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Special Feature: Medication Reconciliation

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Med rec: It may be the monkey on your back but it's not going away

The challenges to tackling medication reconciliation

"This has been the single most difficult process I have ever worked on to try to implement," says **John Benson,** PharmD, quality manager, department of pharmacy services at Intermountain Medical Center in Murray, UT.

While no one will deny medication reconciliation is a complex task, and even The Joint Commission has said it will not base accreditation decisions on the goal in 2009, the requirement isn't going away. So what can you do to get your processes in order? *Hospital Peer Review* spoke with several experts who will share strategies they used at their respective hospitals to help you get your med rec game up to speed.

• Med rec is only part of a larger system problem.

"I don't have a silver bullet. I wish I had a silver bullet. The takeaway is that it is very complex; however, some of the problems are not medication reconciliation problems but are symptoms of other system problems," says **Frank Federico**, RpH, content director at the Institute for Healthcare Improvement, pointing to communication as a weak spot in health care — communication between providers, during hand offs, and with the patient and post-acute care providers.

When there are problems communicating with the patient's next provider of care, that can create problems with the discharge summary, Federico says. Often the hospital is unable to get the patient's primary care physician on the phone. "So that's a real challenge," he says. "I think what hospitals have uncovered with medication reconciliation is that we have this problem and it has nothing to do with medication reconciliation. It's a hospital problem. If they can't get the list out, it probably means there's problems with the discharge summary as well. So when I coach teams and talk about it and they say, 'It's such a challenge,' I'll say, 'Is that really a problem with the improvement you're trying to make or is that a symptom of a larger system problem you have?'"

The internal communication surrounding internal transfers is indicative, Federico says, of the "hand-off problems in hospitals." The intent of med rec was to ensure that as patients moved through different levels of care, providers did not forget to reorder medications that should be reordered or that medications that were discontinued at one level need to be restarted at another or that

medication administration needs to change from oral to IV, he says.

• **Physician involvement is key.**

All the experts *HPR* spoke with agree that engaging physicians in the med rec process is not only key but necessary.

Steven Tremain, MD, ABFP, FACPE, chief medical officer and chief medical information officer at Contra Costa Regional Medical Center in Martinez, CA, and senior medical director, Contra Costa Health Service, says: "Our champion physician on our task force, at the very first meeting, said this is a physician's job; it's not a nurse's job. This is medication. We're the only people in this place licensed to write prescriptions. Medications can kill people. This is the doctors' job. We know a lot of people who say this is a nurse's job. I think that's wrong and I will take this torch to my colleagues. So this is a physician's job.'"

The key to success for any facility undertaking med rec, and the key to his system's own success, Tremain says, is having physicians on board, and, perhaps more important, to listen to what their days are like, what their work flows are, and what they think the problems are.

Benson learned the hard way that not having physicians on board ultimately can hurt the process. "If I had to do this over again, one of the first things I would do and recommend to others still really early in the process is try to get physician involvement very early on because they really play a much bigger role in this than we ever considered." Initially, the Intermountain team thought the process would be done with the involvement of nursing and pharmacy. But it found that the lack of physician involvement at discharge, which Benson says "is very much a physician process," complicated the med rec process.

"So having physicians involved and speaking to how this affects them and having it be a really successful process requires that they be really involved," he says.

"The key about any of this is physician engagement, physician engagement, physician engagement, physician engagement," Tremain says. "Most of the places where I've seen this done wrong have made some feeble attempt to include the physicians. The docs are resistant, the docs didn't want to play, [saying,] 'Oh my God, it's a Joint Commission thing.' So [the team] designed a process with 99% of the doctors out of the loop and the process frankly does not become a patient safety project, it becomes a compliance project."

• **Take it out of the classroom, engage staff.**

When staff hear Joint Commission, they may think, "Here we go, another job for me to do," and this is where quality improvement directors often get push-back. When processes are presented as helping employees to do their job and not as a requirement coming from the top down, there is a much better likelihood for compliance.

Speaking to this, **Beau Richmond**, MA, performance improvement specialist at Barnes-Jewish

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Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).
Managing Editor/Writer: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).

Editorial Questions

For questions or comments, call **Jill Robbins** at (404) 262-5557.

Tips, Keys on Implementing Med Rec

Tips

1. Segment pieces of the improvement process in bite-size increments.
2. Short weekly team meetings.
3. Test measurement tool thoroughly.
4. Measurement is for learning, not for judgment.

Keys

1. Find and tell the stories.
2. Multidisciplinary team.
3. Use "What's-In-It-For-Me" (WIFM) approach in workflow design.
4. Customize when necessary; standardize when possible.
5. Make it easy for staff to use the new process and difficult or impossible to use the old process.
6. Harness informal champions.
7. Identify & mitigate failures.

Source: Steven Tremain MD, ABFP, FACPE, Contra Costa Regional Medical Center, Martinez, CA.

Hospital in St. Louis, MO, says "when you engage frontline staff and those who do it every single day, you not only get their buy in, but within time they actually come around generally. Some of the biggest proponents are now the ones who praise us and say, 'I don't know what I would do without my med rec form.'"

One of the biggest lessons the team at Barnes-Jewish learned through its med rec implementation process was that "you've got to get out the classroom," he says.

Richmond, who as performance improvement specialist, often leads teams through process changes says, "With just about everything I'm involved in, a key to success is having a multidisciplinary team at the table. People from all venues that are going to by affected by the process... Engaging your frontline staff, I cannot stress enough with the initiatives I'm involved with. Those are the ones where I truly have success."

He adds that it's valuable to also have a third-party discipline, not affected by the process change, that can review what you're doing and question processes that don't make sense intuitively.

Echoing Richmond's assertion about "getting out of the classroom," Tremain says creating an environment where change is possible involves "including a lot of those frontline workers, and critically important is getting out of the conference room" and seeing the proposed process played out in real time with frontline staff work flow. This is where modifications or changes that needed to be made present themselves.

"For us," he says, "it was sitting down with the attendings and the residents and understanding the work flow. It took time to invest in spending and actually watching them do an admission, watching them do the paperwork, make some suggestions and listen to their push back and listen to their ideas and incorporate those. That is critical."

His team refined the process over 18 months "and we had many, if not all, doctors on board. Then we reached the tipping point where we needed to mandate it. But we didn't mandate it with 5% of people on board. We mandated it when we had refined it. Fifty to seventy percent of the people were doing it. Then we mandated it, took away the paper prescriptions, so they had no choice, and then we helped them learn."

• Make less work, not more.

Everyone acknowledges health care workers are overburdened with work these days. "We understood their work flow when we put the process into the work flow and we did something critical for change management — we gave them less work, not more work," Tremain says.

With regard to change management, "it's really about understanding the work flow, respecting the employees, recognizing the line employee is an LKE [a local knowledge expert]. They know what's happening in their area. It can't come down from the C suite, it can't come down from the nurse manager's office."

• Understanding change management, using iterative processes and rapid cycle change.

Each hospital *HPR* spoke with uses some sort of change management system — whether it be Six Sigma, Lean techniques, rapid cycle change, iterative process change, or IHI's model of improvement or the plan-do-study-act (PDSA) process. So understanding and using one of these types of processes should help inform your process change.

Benson says, "One thing that we learned and built it into the proposal was to do an iterative process in implementing medication reconciliation. In other words, we would meet as a group with nursing and pharmacy leadership of the unit when we were implementing medication reconciliation and we would talk about what the process needed to be, the forms we needed to develop, and so on. Then we would implement what we'd talked about and run that for a week or two and then we'd get back together and talk about what's working, what's not working, and where we needed to make adjustments. We did that about three times before we called it implemented."

Once you've implemented it, Benson cautions to not think of it as done, checked off. "One tip would be to continue to reevaluate your process periodically. I think that's important, to not just think it's done... you need to keep looking at it."

• Use "stories" to motivate staff. Data lacking on the efficacy of med rec.

With not much data on how medication reconciliation affects medical error rates, a lot of team leaders have found using "stories" of where med rec might have saved a life or mitigated a harmful event useful. In the face of limited data, Tremain says, "This is where you use the power of stories. Data talk to the head, and stories talk to the heart. You'd like to use both, but sometimes you don't have enough data and then you have to use story."

Throughout the rollout, Tremain says he used such stories. For instance, he told the story of a patient discharged from a unit that had not yet adopted the med rec process. That patient was discharged on warfarin. Once at home, the patient also took the Coumadin in his medicine cabinet not knowing, of course, that one of the two should have been discontinued. "There was no big tragedy; they came in, they had some minor gum bleeding and saw the ER doctor, who saw they had real high levels of Coumadin. If that patient had been on 4B [where the med rec process was in place] that would not have happened," Tremain says.

But Benson does have some numbers in his arsenal to prove the importance of med rec. Together with a PhD nurse researcher, Benson was awarded a grant from the American Society of Health-System Pharmacists to study med rec. He chose two hospitals within the Intermountain system similar in size that also had similar nursing units. Med rec was to be implemented at only one of the facilities, and the team would research baseline data on medication errors in the nursing units and then after med rec implementation at one would do another comparison of error rates.

Pharmacy technicians collected the data from a "very careful" medication history from the patient compared to the admission orders written by a physician and transfer/discharge orders. They looked for errors, duplications, omissions, etc. Comparing those, Benson says, "we calculated how many errors occurred at each site in each of those stages — either pre-implementation or post-implementation phases — and then we compared them to the two sites." The end result? "We found a fairly remarkable difference. There was a statistical and quite a significant difference in medication error rates at the site where we implemented medication reconciliation."

Of course, that afforded Benson with pretty good ammunition to prove the case to implementing med rec at Intermountain. "Once you start showing them hard data that say this makes for less errors and less mistakes and it improves patient safety, everybody pretty much was able to respond to that... It's not only a Joint Commission thing, but this is the right thing and it works." ■

Using change management to install med rec process

Contra Costa uses rapid cycle change for success

Why has The Joint Commission backed away from medication reconciliation for 2009? "Basically because they realized it's very, very, very hard to do. I've been involved in the IHI community, and I don't think anybody had any idea how hard this would be to do, even people in the trenches. I don't think anybody realized how complex this was," says **Steven Tremain**, MD, ABFP, FACPE, chief medical officer and chief medical information officer at Contra Costa Regional Medical Center (CCRMC) in Martinez, CA, and senior medical director, Contra Costa Health Service.

When work on medication reconciliation began at Contra Costa in 2005, Tremain, trained as a family physician, was director of system redesign and executive sponsor for innovation work at the Institute for Healthcare Improvement.

Tremain begins the med rec story with the three things that set the hospital up for a better chance of success.

One, he says, "We are not a community hospital, we're a closed medical staff. And we're not even a university hospital, we are a residency program; we train family medicine residents, and we have basically family medicine or general internist hospitalists oversee the care of every inpatient and teach the residents along with the subspecialists who are appropriate. But basically every patient in the hospital belongs to a generalist hospitalist team. So there is a generalist who owns every patient. We don't have this thing of five different specialists not wanting to take responsibility that they didn't prescribe."

Two, the physician champion on board recognized from the get-go that physician involvement

and ownership was essential to the med rec puzzle.

Three, the team's understanding of human factors and change management systems. We had a very acute knowledge of change. "We learned the [IHI] improvement model; we even sent our team leader back to the IHI, and she participated in their improvement advisor program.

"So we didn't try to do this from the seat of our pants. We begged, borrowed, and stole from others, and then we made this a high priority in the organization because we knew how difficult it would be," he says.

Short team meetings important

Initially, the team met every Friday for 45 minutes, from 11 to 11:45 am. The team included the hospital's director of ancillary services as lead; a physician champion; a resident; a nursing champion; two pharmacists; one pharmacy technician; a clinical informaticist; a forms expert; a nursing rep for every service; and an MD for every service.

"They followed the whole improvement model to the letter. They understood small tests of change; they understand rapid cycle improvement," Tremain says.

"If you would Google high-functioning team, you would find several attributes for that team. This team met every one of them: multidisciplinary, goal-oriented, and a lot of team collaboration."

Within the first meeting, the team reviewed other mentor hospitals' policies and procedures and drafted a procedure for CCRMC that they planned to trial the following Monday. They chose an 8-bed telemetry unit. "It's a controlled environment, there's less staff, and it's only 8 beds," Tremain says. How small was the small test of change scheduled for the following Monday? One patient.

Use small test of change

As part of its small test of change, an element of IHI's model of improvement, the team decided to test the first patient admitted to the tele unit Monday morning. The direction was first to tackle admission, then transfer, and finally discharge and after testing to roll out it out in that order.

Using the med rec form, dummied up in the initial meeting, the resident admitted the patient. It didn't work. "Of course not. Where have we ever gotten this presumption that we can design something in a room and it would work? The Wright brothers' plane didn't get designed in a room," Tremain says.

The team huddled immediately after this trial and changed the process and the form based on what they saw in the test and scheduled another test of change for the very next day.

"They cycled this. And over 14 days, they had somewhere between six and eight iterations of this process. That was August 2005, and we've changed it once since then — the real proof of a well designed small rapid test of change," Tremain says. "To the casual observer it sounds like, 'Oh my God, we've got this mandate from The Joint Commission. We've got to do it in five months. What do we do? Why are you wasting your time on one patient?' Because that's where you learn."

So the team worked out the kinks in the new admission process within two weeks. During that time, the team met with residents who do the majority of admissions at CCRMC. Historically, Tremain says, the residents would write the medications in the patient's history, then write them again on the order form. "And then we were asking them to do this med rec process a third time? So understanding the work flow, we said, 'Hmm, what if we declare this med rec form part of the medical record and when we get to the H&P, the resident can write 'see med rec form'? The resident writes down the meds on that form and then we have a simple discontinue, continue, modify; circle one and now that's the order form, too. So the physicians have to write down the meds once."

Taking away steps, making jobs easier, the work panned out for CCRMC. The change also affected the nursing process of med rec. Previously, the nurses were doing their own medication reconciliation. "Do you think the nurses' lists and the doctors' lists were ever reconciled against each other? No. So we told the nurses, 'Stop writing down your lists. You can write on the med rec form on your intake, too,'" Tremain says. The nurses then could take the med list completed by the physician and verify it verbally by reading it to the patient.

"Now we're doing a second check. And they're not unlinked. So we basically went from writing it down twice for the doctor and once for the nurse to writing it down once by the doctor and none by the nurse.

"Overall, this was really an exercise in change management, and we didn't do it by beating people over the head," Tremain says. He's often asked to come into a hospital to help implement a med rec process. "This is where I criticize some of the other organizations, particularly about med rec. I've been in and out of quality since 1983, and I don't want to

go through all this just to check the box, to have a better look at core measures or a better look at The Joint Commission. If this is not going to benefit patient care, then I don't want to be a part of it. I will not just do it to put a veneer on a bad subfloor," he says.

"I've seen so many hospitals that I've gone to to help them do this; they've scanned the margins of the regulation and a doctor signs and says I've reconciled them and nobody knows if they have. And you walk away thinking, is patient care better here or not? There's a lot of push back about medication reconciliation because of how it's being done; the organizations don't see value added to it because they're just checking the boxes."

Using change management models

"The principle issue of our success was the very fact the whole design and roll out was done with modern change management and human factors and the whole model for improvement, and it was not shoved down their throats. And so they drove it. All the enhancements were staff-driven. They weren't management-driven," Tremain says.

"And so we had initially a sort of captive spread until it had enough momentum and we'd refined the process enough to roll it out and we used all the same change management processes to transfer it to discharge. And we found out when we got to discharge, 'Oh oh, we've got a flaw in our process that you're never going to pick up until you get to the discharge process.' So we had to go back and refine the admission process," he adds.

The team completed six or seven rapid cycle change iterations in their trial run on the tele unit. The key to the success? Thinking small in terms of tests of change. And helpful in this, Tremain says, is speaking to frontline staff. Talking with a surgeon, for example, who regularly uses the pre-op form and asking: Why are using it some days and not others? "You might get an answer that has eluded you in just five minutes. So that's really the key," he says.

"One of the phrases we use is 'make it easy to do the desired thing,' whatever that is. Then as you get good at that 'make it hard to do the undesired.'"

The process today

When a patient is coming in as a direct admit from a physician's office, the admitting physician talks with the patient as the first attempt to complete a home med list and compares that to the information in the medical record modules. The physician makes any necessary changes and the patient is admitted. If the patient enters the system from the emergency department, the bedside nurse there, along with the assigned physician, goes over the list with the patient and reconciles it. If that patient is admitted, the admitting resident does it again as a double check. Then the admitting resident or the attending physician writes down all the meds and circles on the form for each med either continue, discontinue, or modify. The nurse takes it off his or her records and the physician adds any additional medications on the form, which is transmitted to the pharmacy. A pharmacy clerk inputs it there and, after approval from the pharmacist, the medications are ordered and sent to the floor.

"We have a check in the ED, a check on admission, and now the nurse is doing his or her intake and they're checking the meds again. When we have questions, we call the local pharmacy. Now we have a reconciled medication list on admission. And then that gets reconciled any time they're moved up or down, not just up but up or down. We do not do lateral transfers because of bed issues and things like that. We do reconcile on the way to the OR and back. We reconcile on discharge," Tremain says.

The last step — discharge — "is where it gets tricky," he adds. At admission, you have the home med list and the admission hospital med list. At discharge, the doctor looks at all the electronic reports, which are manually entered in the pharmacy every time an order is made; the system does not yet have direct order entry. The discharging doctor prints out this report — the home list and the active inpatient med list, and for each medication marks continue, discontinue, or modify. That serves as the outpatient discharge prescription. The goal, Tremain says, is to combine steps when possible and simplifying a process "as long as you can maintain its accuracy." Simplifying tough processes, he says, besides making them faster, makes them more accurate, as there are fewer steps where mistakes can be made.

When the patient is discharged and goes to the ambulatory center in the CCRMC system, the provider can see the discharge list on his or her PC.

Use WIFM

WIFM stands for "What's in it for me?" a principle in not just motivating staff but encouraging their acceptance by proving that it's helpful to them doing their job. At CCRMC, Tremain says, "the doctors are the drivers for admission and discharge, and the nurses are the drivers for transfers."

"The WIFM for the transfers all comes to the

nurses because they've been scratching their heads. So the nurses are the main drivers of the transfer process because they have the most to gain from it," says Tremain. Keeping WIFM in mind in designing systems is a critical component. ■

Make med rec intuitive, not just another step

Identify value- and non-value-added steps

Barnes-Jewish Hospital submitted its medication reconciliation initiative as a poster for the Institute for Healthcare Improvement. Work began in January 2005 and the process was implemented in May 2005 — a quick turnaround — but it "is continuing to evolve and is a reasonably strong practice," says **Colleen Becker**, RN, MSN, CCRN, perioperative services patient care director of the St. Louis, MO-based hospital.

The hospital is an academic medical center, with residents, private and faculty physicians, as well as nurse practitioners and physician assistants. "So we have a lot of prescribers in our lives," Becker says.

The med rec team included the hospital's manager of clinical pharmacy services, Tony Kessels, PharmD, as Becker's co-lead, as well as surgeons, attending surgeons, residents, attending medical providers both private and faculty, medical residents, and nursing, and **Beau Richmond**, MA, one of the hospital's performance improvement specialists.

The goal from the beginning, Becker says, "was that we would try to not make more work for everyone. That we would build what we thought was already occurring, just into a documentable fashion. So we thought that people were already doing medication reconciliation in their head; we just needed to provide them documentation tools to make that visible. And so that was our promise."

Medication lists also serve as order lists

The med rec process starts at admission or entry into the organization. When a patient's history is taken, all the drugs that patient is currently on are written down. "Then in that same document, we worked with pharmacy so the prescriber can turn that into an order by checking boxes and signing off on it. And so then the bulk of the work that they already were doing, they would still be doing but it's one and done as reconciliation. Where we had electronic documentation, we built med rec into that as much as possible." Though there were limitations to what that system could do, Becker says the team was able to decrease potential transcription errors and errors due to legibility.

If the list remains a list and is not used as an order form, a report goes into the patient's medical record. If there is an order, it gets scanned to the pharmacy, which reviews it along with the patient's allergy history and dispenses appropriate medication.

"When [prescribers] write for something, they have to sign it and say I'm on Xanax 0.5 mg one per day. So that's the history part. And then what they do, if it's going to turn into an order for reconciliation it says continue this patient on this medication — yes or no. And it's also in the electronic system. If they check yes, we have an internal requirement where we also require a reason as to why the patient is on the drug," Becker says. The reason can be something simple, such as fever or anxiety, but a reason must be documented.

Richmond says, "the physician has made an active decision to either continue or not continue one of those home meds as part of the active med regimen."

A facilitator on the team, well versed in Lean, educated the team on the system's principles. After the education portion, the team was split into two-member groups, which went to every place in the hospital where orders were written. Each team flowcharted every step of the admission medication process, which were put up on the wall for the whole team to see and evaluate. "And so that was so visual and so demonstrative and so powerful a tool. We didn't add any additional steps, no additional pieces of paper. So we had metrics from the very beginning; we started designing our process, and we maintained metrics through our process, and so we did a pilot, a small test of change, with our new process on surgery and medical departments," Becker says.

Evaluating steps

With its guiding principle of creating less work and making the process as intuitive as possible, the team looked at all the steps, counting them and defining them as either value-added or non-value-added items. Those identified as non-value-added were eliminated.

The initial measures the team looked at were:

- number of locations in the chart providers had to look for the list of home medications;

BARNES-JEWISH Hospital BJC HealthCare

HOME MEDICATION RECORD/ORDER

Washington University in St. Louis School of Medicine

Please check (✔) the appropriate box (☐) and fill in the blank(s) as needed.

UNLESS THE WORD SPECIFIC IS WRITTEN AFTER A DRUG ORDER BY TRADE NAME, A GENERIC EQUIVALENT DRUG APPROVED BY THE PHARMACY AND THERAPEUTICS COMMITTEE MAY BE DISPENSED IN ACCORDANCE WITH THE MEDICAL STAFF BYLAWS.

ADDRESSOGRAPH

Home medication list obtained from: ☐ Patient ☐ Family ☐ Chart ☐ Pharmacy ☐ Other_____

Home Medications (includes OTC, herbals, etc) **This may not be a complete list of home medications.**

Information obtained by: Date/Time:_____/_____ Signature:_____

Date/Time:_____/_____ Signature:_____

Date/Time	Medication	Dose	Route	Frequency	Continue Medication		Indication for Use / Reason for Discontinuation	Prescriber (MD, DO, PA, NP) Signature
	☐ **No Home Medications**				☐ Yes	☐ No		
					☐ Yes	☐ No		
					☐ Yes	☐ No		
					☐ Yes	☐ No		
					☐ Yes	☐ No		
					☐ Yes	☐ No		
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BJ 5-3343-1653 (11/10/06) Page 1 of 2 TAB: ORDERS

DO NOT WRITE BELOW THIS LINE

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Page _____ of _____

Source: Barnes-Jewish Hospital, St. Louis, MO.

- time to reconcile medications;
- number of transfer process steps;
- percentage of time that evidence of medication reconciliation is available in the chart;
- number of physician process steps during admission.

To begin with, these measures were valuable, Richmond says. "Some of the questions we started asking ourselves initially were: Where does this exist? Where does this medication list exist? Is it just in the H&P? Is it in other notes? Where can I find the information?"

Now, the "list" is in the order section of the patient's medical record and is electronic.

When patients are transferred between inpatient divisions, the patient already has a med rec form in his or her chart from admission. Those data are entered into the nursing electronic system as well, creating what's referred to in-house as "Eemer," the Emtek medication reconciliation report.

The Eemer has both the patient's home medications and active medication list "so the prescriber can look at all of those and it has the yes/no checkbox on it. They make their clinical medical decision whether to continue the drugs with indications and then [the form] also has blank spots on the bottom so if [prescribers] want to add something, they can. And then they sign off and it becomes an active order, again scanned to pharmacy," Becker says.

The Eemer is helpful because "when it's printed out, you can see at the very top of that form what the home meds are, if there were home meds entered on entry to the organization. Whatever clinician is looking at that paper doesn't have to go back to the paper chart and start flipping through the order sections. It's right there at the top of the sheet," Richmond says.

Use of the form also eliminated several steps from the process as it had been. Physicians can print the form themselves when a patient is going to be transferred. "I don't have to look for a chart, I don't have to look for a piece of paper and then

go find the chart. There was such waste in the process. It was amazing. Not just the number of steps but the amount of time that it took those people to be able to do their work," Becker says.

The Eemer is also useful in the next stage — discharge. The nurses have it available when physicians are ready to write their order for discharge. The form, though, Becker says, is written for clinicians, not patients. The nurses are tasked with translating the information into language patients can easily understand and adhere to. "Then it goes into documentation as the form the patient will take home. It goes with them and to each facility transfer," Becker says. ■

ACCREDITATION
Field Report

TJC still focusing on NPSGs, Universal Protocol

Wayne Memorial Hospital in Goldsboro, NC, was surveyed Jan. 26-30, 2009. But the 316-bed hospital, prepares for its survey just about every other day of the year.

Debbie M. Phillips, MPH, RN, ONC, director, accreditation and regulatory/patient safety officer, says a regulatory committee meets monthly. Each "chapter leader" reports on progress associated with his or her area. Phillips also performs two tracers every month. Directors, educators, and rotating staff personnel participate, and Phillips reports her findings at performance improvement meetings attended by all department directors and administrative staff, who take the information gleaned back to their staff.

Phillips publishes a monthly newsletter based on reading she has done of compliance publications. She highlights "hot spots" and posts the newsletter on the hospital's intranet. She also posts a multiple-choice "question of the month" to test regulatory knowledge. Rationale for the correct answer is provided.

In 2008, Wayne Memorial hosted a quarterly "Joint Commission Fair," with booths based on different chapters of The Joint Commission manual. At the end, staff take a clinical and a non-clinical test.

Tracer results also are posted online so staff can see what other staff are doing. "You find the same things sometimes for multiple units, so if something has worked for one unit then maybe they'll share that with other units," she says. She tries to limit tracers to one hour. They are good practice for staff to ready themselves for the surveyors' tracers. "I tell them, 'I'm friendly fire,'" she says. "And I do think they help with staff communication with surveyors; it takes away that fear factor by doing this. And then when I report all of this, I report the areas that need improving. I also report the things they're doing well. And I give kudos to individual staff members as well."

Every two weeks, she speaks at the hospital orientation on patient rights and safety in which she presents some Joint Commission and other regulatory information. Twice a year, the hospital hosts a new manager orientation during which Phillips gives an hour talk on regulatory information.

Scoring changes process

Referring to changes in 2009 Joint Commission standards, "the scoring in itself makes the standards change because every standard now is labeled direct impact or indirect and based on the criticality," Phillips says. "That in itself, although the verbiage of the standards hasn't changed, the fact that they are scored that way, to me, much more impacts your ability to be accredited because, based on your bandwidth or based on the hospital beds and your survey days and the width of which you are given so many direct impact requirements for improvement [RFIs], that's how you determine your accreditation status. The fact that the standards are divided [that way], you can shut the doors of the organization if you don't wash your hands, for example."

Now, she says, a hospital can have multiple supplemental findings so "an organization can have several of those and not meet the standard, but where your accreditation lies and based on what I've understood, it's the number of direct impact standards that you are not compliant with," she says.

"And so when you look at it, say an organization has six direct impact standards that they don't meet but they can have 20 indirect that they don't meet. You used to look at that and say I have 26 RFIs, but now the focus is really on that direct impact. Once you look at that, then you can kind of see where the focus is, where the emphasis is."

Two surveyors were at the hospital for five days, and a life safety code specialist visited on day two.

So where would she tell hospitals to focus now in preparation for their surveys? "If I would say focus on anything, I would say look at those NPSGs [National Patient Safety Goals]. There wasn't a tracer any day, any event that went by where what was done wasn't related to those NPSGs. Those are critical.

"And this to me was one of the more intense surveys I've ever participated in. I've been a nurse for 32 years. The gray is gone. It's black or it's white. So that takes away a lot of the surveyor bias, although I still think that's possible and noted," she says.

The surveyors also focused on the Universal Protocol and the added elements to the time out. "They watched time outs everywhere — in the OR, interventional radiology, to see that you were doing them the same and what your focus was. And it shouldn't just be a checklist that you're checking off. The staff performing the time out need to associate that time out with the rationale for why they're doing it," Phillips says.

The hospital was applauded on how it maintained the integrity of crash carts. "They like the fact that we had turned ours around so that the average public couldn't look and see what this cart was. They liked that a lot. That promoted safety as well as promoting the integrity of the cart. So the next time it's used, you would know that what you needed was there," she says.

Surveyors also praised the follow up Wayne Memorial was doing. "We had a progress report on all of the projects we're working on. A project tracker so to speak. They liked that because it identified the problem you were working on, what your plan of correction was, who was responsible for it, and then follow up," she says.

"Your environment of care documents and, of course, your staffing effectiveness and patient flow data are really big — how do patients get in and out of your organization and what are your problems associated with patient flow and showing what you did about that problem? So tell a story. You have to do now an analysis of a high-risk process, and that analysis is not a failure mode effects analysis. They want you to look at a process — what are your risk points, what have you done about it?"

Phillips chose to share the process for bar coding medication administration. And share it as a story — "that's what you need with your performance improvement; it needs to tell a story," she says. Surveyors want to see your analysis, why you chose that particular process, who the team players at the table were, and whether the process crosses interdisciplinary lines.

Surveyors also praised the hospital for its work on implementing a medication reconciliation process. "We use Meditech, and we have a customer-defined screen on admission where we capture the patient's medications. That screen flows to the discharge, and it can be used as an order sheet," Phillips says. That information continues through to discharge with physicians able to

CNE *questions*

13. Which of the following do experts see as key in implementing a medication reconciliation process?
A. physician involvement
B. using change management systems
C. taking it out of the conference room
D. all of the above

14. According to Steven Tremain, MD, ABFP, FACPE, chief medical officer and chief medical information officer at Contra Costa Regional Medical Center, is testing just one patient too limited to run a small test of change?
A. yes
B. no

15. Which measures did Barnes-Jewish Hospital collect data on at the beginning of its med rec project?
A. number of locations in the chart providers had to look for the list of home medications
B. time to reconcile medications
C. history and physical procedures
D. A & B

16. According to Debbie M. Phillips, MPH, RN, ONC, director, accreditation and regulatory/patient safety officer at Wayne Memorial Hospital, surveyors looked at patient flow data.
A. True
B. False

Answer Key: 13. D. 14. B; 15. D; 16. A.

CNE instructions

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mark either continue or modify each medication, as well as add new medications. Surveyors suggested that if the physician offices had Meditech as well, the med information could be stored so it was easily accessible to the next provider of care.

Going forward, Phillips says, the hospital will continue to work on the NPSGs to ensure every element is completed. "Flow of information was really important in this survey," she reiterates.

"Performance improvement data, in particular, how they get up the chain to administration and the board and how they flow down the chain to the staff level. The expectation is that your staff know your percentage in compliance rates. Even if it's organizationwide, they expect the staff to know what your organizational compliance is and to know how their specific unit fits into that compliance. Sometimes when you're the frontline caregiver, you know where you stand reasonably speaking, but specifically the average nursing assistant might not know that," she says.

You have to provide minutes of how that information flowed up and down. "I can't enforce enough whoever is responsible for the survey, having those documents ready and staying in tune to that survey activity guide" is important, she says, adding that which documents are required changed at the very end of 2008.

There also was a focus on last year's Goal 16 on rapid response. Phillips says surveyors looked at data and whether your resuscitation data show an increase in your rapid response and a decrease in your code rates. "Are you effective? That's the key thing: Is it effective and how do your data show that what you're doing is effective and has worked or do you need to go back to the drawing board and change what you're looking at? Of course we had done well with that. Our rapid response events have gone up and our code events have gone down. That's what you expect to see with that and indeed that is what happened with us."

Surveyors also looked at the timeliness of history and physicals and that your orders are dated and cosigned and timed within the 48-hour required time line. ■

DNV surveyors focus on CoPs, process measures

Hays, KS-based Hays Medical Center was accredited by The Joint Commission for more than 30 years, but in November 2008 decided to go with Houston, TX-based DNV Healthcare. "We basically decided to make the change because where we are in our journey of quality; we're very interested in the ISO standards and implementing those in our institution. We thought this was a good time for us to go with a different organization," says **Judith Purdy**, RN, director of risk and quality management.

"We believe that implementing ISO will help with quality structure from the inside out," she adds. The 194-bed hospital was surveyed by DNV Oct. 6-8, 2008.

As for preparing for the survey, a question she is often asked by peers, Purdy says it was mini-

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- 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. ■

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mal. "There's nothing to get ready for the survey. Any organization that is already accredited, they should be able to do fine on the DNV survey because the DNV survey is surveying the [conditions of participation] CoPs, which hospitals already should be compliant with."

Another question she often hears is whether your facility must by ISO-compliant to be accredited by DNV. "The thing is, you do not need to be ISO compliant for two years after your initial survey with DNV. You have those two years to become ISO compliant," she says. "The thing, too, is people have more access to ISO in place that they realize. Some is terminology. They've already got a lot of the documentation and processes in place that they need."

Focusing on the CoPs, DNV surveyors used the tracer methodology. "Of course they did patient care visits, patient care interviews, facility interviews, or walkthroughs to make sure you're meeting all of the environments of care you need [required by] both the government, OSHA, life safety codes. Nothing that anybody isn't used to already. I would say that the survey is definitely process-oriented," Purdy says.

They look for evidence of the standard CoPs that CMS looks at, Purdy says: blood usage, mortality review, restraint usage. "They're also looking at, and that's when you get into the ISO usage, process — how the patient moves through the entire system," she adds.

What she likes about the DNV process is that it encompasses non-clinical areas — "your entire organization," she says. Financial services, such as the process of billing a patient, are reviewed during the survey. "Nobody ever looks at the financial services, like the process of billing a patient. How does that all work? So I think that will be a good thing because typically those parts have not been involved in the survey — materials management, administration, those aspects."

What they look at in terms of financial services depends on what the facility has determined it would like to look at in depth. "The nice thing, too, is within this DNV survey process you do your internal audits of those processes," she says. One component of a successful audit process, she says, is having different disciplines review process instead of auditing their own area. For example, if you're looking at the inpatient surgical care process, Purdy might not use a nurse but maybe a pharmacist or a respiratory therapist.

Internal audits are required components of ISO. And what is audited is decided on by the hospital itself. Purdy says typically hospitals identify 10 to 12 areas they'd like to analyze.

Another emphasis is documentation management — not an easy task, Purdy says, and one the hospital is working on. Especially in health care, "it's challenging to make sure everybody's following the current policy with the most current revision and likewise on forms that everybody is using the most current form with the most current revision," Purdy says. The best way to do it, she says, is putting everything online.

Beyond preferring an annual survey vs. a triennial one so everything stays fresh in the minds of hospital staff, Purdy agrees with the DNV principle that while hospitals are required to comply with CoPs and become ISO compliant, "hospitals are allowed the ability to do it in a manner that works for them; however they can accomplish it, which is very attractive to physicians for one thing," Purdy says.

"It's always better if you can do it how it works in your organization and not someone being prescriptive and saying you can only do it this way when maybe that does not make sense with your organization, your patient population," she says. "We like the ability to determine for ourselves which national goals we find to be valuable, evidence-based, and important that we want to collect data and make improvements with rather than somebody indicating what those will be and how you will do it." ■