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NPSG compliance problems hospitals face now; where do you stack up?

Hospitals struggling with all NPSGs

The Joint Commission has put a one-year moratorium on its National Patient Safety Goals (NPSGs), as it reviews current goals with input from the field. One goal in particular, Goal 8 regarding medication reconciliation, will no longer be scored as part of the accreditation decision until a more refined goal is set forth in 2010.

So in what areas do the experts *Hospital Peer Review* spoke with still see hospitals struggling to comply? "I think they're struggling with many of the National Patient Safety Goals, but medication reconciliation was a particular hardship," says **Grena Porto**, RN, ARM, CPHRM, principal of QRS Healthcare Consulting Inc. in Hockessin, DE, who has worked with The Joint Commission's patient safety advisory group. "The universal protocol also continues to pose challenges for hospitals."

In 2003, when the NPSGs first were rolled out, they were pretty straightforward, she says. As they have progressed, though, they've "become more complicated, because all the 'low-hanging fruit' is gone. What is left is the hard stuff, like medication reconciliation," she says.

It is becoming more and more difficult to create a "one-size-fits-all goal," Porto says. For example, initially only KCI was cited as a concentrated electrolyte that had to be removed from patient care units. Later, all concentrated electrolytes were included in this. Then it was found that some units actually needed exceptions to this rule. Even the requirement for surgical-site marking — an apparent "no brainer" — presents a number of challenges to compliance and exceptions to the rule, Porto says. So, as the NPSGs have grown and the years have passed, she says, the NPSGs themselves are more complicated, and hospitals are struggling more and more.

The following are only some of the areas experts see hospitals struggling to comply:

- **Medication reconciliation.**

The No. 1 NPSG the experts cited as troublesome for hospitals was Goal 8 (accurately and completely reconcile medications across the continuum of care), and in a nod to this, The Joint Commission itself has taken this goal out of play in the accreditation decision and in generating any requirements for improvement. In compliance data posted on The Joint

Commission's web site, compliance with the medication reconciliation goal has gone from 100% in 2005 to 81% in 2007 and 78% so far in compiled survey data from 2008.

"Hallelujah!" says Porto, of The Joint Commission's decision on the med reconciliation goal. It has been awhile in coming, she adds.

"[E]verywhere I go, they're struggling with it," and from her perspective, the compliance issue gets to the very core of the health care industry as it is now: fragmented. "It's because we don't have a real health system. Instead, we have a patchwork of providers, and none of the components speak to one another or even use the same language."

This, she says, is compounded, or perhaps caused, by two things: the fact there is no universal health record and the way the health care culture has cast the patient, in a very passive, nonproactive role. She thinks patients must be much more active in their own health care. "Even then it's a stretch," she says, "because the system is so fragmented.

"For medication reconciliation to work, the patient has to own the list. Because they're the only common denominator between all the health care settings and providers that the patient travels through," Porto says. "I think that's an example of a goal that people are really struggling with and that has failed as a goal just because there is not an infrastructure for it."

Unfortunately, neither patients nor health care in general are yet set up to see the patient as the active participant, Porto says. "When you look at what percentage of patients have all of their updated information, even ask for it or care about it or display any interest in it, it's a real minority."

Does she carry a list of medications for herself? No, she says, laughing. She compares this to the push for advance directives. Health care has been pushing people for 20 years to have advance directives in order, but still only a small minority of patients have them, she says.

Following a theoretical patient through the hospital, she says, the first problem with med reconciliation occurs upon admission when the patient is asked what medications he or she is on. Often, they might not know the name or dose of the drug. For instance, Porto says, they might just say, "I take a heart pill."

So, she says, you start off with an incomplete list. Often, it's the emergency department that bears the brunt of this. A patient comes in, doesn't know his or her medications, but the ED is required to treat the patient upon presentation.

Then the ED patient is admitted to a floor, and the admitting nurse, an already overburdened employee, Porto says, must get the patient's medications from a primary care physician. Then the physician has to deal with HIPAA issues and not

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being able to give the medications over the phone. Also, the patient could be seeing other providers in addition to his or her PCP, so even the PCP might not have a complete list of the patient's medications.

"The system of multiple, unaffiliated providers who don't communicate means that there's really no way for anyone other than the patient to know what a patient is taking. And then there's the whole issue of patients not being complete or truthful — either intentionally or unintentionally they leave stuff out. Now you're relying on the memory of the patient, and that's not always so good. It's kind of a huge big mess no matter how you slice it," Porto says.

There's a lot of work involved with med reconciliation, and it's a cumbersome process, says **Kathleen Catalano**, RN, JD, director of healthcare transformation support for Perot Systems Corp. in Plano, TX. She suggests hospitals "literally need to walk through the whole process and look at the handoffs, just like we do with everything to see where the problems are."

Getting all the information together is a tough job, she says, and who's responsible for keeping the medication sheet up to date: the nurse, the pharmacist?

• **Handoff communication.**

Inherent in the medication reconciliation problem is the problem of active handoff communication.

"The big struggle" with medication reconciliation "is really the transfer between the units and then if [the patient is transferred out] to another level of care and then transferred back in," says **Darla Farrell**, RN, BS, FACHE, CPHQ, who consults with hospitals on Joint Commission-related compliance and mock surveys and works in the compliance department of Kindred Healthcare.

She says hospitals using electronic medical records are having an easier time with med reconciliation, adding, "I think it's the level of sophistication of the technology that the hospital has. Because I'm finding that hospitals that have a higher level of sophistication in their IT departments are finding it much easier to accomplish."

But Catalano says many hospitals are not making handoff communication documentation regarding the patient's care and medications part of the medical record. "It doesn't say it has to be documented. But I don't know how you prove you've done something if you don't have it documented," she says.

• **"Time-out" before surgery.**

"The whole pre-op time-out, surgical site marking... There is still pretty significant noncompliance with that," says Porto. And according to compliance data on The Joint Commission's web site, compliance was at 91% in 2003 and 78% in 2007.

The actual requirements are "eminently doable" and "pretty straightforward;" the challenge is simply a behavioral one, she says. One area she hears discussion about is cases of multiple procedures by multiple surgeons. For instance, if the patient is first going to be operated on by an orthopedist and then later a plastic surgeon, "how do you do the time out? You're supposed to have all of those people there at the same time, and that gets difficult from a logistics perspective."

• **Two patient identifiers.**

The problem with the goal on patient identifiers is not identifying the identifiers, but rather the fact that the identifiers are not checked every time. **Ode Keil**, MS, MBA, president of Ode Keil Consulting Group, which specializes in preparing organizations for Joint Commission accreditation, says when the bedside nurse visits Joe Smith to give him his medication, he or she often may not check the wristband or follow the mechanics of the NPSG.

"I think there's some reasonableness to the argument that the guy has been there for three days; he hasn't changed," Keil says. "But [the nurse] is supposed to check the medication administration record, the physician orders, to make sure it's the right med, the right dose, the right time, the right method of administration."

• **Hand hygiene.**

Another area in which Keil sees a lot of noncompliance is hand hygiene. "Hospitals are struggling to balance out the desire of infection control to put some sort of hand-cleaning compound every inch or two along the corridor walls according to fire safety code in terms of the amount you can put in a given area. I hear that a lot in terms of compliance," he says.

The real struggle is not logistics, but behavior. "It doesn't matter how many cans or bottles of the hand sanitizer you put out; if people don't push the pump or squirt the little ball of foam into their hands, it isn't good for anything," he says.

• **Anticoagulation therapy.**

Farrell says she sees hospitals struggling with

anticoagulant therapy. Where exactly are they falling short? Education of the patient and family members and updating the plan of care as the patient's needs change, she says.

• **Reporting critical test results.**

Compliance numbers shared by The Joint Commission on this goal have slipped from 90% in 2005 to 64% in 2007. Farrell says the challenge for many facilities she sees is the identification of the critical test. Hospitals "have the values and they're reporting their time limits," she says, "but they have not identified the critical test." She says she has seen this in "at least 75% to 80%" of the policies she reviews.

The real deal? When it comes to NPSGs, Keil says, hospitals are having problems with all of them. ■

Study: Safety checklist reduces mortality

International study supports use of WHO guidelines

According to a recent study in the *New England Journal of Medicine*, "data suggest that at least half of all surgical complications are avoidable."[1] The article goes on to say that teamwork in surgeries has been shown to lead to improved outcomes.

In the international study, led by **Alex B. Haynes**, MD, MPH, researcher at Harvard School of Public Health and a surgeon at the Massachusetts General Hospital, a 19-item surgical safety checklist created from the World Health Organization's guidelines for surgical safety was used at eight hospitals in eight cities to access the effect on the rate of complications, including mortality, during hospitalization within 30 days post-procedure (non-cardiac surgery). **(To see checklist, visit www.safesurg.org.)**

Before introduction of the checklist, the rate of death was 1.5%; that rate declined to 0.8% with use of the checklist. Inpatient complications at baseline occurred in 11% of patients; after the checklist was introduced, that number fell to 7.0%. The study used six safety measures to indicate process adherence.

Does use of the checklist represent a simple fix to hospitals still struggling to comply with The Joint Commission time-out before surgery goal? The checklist "is very simple on a very superficial level," Haynes tells *Hospital Peer Review*. "What's underneath is a very complex change in the way care is organized in the operating room, in the way teams behave."

What's key about the checklist, he says, is that it's not just a piece of paper in a pile on some corner desk, "but rather that it's an active document that requires active participation and verbal participation from all team members."

Another challenge to implementing such a system, he says, is that OR personnel have myriad documentation tasks and "there is a misperception by many people that the checklist is simply a documentation tool, which is not at all the intent of it."

Many sites, which were encouraged to modify the checklist to their needs and population, didn't include check boxes at all. Often the exercise, he says, was done verbally. No sites kept the checklist as a tangible document; some kept compliance questionnaires in which they would mark whether the checklist was used.

Providers can "get lulled into complacency" with written documentation, Hayes says. "Evidence in aviation has shown the difference between a verbal checklist and a written checklist is about a tenfold improvement in intertrapping. Verbal performance, in order of magnitude, is more effective at catching errors than a written checklist," he says.

Each study site had a local co-investigator who was in an esteemed position at the hospital.

Because of their participation, Hayes says, they were able to convince administration of the importance of the study and the checklist.

Behavioral changes

Changes in processes related to the study included giving antibiotics in the OR rather than peri-operative suites and confirming patients in the OR by OR personnel. "A lot of the sites relied on a patient confirmation that took place in the pre-op holding room rather than in the operating room or by the team who was actually going to be caring for the patient in the operating room," Hayes says. "That just allows one more possibility for errors to occur."

Hayes does not recommend regulating use of checklists like this one. "The kind of behavior changes that are a part of it are not things you can impose upon people," he says. "You need to get people educated and to accept them on their own."

He points again to the aviation industry. "Even in the airlines, where checklists have been ubiquitous for decades, the FAA doesn't mandate these specific checklists or specific sets of steps for airlines — just simply that they use safety measures, that's the only mandate."

He suggests that facilities implementing this checklist approach not put "everything under the sun" in it. "We would suggest anyone who is modifying it do it in a thoughtful fashion... You can't solve every problem in health care by putting it on the checklist."

He suggests sites use it as part of a quality improvement endeavor they already track data on and to collect information early to identify where the checklist isn't being used.

"I think a key to making this work at an institution is to obtain buy in from both the top and the bottom. This really needs to be clinician-led. You need to have a champion in the OR," he says. Use it in one OR and test it again in that setting before rolling it out to others. And he suggests obtaining feedback from personnel using it and providing that feedback to physicians.

Reference

1. Haynes AB, Weiser TG, Berry WR, et al. "A surgical safety checklist to reduce morbidity and mortality in a global population" *NEJM* 2009 Jan 29;360(5):491-9. ■

ACCREDITATION
Field Report

Accountability, vigilance make this hospital grade A

'Everyone' involved in Joint Commission readiness

Preparation for Joint Commission surveys and measuring performance improvement at St. Vincent's HealthCare in Jacksonville, FL, involves all staff. And it seems to be a method that works. The hospital was just recognized for the fifth consecutive year as a Distinguished Hospital for Clinical Excellence by HealthGrades.

Survey preparation

As part of the "chapter champions" team at St. Vincent's, one person is assigned to be the lead of each chapter of The Joint Commission's accreditation manual. Under each team leader are team members with specific tasks. The team meets on a weekly or biweekly basis to study all the regulations and all the elements of performance to understand how to measure them, how to abstract the data, how to do audits, and then how to identify weaknesses and strengths from those audits.

A weekly memo goes to every nursing unit and all nursing personnel on Joint Commission readiness or whenever a change or a new policy is introduced. Staff are required to sign off as verification they have read and understood the memo.

Readiness at the hospital involves constant reinforcement and education, as well as having accountable leaders, says **Phil Perry**, MD, MBA, chief medical officer. "The team leader on the skin ulcer bundle can't visit 400 patients a day to see if they're being turned and if their bed surface is proper and that they're getting good nutrition. It doesn't work that way. Each caregiver has to be responsible for that," he says.

Data on standard measures such as falls, skin ulcers, and DVT prophylaxis are posted in nursing break rooms, in the hallways, and in doctors' lounges so that physicians, nurses, and patients can see how the hospital is measuring up. "It helps people understand what we're measuring and what their performance is. People are natu-

rally competitive. They don't come to work wanting to do something poorly, so when they know they are being compared to their peers, they tend to have a healthy competition," Perry says.

The survey

St. Vincent's was surveyed Nov. 15, and Perry says surveyors focused heavily on the National Patient Safety Goals. There also was a "big emphasis" on patient safety in terms of anesthesia, sedation, and the process of medication safety. "Medication management is a big deal; medication reconciliation is still a trouble spot for most hospitals because it's very difficult to do it completely and satisfy what The Joint Commission is requiring," Perry says.

The reconciliation process might look easy on paper, he says, but "it's very hard to do in the real world, particularly getting medication lists to the patient and to the patient's next provider after discharge." But, he says, St. Vincent's is doing "pretty well" on it, and having electronic medical records has helped that along. Getting a complete list at admission is difficult and an "imperfect science," but if you can capture a complete list in an electronic medical record, "you're much more likely to have that same proper list on discharge."

Perry says the 513-bed hospital did a good job on the life safety portion of the survey. "The key," he says, "is that you have to survey yourself ahead of time." If your hospital is new, you must identify deficiencies and start forming a plan to bring it up to speed, for instance with fire safety codes or if you're in a hurricane-risk area shutters on all of your windows.

"Making sure people are trained to do what they're doing is important, too," Perry says. "Showing that people have had adequate education and reeducation, reorientation, and updated credential files — those things were looked at in a lot of depth."

Overall, "we got a lot of positive feedback," Perry says. "One thing was the organization was well prepared and enthusiastic about getting the survey. We were ready to get surveyed." He says the med-surg unit had worked hard to prepare for the survey, and when the last morning of the survey came and the unit had not yet been visited, staff asked surveyors to visit the unit and volunteered to have a tracer. "That just shows you that people were ready and confident," he says.

His advice to QI directors: "I think that having a commitment from the leadership, both from the medical staff leadership and the nursing leadership, with the support of your operations (the COO and CEO)" is important. "The board of directors have to be committed to it as well. The board has to set the tone that it's an expectation — not a request, but an expectation, a requirement — that patients are treated as safely as possible. When that happens at the top, people are empowered at the bedside to find ways to make it happen."

Another important element to readiness is when you see a problem, to make a rapid cycle change and to educate staff on it, he says.

HA pressure ulcer rate = 1 per 1,000 patient days

One area the hospital received kudos from The Joint Commission on was its work on pressure ulcers. "I think they were very impressed, particularly the nurse surveyor because she spent the most time going over it, with the consistency on patient assessment, particularly with skin bundles," Perry says.

St. Vincent's, as part of Ascension Health, was selected in 2004 as an alpha site to work on decreasing hospital-acquired skin ulcers, a still-significant problem nationwide. In creating a bundle that worked for the hospital, "we identified things like bed surfaces and different types of sheet covers and different types of pads that can raise or lower skin ulcer rates." It was a detailed process, but in doing that they found that one type of bed pad, which was thought to be more economical, was actually leading to skin redness and irritation. "You really have to be vigilant about your data collection and analysis when your data have changed for better or worse," Perry says.

All patients, he says, should be viewed as at risk for pressure ulcers. For example, patients who have had prolonged neurosurgical procedures "can get skin breakdown from the pressure on the forehead or the pressure on the shoulders or knees. So you have to take extra precaution to make sure that sheets are gathered up, that you have padding at all the pressure points," he says. And to act when the patient is able to be lifted to allow for recirculation.

Accountability also has played a role in the hospital achieving its current rate of one case of hospital-acquired pressure ulcers per 1,000 patient days. For each NPSG, core measure, or other significant quality measure, St. Vincent's HealthCare appoints a nurse as a lead. He or she reports to the chief

nursing officer, Karen Darnell, RN, MBA, "who has a very active engagement in expectations of accountability," Perry says. The leaders meet on a regular basis to discuss successes and failures. "You want to celebrate your successes, but you want to examine your failures," he says.

The leaders make rounds, and when they identify a patient with a skin breakdown, they look to see what was done properly using the SKIN bundle:

- Was the bed **S**urface proper?
- Did we **K**eep the patient moving appropriately?
- Were there problems with **I**ncontinence?
- Is the patient getting proper **N**utrition?

Those leaders, in turn, provide feedback to the nurses caring for the patients on what was done well and what was not done that should have been done. "That feedback is very important," Perry says. "You want to add more positive feedback than negative or you discourage people from succeeding. But you've got to have ongoing analysis."

Door-to-balloon time decrease

Another area St. Vincent's has had success is in lowering door-to-balloon time. Perry says they first realized the time was too long so they gathered personnel, including ED physicians and nurses and cath lab cardiologists and nurses, together to examine each data element of the process and patient flow. By breaking down each step and recording the data, "we could identify which steps seemed to be the constraint in getting the patient into the cath lab and a balloon into the distressed artery in 90 minutes or less."

Looking at individual cases, the team started eliminating barriers. The team realized that if they added a stopwatch to the patient "with an expectation that we want you to the cath lab within 90 minutes, everyone could see the watch as a reminder that time is critical." By getting members on board collaborating and then educating staff on the findings, they started to see door-to-balloon time decrease, Perry says. Once they started seeing successes, they looked to see what made that case quicker. "Then you look at those same data elements and say we eliminated 10 minutes here, six minutes here, eight minutes there and ask what did we do different this time." Now their numbers are, on average, below nine minutes.

"We know that it can be done and it's possible. One of the things that was very helpful as positive reinforcement for the emergency room staff and physicians was to take still pictures of the fluoroscopy that's done during the procedure and show the before and after of the actual arteries.... That kind of positive reinforcement really gets people excited." ■

How MN's reporting laws have changed the state

Report shows safety higher priority across state

Five years after implementing the Adverse Health Care Events Law, which requires hospitals and ambulatory surgery centers to report on 28 quality measures, the Minnesota Department of Health published a retrospective report: "Adverse Health Care Events Reporting System: What have we learned?"

In its evaluation, the health department has found the law has changed the way safety is viewed at facilities across the state. According to the report, 72% of responding facilities say they feel that the reporting law has made Minnesota safer than it was in 2003, when the law was introduced.

Diane Rydrych, MA, assistant director of the division of health policy at the Minnesota Department of Health, says "the reasons we know we're safer are that our processes are more standardized, people are following them more closely, leadership is more involved than they were, we're talking about these issues much more than we have in the past, we're talking about things that go wrong or where things could potentially go wrong and making sure we're putting processes in place to prevent those things from happening. Just the awareness overall of risk and of the potential for risk is so much higher than in the past."

Adopting best practices

A central element of the health department's work, in conjunction with the Minnesota Hospital Association, is ensuring that hospitals are implementing and using best practices. Rydrych says the association has established four campaigns called "calls to action" related to the top four adverse events reported between 2003 and 2008: stage 3/4 pressure ulcers, foreign objects, wrong-site surgery, and unstageable pressure ulcers.

The hospital association has worked "with content experts to determine what the best practices should be for prevention of those events, and they've designed a whole campaign to get hospitals from around the state to sign on," and to get CEOs on board, Rydrych says. Each quarter, the association tracks what percentage of those best practices are used in each facility, which are provided with tools, training, and conference calls in which participants can discuss what they're doing. "They've just had great results," she says.

In the beginning, the average of best practices implementation at participating facilities was about 60%. For each campaign, that number has risen to 90%. "The percentage of best practices for each of those events has grown hugely from what it was before the campaign started," she says.

The next step, Rydrych says, is tracking the outcome measures related to the use of each best practice. "It's harder to get that connection," she admits, "but we're trying to work on that."

In the report, hospitals were asked about the implementation of best practices related to data sharing and transparency. Since adoption of the law, hospitals are reporting at least an 80% improvement on these best practices:

- sharing of adverse event data with the board;
- sharing of adverse event data with staff;
- sharing of adverse event data with other facilities;
- policy of disclosing adverse events to patients/families;
- leadership walk arounds;
- administration sets measurable patient safety goals;
- regular assessment of patient safety culture.

One message that came out of the report, Rydrych says, was that hospitals wanted more help on how to disclose adverse events to patients and their family members. The hospital association has put some guidelines together for facilities to use, and Rydrych says, "that's something we would like to provide more resources on going forward."

Leadership walk arounds are something "we've hoped would happen," and seem to be doing a good job in generating a strong culture of safety, Rydrych says. "If staff don't feel like these efforts aren't supported at the top of the organization, then they're just not going to stick. Solutions often come from frontline staff, but they need to know that they're supported. They need to know resources are going to be available to them."

Looking back now five years since the start of the reporting legislation, Rydrych says, "I do feel like we've started down the road in changing the culture here, although there's a long way to go. Health care is so complex and involves so many shifting groups of people, and there's hierarchies all over the place. But I do feel we're starting to make some real progress here." ■

Care Initiation Area yields dramatic results

In February 2008, 12% of the patients who presented to the emergency department at Gaston Memorial Hospital in Gastonia, NC, left without being treated. By the end of January 2009, that figure had dropped to 1.3%. In that same time period, hours on diversion dropped from 107 to zero, and the average turnaround time fell from 247 minutes to 184 minutes, even though even more patients were being seen (7,677 vs. 7,810). Press Ganey patient satisfaction scores for the ED's arrival section jumped from the 68th percentile to the 99th percentile.

How could such dramatic improvements be made in such a short time? The ED team credits the Kaizen (Japanese for "continuous improvement") methodology, pioneered by Toyota, for helping it identify inefficiencies, and the introduction of a new Care Initiation Area (CIA) and a physician in triage.

"We decided we needed a care initiation area because we were redesigning processes," explains **Kathleen Besson**, RN, BSN, MBA, NEA, BC, director of emergency services, who notes that the triage area had been identified as a bottleneck.

"In looking at ways to improve our processes, we wondered if there was an opportunity to use space not being utilized any more and turn it into the CIA," Besson says. "We used simulation software we had here in the building to analyze arrival patterns, decide peak arrival times by the hour, and patient disposition, so we could estimate how many patient spaces we needed in the CIA so patients could come right there instead of the waiting room." The creation of the CIA, including equipment, cost about $800, she says.

The new process works like this:

- The patient presents, and triage and registration are completed at the "reception podium" of the ED.

• The patient goes to the 16-chair ambulatory CIA, which is in an open area in the middle of the ED. There also are four EMS care initiation bays.

• In the CIA, the patient is seen by a nurse and a physician, diagnostic testing is completed, pain is treated, and the patient is monitored.

• If the patient is not sent home from the CIA, he or she proceeds to a room in the ED.

• Tests are returned.

• Intervention is ordered and delivered.

• Disposition proceeds.

• The patient is admitted, placed in a hallway bed, or sent home.

Sonya Carver, RN, the ED's clinical manager, says, "In Kaizen, you have your current state, and you have the future state you need to move to. You map out to the tiniest detail exactly what happens with the patient, even to the point of saying, 'The patient walks in the front door.'"

The reason for examining the processes in such detail "is that you can very easily see if there's something that is repetitive and ask yourself why you do that — very minute details you do not think about day by day," she says. ■

Kaizen methodology means rapid changes

While the Kaizen methodology, developed by Toyota, involves examining processes in minute detail, it ironically can lead to rapid improvement in ED processes, says **Sonya Carver**, RN, clinical manager/days for the ED at Gaston Memorial Hospital in Gastonia, NC.

"In one instance, we had a one-day meeting and then did that work product immediately," she says.

Kaizen already had been adopted by the facility to be used for process improvement when the ED set out to improve its triage process, Carver says. "We looked at what was wasteful in our triage design — for example, serial processes as opposed to parallel processes — and developed the methodology that triage is a process and not a place," she explains. With Kaizen methodology, the focus is on the customer, which in an ED can be the staff or the patient, "so, it can be used to improve staff work flow so you work smarter and not harder," she explains. "If you can do more with less, like walking fewer steps to a piece of equipment, you eliminate waste and improve quality."

Carver was trained in Kaizen by the hospital's organizational improvement department. **Kathleen Besson**, RN, BSN, MBA, NEA, BC, director of emergency services, says, "You learn how to lead a group through a Kaizen event and also how to complete documentation so you can come out and have data — before and after, what you have gained — and actually put a dollar or time- saving figure to it. It's a very data-driven, deliberative process, and every project goes through the same steps."

The facilitator has to make sure he or she has the right people on the team, then assess the process, establish goals, work through each step, and see what the best opportunities for improvement are, Besson says. "When you come out of the meetings, you implement the changes fairly quickly. It doesn't take months or meetings regurgitating the same things over and over," Besson says. "At most, it's a two-meeting process."

Jodie Cook, RN, ED clinical manager/nights/weekends, who took the lead in staff education, says, "We educated the staff through staff meetings and e-mails, and informed them of the process and what everyone's responsibilities would be. We had a book in the CIA [the Care Initiation Area, one of the Kaizen solutions] describing the new process, and a place in the unit where staff could put suggestions and comments." In addition, she says, the leadership team would meet and debrief after each Monday and Tuesday to see how things were going. "We talked with the charge nurses to see what worked and what didn't," she notes. ■

ED slashes average wait time by more than an hour

Team studies facilities, creates own model

No emergency department cuts its average door-to-doc time from 93 minutes to 20 minutes by accident. The success story at Memorial Hermann Memorial City Medical Center in Houston was the result of discovering a patient flow model at another facility that was superior to theirs, and then continuing to search out additional models to come up with their own system that best addressed their specific needs. The result was a model they call ExcelERate, which includes a more detailed nurse assessment up

front, parallel processes, and the carving out of an intake area within the ED.

"We reoriented our entire space, putting divider screens in four rooms to duplicate our capacity," explains **Michele Bell**, RN, MBA, chief nursing officer at Memorial Hermann. The department now has 10 intake and procedure rooms; five continuing care rooms with stretchers; four rooms with two recliners each, separated by curtains, with 13 spaces for continuing care and 13 acute care beds; and an overflow room that has 10 chairs.

The changeover began when **Jim Parisi,** RN, Memorial Hermann Healthcare System executive of emergency services, went to Phoenix to visit Banner Estralia Hospital at the invitation of its client, Cerner. Banner Estralia was using Cerner IT systems and had gone paperless. "We took a tour of the hospital that started in the ED — and we just stayed there," he recalls.

What impressed Parisi was that the busy ED (60,000-70,000 visits a year) "seemed so well organized and relatively quiet." He started asking lots of questions, and when he came home, he met with TeamHealth, which provides ED coverage for the system. "We agreed that while this would not do everything for us, their 'split-flow' process had the most chance of anything we had seen to help us," says Parisi.

Then, a team that included physicians, nurses, and representatives from the lab, radiology, and administration visited the Banner facility. "As an interdisciplinary team, they had to envision how this would work in our physical plant," says Parisi.

Children's hospitals toured

The research didn't end there, says Bell, who joined the team on the Phoenix trip. "We also saw several children's hospitals in Cleveland, because we will be putting in a children's ED in June, and then we kind of combined the best of all the models," she notes.

Because the staff already had had extensive experience with Six Sigma methodology, the conversion process also was facilitated by Black belts and Green belts, "so we knew we could show measurable improvement," says Bell.

That they have accomplished: Parisi says the left-without-treatment rate had been as high as 9%-10%, "and now it is way less than 2%." That improvement, adds Bell, also is reflected in the department's Press Ganey patient satisfaction scores. "We started in very low digits and now run anywhere from 80 to 95," she reports. ■

CNE *questions*

9. Which National Patient Safety Goal will The Joint Commission not consider in accreditation decisions in 2009?
A. Goal 1
B. Goal 5
C. Goal 8
D. Goal 10

10. The *New England Journal of Medicine* study led by **Alex B. Haynes**, MD, MPH, researcher at Harvard School of Public Health and a surgeon at the Massachusetts General Hospital, used the WHO guidelines for safer surgery as a template for a checklist.
A. True
B. False

11. Using the SKIN bundle, St. Vincent's HealthCare in Jacksonville, FL, has reduced hospital-acquired skin ulcer cases to how many cases per 1,000 patient days?
A. one
B. five
C. 10
D. 15

12. Minnesota's Health Care Events Law includes reporting on how many adverse events?
A. 27
B. 28
C. 45
D. 51

Answer Key: 9. C; 10. A; 11. A; 12. B.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

There is no 'I' in ED team care

Winning a malpractice case takes more than success in the courtroom: It also requires ongoing best practices on the part of the ED manager to educate and prepare the staff for possible lawsuits. One important thing for the manager to remember is that they are not an island, offers **James J. Nosich**, Esq., of the Coral Gables, FL, law firm McGrane Nosich.

"They have to understand that their role is limited in the ED to the team they have," Nosich explains. "They need to do their best to always try to educate physicians, nurses, techs, and midlevel providers that they are all on the same team and they all have one goal in mind, rather than trying to do it all themselves or blame other people on the team." More time should be spent "on having the best team you can," he says.

Teach your staff to document in a factual and nonconfrontational manner, says **Arthur L. Diskin**, MD, FACEP, vice president and global chief medical officer for Royal Caribbean Cruise Lines Ltd., who formerly oversaw the management of numerous ED physician groups and was a client of Nosich. "Document thoroughly the facts and sequence of events, without documenting arguments with other medical people in the medical record, like, 'I called the guy five times, and he still did not respond to my call,' or 'I told him the patient needed to be admitted, and he said I was an idiot,'" he says. ■

NEWS BRIEFS

Appeals court elucidates how far investigation goes

A recent federal appeals court decision clarifies how far an investigation into "disruptive behavior" goes under the Health Care Quality Improvement Act.

The case involved a physician who was inves-

CNE objectives

To earn continuing education (CNE) credit for subscribing to *Hospital Peer Review*, CNE participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from The Joint Commission or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

- ■ HIPAA enforcement laws passed
- ■ How Obama's stimulus package could affect your hospital
- ■ Educating our health care consumers
- ■ How is your quality improvement department organized?

tigated following a nurse's complaint that he had threatened her. The medical executive committee suspended the doctor's privileges, while another committee evaluated the allegations. The executive committee, based upon the investigating committee's report, was going to reinstate the doctor's privileges with his assent on certain conditions, but he rejected those and voluntarily resigned. The hospital then reported him to the National Practitioner Data Bank, believing the investigation had yet to be concluded. The physician appealed the decision, but ultimately the court sided against him, saying the formal investigation had not been concluded when he resigned.

"We've not had any guidelines on what this means. There hasn't been case law in this," says **Alice Gosfield**, a Philadelphia-based attorney and consultant specializing in quality improvement. "So what this case stands for is the proposition that as far as the courts are concerned, or at least this court looking at this case, the investigation is not over until the medical executive committee takes final action.

"How far does an investigation extend? Say for instance if you leave and they've not actually convened, they haven't made a formal investigation with regard to what they're going to do to you, did you leave before the investigation, did you leave when the investigation was concluded? His argument was they had concluded what they were going to do because he left. And the hospital said no, we were on the glide path of corrective action. And the court said the investigation isn't over until medical executive committee concludes its position but it had not done." ▼

NQF reviews Nursing Sensitive Care Measures

In 2005, the National Quality Forum endorsed a set of national standardized performance measures to assess nursing in acute care hospitals and the role of the nurse in patient safety and health care quality. Now that list is being reviewed and updated.

The measures NQF initially established were tested and analyzed by The Joint Commission in 2007 and 2008. NQF is looking at the updates recommended through that process and sought public comment on the proposed updates, which include clarification of data collection approaches, specifications and exclusions for pressure ulcer staging, and clarification of definitions. Stay tuned for the final version. ■