which web sites change is the reason for the shorter period.)

❒ Accreditation reviews will consist of analysis of the web site and related documentation and a visit by a reviewer to the primary physical site of web site operations. (It is undecided whether the site visit will occur every accreditation cycle or every other accreditation cycle.)

❒ The accreditation process will also include review of the web site by consumers.

❒ URAC will conduct random checks of accredited web sites during the accreditation period.

❒ URAC will administer a mechanism for consumers to register concerns or complaints about accredited web sites. Depending on their severity or frequency, complaints may trigger additional review of the web site, followed by appropriate corrective action.

To achieve URAC accreditation, parent organizations and web sites must comply with established standards in the following areas:

I. Policies and Procedures
II. Quality Oversight Committee
III. Disclosure
IV. Health Content
V. Linking
VI. Privacy
VII. Security
VIII. Accountability

[Additional details regarding the web site accreditation process will be available as the program approaches implementation. Check URAC's web site at www.urac.org for updates. For more information about the pre-application process, e-mail businessdevelopment@urac.org, or call URAC at (202) 216-9010.] ■

THE QUALITY - CO$T CONNECTION

Improve performance in trauma care

By **Patrice Spath**, RHIT
Brown-Spath Associates
Forest Grove, OR

Many states have adopted trauma program legislation that includes a statewide trauma registry and performance evaluation activities. Hospitals participating in the trauma network are required to support the statewide activities through submission of data about the trauma patients they treat. In response to state statutes, designated trauma centers have established an internal trauma registry to collect information about trauma care experiences. The registries document, at a minimum, the severity of a patient's injury upon arrival and the outcome of care (survival, length of intensive care unit stay, and hospital stay).

The data are used to evaluate the hospital's trauma care experience. Regular multidisciplinary trauma conferences that include all members of the trauma team are held. By analyzing the quality of care provided to trauma patients, the trauma team members work to improve their

services. Overseeing many trauma programs is a medical staff trauma committee that includes physicians and administrative and staff representatives from each of the trauma care disciplines.

The first step toward identifying performance measures for the hospital trauma program is to describe the scope of care and services. Because quality of care is strongly influenced by many disciplines, it is best to take a "key functions" approach when identifying performance measures. What are the key functions of trauma patient care that have the greatest impact on the quality of care the trauma patient ultimately receives?

These key functions may include: medication use, blood use, infection control, diagnostics, clinical decision making, nursing care, use of surgical and other invasive procedures, and nutritional support.

Select measures

Using the key functions as the foundation, the trauma program leaders then select those important aspects of care that should be monitored regularly. Input in the measurement selection process should be obtained from each group of professional disciplines that provide care for trauma patients. Obtaining multidisciplinary input in this process ensures that the entire continuum of trauma patient management is covered.

Although many important aspects of trauma care can be identified, the resources of the organization may prohibit evaluating each aspect all the time. Therefore, the trauma committee should consider prioritizing the review activities. Some critical elements of trauma care may be routinely evaluated while other aspects may need only periodic evaluation.

Examples of important aspects of trauma care as they relate to the key functions include:

Diagnostics

- Timeliness of test completion
- Appropriateness of diagnostics chosen to evaluate patients' presenting symptoms
- Trauma patient, comatose upon hospital arrival, receiving CT scan > 1 hour after arrival

Clinical decision making

- Physician management of the comatose trauma patient
- Physician management of the trauma patient with dyspnea
- Use of mast trousers in trauma care

Nutritional support

- Postoperative nutritional assessment / management of hospitalized trauma patients
- Use of preoperative nutritional supplements for the severely malnourished patient

Medication use

- Availability of necessary drugs in the emergency department
- Management of patients requiring chemical paralysis
- Appropriateness of drug use during cardiopulmonary resuscitation

A number of performance measures can be used to monitor the quality of trauma care. These indicators are cross-departmental because of the multispecialty aspects of trauma patient management. **Shown in the box on p. 70** are examples of measures that might be useful to the trauma program's assessment process.

Some of these measures are occurrence screens that can be used to identify important single events needing more in-depth review by the trauma committee. Other measures provide rate-based information useful for ongoing monitoring activities.

A more extensive analysis is done only when the measurement result triggers a pre-determined threshold or when the aspect of care is selected for improvement activities.

Focused studies

In addition to ongoing performance evaluations, the trauma committee may periodically conduct focused studies of particular topics of interest. Listed below are two examples of trauma care study topics and evaluation criteria that may be used to assess the adequacy of nursing care for trauma patients:

Study topic: Nursing management of the comatose trauma patient

Study criteria:

- Cases with complete set of vital signs, repeat as needed
- Cases in which admission evaluation of patient's airway is documented
- Treatment delays attributed to unavailability of suction equipment
- Cases in which initial nursing assessment includes patient history obtained from family / emergency medical technicians (previous history, precipitating illness or fever, chronic illnesses)
- Patients with peripheral IV line within "X" minutes of emergency department arrival

(Continued on page 71)

Occurrence Screens and Performance Measures for Trauma Services

- ✔ Trauma patient transferred to another hospital > 6 hours after emergency department arrival
- ✔ Emergency department time > 2 hours (admission to disposition, including radiology) with admission supine blood pressure < 90 mm Hg
- ✔ Trauma surgeon not present in emergency department upon patient arrival when patient meets trauma service criteria
- ✔ Neurosurgeon not present in emergency department within 30 minutes from time called, when Glascow Coma Scale is < 14
- ✔ Lack of hourly emergency department nursing documentation from patient arrival to transfer or death that records physiologic parameters for trauma patients with revised trauma score (RTS) of 10 or less
- ✔ Lack of hourly emergency department nursing documentation in record of neurological status evaluations for trauma patients with diagnoses of skull fracture, intracranial injury and/or spinal cord injury
- ✔ Trauma patient admitted to nonsurgical service
- ✔ Abdominal, thoracic, vascular, cranial procedure performed greater than 24 hours after admission
- ✔ Epidural/subdural hematoma not operated on
- ✔ Epidural/subdural hematoma receiving craniotomy > 2 hours after completion of CT scan
- ✔ Unscheduled return to surgery within 48 hours
- ✔ Interval of > 6 hours between emergency department arrival and initial surgery for open join injuries or blunt compound tibial fracture
- ✔ Trauma patient not receiving laparotomy for hemoperitoneum within 1 hour of emergency department arrival
- ✔ Trauma patient with low Glascow Coma Score or stab wound to the abdomen that did not receive laparotomy
- ✔ Blood transfusions > 2 units without surgery
- ✔ Blood transfusions in emergency department or operating room of > 4 units
- ✔ Emergency department time > 8 hours
- ✔ Discharge diagnosis of cervical spine injury not indicated in admission notes
- ✔ Patients with Glascow Coma Score of < 9 who do not have a mechanical airway placed prior to disposition from the emergency department
- ✔ Patient develops complication following treatment in the emergency department, i.e.:
  - deep-vein thrombosis
  - pulmonary embolus
  - iatrogenic pneumothorax
  - reintubation within 48 hours of extubation
  - tension pneumothorax discovered by X-ray
  - recurrent pneumothorax requiring chest tube after chest tube removal
  - wound dehiscence
- ✔ Failed intubation
- ✔ Nasotracheal tube in > 7 days
- ✔ Patient not intubated who is unable to follow commands
- ✔ Intubated patient transported without oximetry
- ✔ CT scan of head > 2 hours after admission in patient unable to follow commands and not operated on
- ✔ Intracranial pressure > 20 mm Hg sustained for > 20 minutes without therapeutic intervention or physician notification
- ✔ Chemical paralysis without kinetic bed therapy in intensive care unit
- ✔ Misplaced thoracic catheters or tubes (chest tube, venous catheters, nasogastric tubes, feeding tubes, etc.)
- ✔ PaO_2 < 60 torr or arterial O_2 SAT less than 90% for greater than 10 minutes without attempted therapy
- ✔ Patient returned from operating room with PaO_2 > 50 torr
- ✔ Patient returned from operating room with hemoglobin < 8 g %
- ✔ Cardiopulmonary arrest in intensive care unit or ward
- ✔ Immobilized patient without compression boots within first 3 weeks of case
- ✔ Inappropriate antibiotic given > 12 hours after organism susceptibility available
- ✔ Aminoglycoside serum level 3 units > accepted peak, and 1 unit > accepted trough on more than one occasion during a treatment course
- ✔ Albumin level l < 2 g %
- ✔ Diarrhea (> 4 loose stools) > 24 hours
- ✔ Patient nutrition < 15 cal/kg or > 40 cal/kg for > 24 hours
- ✔ Missed fractures (diagnosed > 24 hours after admission)
- ✔ Inadvertent drain removal
- ✔ Unplanned hospital readmission within 2 months of discharge
- ✔ Ambulance scene time > 20 minutes excluding entrapped patients and multiple victim rescue
- ✔ Emergency department time > 2 hours from admission to disposition (including radiology time) with an emergency department admission systolic blood pressure less than 90 mm Hg if age > 8 years and patient subsequently required major surgery or died
- ✔ Patient admitted under care of attending physician who is not a surgeon and injury severity score (ISS) > 10
- ✔ Unplanned return to operating room within 48 hours of initial procedure
- ✔ ISS missing unless patient DOA without autopsy report
- ✔ RTS missing unless patient intubated
- ✔ Epidural hematoma or subdural hematoma, which is not operated on with midline shift of > 2 mm on CT scan or identified on autopsy
- ✔ Patient transferred to another facility without written consent of patient or family
- ✔ Patient transferred to another facility prior to being stabilized in the emergency department

Source: Patrice Spath, RHIT, Brown-Spath Associates, Forest Grove, OR.

Study topic: Nursing management of the trauma patient with dyspnea

Study criteria:

- Cases with inadequate nursing documentation of patient's current symptoms and history of respiratory status
- Cases lacking documentation of patient's home oxygen use (present or absent)
- Cases lacking oximetry testing within "X" minutes of patient's distress
- Cases with in adequate documentation of vital signs every hour or more often, as patient condition requires
- Patients not placed on cardiac monitor
- Cases lacking documentation of patient's skin temperature, color, and consistency

Whether your facility is designated as a Level I, II, or III trauma center or has no trauma designation, evaluating and improving the quality of care for accident victims is an important interdisciplinary activity. Designated trauma centers usually are required by state regulations to track injuries and treatment of patients in the hospital. However, there are many hospitals in large urban population areas as well as rural sites that provide care for trauma victims but have no trauma center designation. Even if your organization is not officially recognized as a trauma center, evaluating the quality of care provided to accident victims is an essential performance improvement activity. Anecdotal information about undesirable events or occurrence screening of cases does not provide sufficient information to ensure that trauma care is adequately being evaluated and improvement opportunities identified. That's

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Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

why routine monitors of important aspects of trauma care and periodic focused studies should be conducted.

[A suggested resource, Trauma Performance Improvement: A How-To Handbook *(2000) by the Committee on Trauma of the American College of Surgeons is available free on-line at: http://www.facs.org/dept/trauma/handbook.html.]* ■

NEWS BRIEF

Drug dissolves clots in catheters, study shows

Surgery remains one of the few options for restoring blood flow to a long-term, indwelling catheter blocked by blood clots. Now, a University of Nebraska (Omaha) Medical Center researcher reports that recombinant tissue plasminogen activator (t-PA) effectively dissolves blood clots and restores function without surgery.

William Haire, MD, presented results of the six-month, randomized, double-blind study of 150 patients with blocked catheters at the recent International Symposium on Endovascular Therapy in Miami. Patients in the study were randomized into two groups. In one group, patients were first given a dose of placebo in their catheter. If catheter function was not restored, patients received one 2 mg dose of t-PA. In this group, researchers found that 17.1% of patients had full function of their catheter after receiving placebo. In patients who received the placebo followed by t-PA, 90% regained full function of their catheter.

In the second group, each patient first received a 2 mg dose of t-PA followed by another dose if the catheter remained blocked. Researchers found that 73.9% of patients had full function of their catheters after one dose of t-PA. Of patients whose catheters remained clogged, 90% regained full function after a second dose of t-PA.

No serious drug-related adverse effects were experienced by either group as a result of treatment, and there were no cases of intracranial hemorrhage or embolism. ■

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