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Peds guidelines include appointment of ED nurse, physician coordinators

Coordinators would handle many duties normally left to managers

Recognizing and re-emphasizing the fact that children are a distinct population of patients in the ED, the American Academy of Pediatrics, the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA) have released a joint policy statement that includes guidelines for the care of children in EDs. The statement was published online in the journal *Pediatrics.*[1]

"We wanted to draw attention to the role that children play in the overall scheme of the ED," says **Alfred Sacchetti**, MD, FACEP, chief of emergency services at Our Lady of Lourdes Medical Center, Camden, NJ, a spokesman for ACEP, and a member of the committee that developed the guidelines. "The Centers for Medicare & Medicaid Services, The Joint Commission, and others have been establishing sets of standards for adult patients, and part of this effort was to say that we also want to have the same attention focused on the children — in other words, don't let the kids get lost in the overall avalanches of protocols being launched by other organizations."

The guidelines should be particularly helpful for EDs in community hospitals, adds **AnnMarie Papa**, MSN, RN, CEN, FAEN, president-elect of ENA for 2010. "When you think about pediatric care, most children's care for emergencies is done

Executive Summary

Among the joint guidelines released by the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association was the recommendation to create two new ED positions — physician coordinator and nurse coordinator — to help ensure optimal care for pediatric patients in the ED.

- Select someone who already has shown a keen interest in pediatrics and who demonstrates that they follow the latest developments in the field.
- Excellent communication skills are a must, as they will be the liaison to other departments.
- Give the coordinators responsibility for performance improvement activities and disaster planning as they pertain to the care and safety of children in the ED.

IN THIS ISSUE

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in community emergency facilities," Papa says. In light of the fact that the Institute of Medicine has called care of children "uneven," "We wanted to address that," she says. "Hopefully our statement provides a good overview about what a basic community hospital needs."

Well-known children's hospitals in major metropolitan areas might not need these guidelines as much, "but most children in the country do not get their care there," Papa says.

Creating new positions

While the guidelines do not hold many surprises, one of the more creative proposals involves the establishment of two new positions in the ED: A physician coordinator and a nurse coordinator. "This allows you to say that this is the one person in the department who will have an area of interest in the care of kids," Sacchetti explains.

The physician coordinator should be chosen by the ED medical director, and the nursing coordinator should be selected by the nurse manager, he says. However, Papa takes a different approach. "I see both the physician coordinator and nurse coordinator being appointed jointly by the medical director and nursing director," she says. "In my experience, I worked collaboratively with the medical director."

The selection process should not be a difficult one, Sacchetti says. "It's almost a natural choice in any department," he explains. "In any ED, you have someone who's really into cardiology, or toxicology, and the same is true for pediatrics."

They might not have done fellowships in the area, says Sacchetti, but they will have demonstrated an interest in pediatrics. "You will almost always have someone who follows the pediatrics literature a little more closely than anyone else," he observes. "They come to doctors' meetings, or nurses' meetings, and say, 'Did you know that they changed the definition of 'X,' or there's a new drug for 'Y'?" The bottom line, he says, is that "You should take advantage of that one individual in your department." **(Your entire staff should meet certain core competencies when it comes to pediatric care. See the story on p. 15.)**

The medical director and nursing director should not only understand pediatrics, but they also should have great communication skills, Papa says. "That's because they have to be the liaison to the rest of the hospital, so that surgery, respiratory therapy, and other departments understand the unique needs of the child," she says. In other words, Papa envisions those people facilitating hospitalwide programs.

Sacchetti says, "They would certainly be responsible for ongoing performance improvement activities that address pediatrics." To address the joint guideline that covers support services for the ED, the ED manager, nurse coordinator, or physician coordinator — or all three — will need to sit down, for example, with radiology managers to discuss implementation of the recommendations, he says.

The coordinators also should be responsible for the pediatric aspects of surge management and disaster

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planning, says Papa. "It's much more difficult than it is for adults, especially if they are separated from their parents," she explains.

Does the creation of these new positions require additional staffing? "There could be a number of ways to do it, depending on your budget," says Papa. "Most people will identify someone in the department who has those skills and then take them off the clinical side for a certain number of hours."

Depending on the ED's volume, "that could be anywhere from 20% to 40% of the time that the person would be doing administrative work," she says. For the nursing coordinator, most often that time would be spent doing data collection, while the doctors would be spending more time on analysis, Papa says.

Reference

1. American Academy of Pediatrics Committee on Pediatric Emergency Medicine, American College of Emergency Physicians Pediatric Committee, Emergency Nurses Association Pediatric Committee. Joint Policy Statement — Guidelines for Care of Children in the Emergency Department. Accessed at www.pediatrics.org/cgi/doi/10.1542/peds.2009-1807. ■

Staff competencies are a key concern

Joint guidelines from the American Academy of Pediatrics, the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA) cover several major areas including staff competencies; improving patient safety; policies, procedures, and protocols; transfer agreements; support services; and equipment, supplies, and medications.

Satisfying nearly all of these guidelines requires an ED staff that is competent in the specialized care children need. What core competencies should be required? "The ED manager has to work in cooperation with the pediatric coordinators to identify them," says **AnnMarie Papa**, MSN, RN, CEN, FAEN, president-elect of ENA for 2010. "Typically what you do when you develop competencies is you look at things like the population base, as well as the types of injuries that are common in your area, since they're all different."

However, there are some common considerations that must be taken into account, Papa says. "Number one is safety," she says. "That includes airway management, and recognizing a child is sick before they start getting sicker, because kids can go downhill real fast."

For nurses, there are some important certifications, such as pediatric advanced life support (PALS), Papa says. "Also, ENA has an emergency nursing pediatrics course, or ENPC, that nurses have to take every four years," she says. "It covers airway management, identifying burns, resuscitation, dehydration, and sepsis." Any nurse that cares for a child should have this course, Papa says. "Some think PALS is enough, but that only addresses airway management," she adds.

In addition, she says, it's important to have the ability to bond with parents and to listen to them. "If a parent says their kid is sick, then they are sick until proven otherwise — and you have to have people who are sensitive to that," Papa says. "You need to partner with them and trust the parent to tell you what has worked in the past, say, for Tommy's asthma."

There is no substitute for this relationship with the parents, she emphasizes. "You can have every certification, have every piece of equipment you need, and be a top clinical nurse, but if you can't develop trust and bond with the parents in the first two minutes, it'll be all downhill," Papa warns.

The pediatrics coordinator should handle all of the competency training or train the trainers, she says. "That gives nurses in the department to opportunity to grow," Papa says. The coordinator also should handle competency evaluations, she adds.

It's important when training your staff to advise them against becoming intimidated by caring for children, notes **Alfred Sacchetti**, MD, FACEP, chief of emergency services at Our Lady of Lourdes Medical Center, Camden, NJ, a spokesman for the American College of Emergency Physicians (ACEP), and a member of the committee that developed the guidelines. "Overall, we tend to underestimate the quality [of care we provide], and as a result, these people tend to be intimidated by children when they shouldn't be," he says. "Once you become intimidated, you basically back away from doing the right thing, and inappropriate intimidation in itself may lead to suboptimal care." ■

Nurses take ownership of rads discrepancies

New process improves communications, responses

A new process for managing radiological discrepancies in the ED at Catawba Valley Medical Center in Hickory, NC, has significantly improved the efficiency with which notifications are received and acted upon.

Basically, "nursing owns this process and relies on the physicians only for order corrections or additions," says **Van Haygood**, RN, MSN, NE-BC, administrator for emergency, post-procedural, and direct admission services. **(Haygood says the process has been a plus in terms of risk management. See the story on p. 17.)**

"I guess we have been doing this exactly as we do it now for about four years," says Haygood, citing several reasons for the change. For one, a new Patient Archives and Communication System (PACs) from GE Healthcare IT, was acquired, Haygood says. **(See resource box, right.)** "After the upgrade, we addressed the old process, where radiologists would fill out a pink slip and have it brought over to the ED," he says. "Some slips made it to the box, some didn't, and sometimes the doctors wouldn't see them, so we decided to take it upon ourselves to develop another process."

Team developed game plan

The new process was developed by a team that included Haygood and the ED medical director. "We identified the key issues and determined exactly what we needed to do to fix them," he says.

The new process works like this: First, as always, films are taken as ordered by the ED physician, who then reads them. All those films are then overread by a radiologist.

"If there is a discrepancy they are required to write it up," says **Julie Carrigan**, RN, BSN, CEN, one of two patient care coordinators designated to oversee the new process.

If the physician still is in the building, the radiologist will call him or her and give notifications about the discrepancy. "For example, they may tell them they found a discrepancy in a chest X-ray and suggest a CT scan," she says. However, sometimes they might be read after the patient has been discharged, which makes the situation a little more complicated, she says.

"Each day, myself and the other patient care coordinator go to the computer system to see if there is a discrepancy. If there is, it's listed on the PACS system," Carrigan says. "We print the discrepancy off, pull the chart, and review the diagnosis and treatment with one of the ED physicians." The physician will tell them what follow-up needs to be done, i.e., a return visit for additional testing, an outpatient visit, or referral to a specialist, she says. Carrigan or the other coordinator then will contact the patient and/or the specialist to arrange for the follow up.

"I then go back into the PACS, where there is a place for a 'discrepancy acknowledgement,'" she says. "I will either enter the fact that I was not able to get in touch with the patient and will send a letter, or, if did I contact them, I type it in the system and the discrepancy goes away." ■

Executive Summary

The ED at Catawba Valley Medical Center in Hickory, NC, has improved its responses to radiology discrepancies by redesigning its process and giving ownership of that process to two nurses. Here are some of the key aspects of the process:

- Every day the coordinators check the computer system, into which discrepancies are entered by radiology.
- Diagnosis and treatment are reviewed with one of the ED physicians.
- If the patient has been discharged, the coordinator will contact the patient via phone or follow-up letter.

Sources/Resource

For more information on handling radiological discrepancies, contact:

- **Julie Carrigan**, RN, BSN, CEN, Patient Care Coordinator, Catawba Valley Medical Center. Phone: (828) 326-3697.
- **Van Haygood**, RN, MSN, NE-BC, Administrator for Emergency, Post-Procedural, and Direct Admission Services, Catawba Valley Medical Center, Hickory, NC. Phone: (828) 326-3697. E-mail: vhaygood@catawbavalleymc.org.

For additional information on Patient Archives and Communication Systems (PACS), contact GE Healthcare IT. Phone: (888) 303-7227. Fax: (201) 934-1171. E-mail: DISinfo@ge.com. Web: www.dynamic-imaging.com.

New process is 'much more timely'

A new process for managing radiological discrepancies in the ED at Catawba Valley Medical Center in Hickory, NC, has proven to be "much more timely" and has been a plus when it comes to risk management, says **Van Haygood**, RN, MSN, NE-BC, administrator for emergency, post-procedural, and direct admission services.

"Anecdotally, the new process has potentially cut days from the process," Haygood says.

The process, which is overseen by two patient care coordinators who interface with the new Patient Archives and Communication System (PACs, GE Healthcare IT), has shown improvement "where follow-up care and treatments were missed," says Haygood. "Having this system in place has made a difference in terms of things not falling through the cracks."

Before, Haygood explains, the MDs were independently responsible to remember to look at the discrepancy reports, pull the necessary records, make decisions in writing, and place the hard copy into a bin so that the charge nurses, in turn, could call patients if necessary and arrange for further testing. "The issues were that the MDs got busy, didn't take the time to look at the reports, and hated the process, so they tended not to want to get involved," he says.

There was not much training needed to implement the new process, says **Julie Carrigan**, RN, BSN, CEN, one of two patient care coordinators, "I just really needed to learn how to access the PACS system," she says. In addition, says Haygood, "the ED medical director had been doing this, so she taught Julie."

Any ED that has a PACS could implement such a process, says Haygood. "If they don't, but if they have any kind of radiological overread system, then someone in the department needs to be designated to do what Julie does," he says.

"You have to have a designated person responsible to do this on a regular basis," says Haygood. In addition, he notes, "I don't think this person can be a secretary. It should be a nurse who is able to understand what the doctor wants."

The reason? The new process, in effect, has taken the MDs "out of the loop" except to present them with the report and obtain immediate feedback in the form of orders, Haygood says. "These orders can only be written and acted upon by an RN — thus, no secretarial involvement," he says. ■

ED Coding Update

Prepare for more monitoring of quality performance

*[This quarterly column on coding in the ED is written by **Caral Edelberg**, CPC, CCS-P, CHC, president of Edelberg Compliance Associates, Baton Rouge, LA. If there are coding issues you would like to see addressed in this column, contact Edelberg at phone: (225) 454-0154. EFAX: (225) 612-6904. E-mail: caral @cedelbergcompliance.com.]*

Although the Centers for Medicare & Medicaid Services (CMS) made several minor modifications to the Outpatient Prospective Payment System (OPPS) for 2010 with impact on the emergency department, none result in a significant change in ED facility coding. However, there are references to several planned projects required to provide data to be used in future reporting and/or rate changes.

With that in mind, it's a good time to rethink and revise how we look at many of the components of our ED facility coding and prepare for increasing monitoring of quality performance for coding and medical care:

• **ED visit levels.**

CMS has no plan to create national ED visit-level criteria. The agency notes that the current distribution and content of internal guidelines result in a relatively normal national distribution of ED visits. CMS has observed a consistent pattern that distinguishes the different levels of service, which is good news for EDs in general. In addition to the visit levels, CMS reconfirms that hospitals should continue to report all HCPCS codes for services rendered by following correct coding principles, CPT code descriptions, and additional CMS guidance. CPT code descriptions that refer to the term "physician" do not restrict the reporting of the code or application of policies to physicians only, but also applies to all practitioners, hospitals, providers, and suppliers.

Good news regarding MAC/RAC audits! Although CMS continues to encourage FIs (fiscal intermediaries) and MACS (Medicare administrative contractors) to review each hospital's internal guidelines for evaluation and management (E/M) level assignment when the facility is audited, there are currently no RAC (recovery audit contractor) activities planned for

E/M services. RAC auditors are required to audit only CMS-approved issues. It's a good idea to monitor your RAC auditor, however, for current audit hot spots. **(There are companies that can help you with this process. See the resource box, right.)**

Although CMS officials continue to believe hospitals do a good job with developing and following their ED facility assessment criteria (E/M levels), they intend to begin tracking the most common diagnoses associated with the Type A and Type B ED visits for review by the ambulatory payment classifications (APCs) panel. This analysis is planned to include hospital-specific characteristics in addition to analysis of the CY 2008 claims data for Type A and Type B ED visits. Based on CY 2008 data, which are the most recent available, CMS identified 344 hospitals that billed at least one Type B ED visit, with total frequency of Type B visits at 220,000. All but five of the 344 hospitals reporting Type B visits also reported Type A visits. Interestingly, most reported only Type A ED visits: 3,238 total hospitals. The total frequency of visits provided in Type A EDs in 2008 was about 11.6 million.

What do these numbers mean for hospital reporting in 2010? As CMS plans to track and compare diagnoses to E/M levels, it's a good time to track that information for your facility to identify any outliers and ensure that your facility criteria are performing as intended. In addition, physicians need to be reminded that assignment of diagnosis codes reflect the physician documentation noted on the record. Thus, incomplete documentation results in diagnosis coding that might not fully support the medical necessity and medical problems managed during the patient's ED stay. Furthermore, ED physician documentation is used for "present-on-admission" indicators necessary for the inpatient coding when patients are admitted through the ED. It looks as if we will be seeing increasing focus on diagnosis coding to support the services we perform, and the data will be available to support future payment decisions.

• Critical care.

CMS reiterates its previous directives on critical care, particularly relating to time. Facility critical care may only be billed for ED services if 30 minutes or more of critical care services are provided consistent with the facility's internal guidelines. Fewer than 30 minutes is billed with the E/M level that most closely defines the service.

For those patients who expire in the ED while receiving critical care, hospitals are instructed to continue use of the –CA modifier for procedures on the OPPS inpatient list used to resuscitate or stabilize a patient with an emergent, life-threatening condition who dies before being admitted.

With regard to trauma team response, CMS continues to require 30 minutes or more of critical care in addition to the 0390 trauma team activation code as "it would be extremely unusual for a patient to require trauma team services, be rushed to surgery within 30 minutes of arrival in the emergency department, and not be subsequently admitted to the hospital as an inpatient" [74 *Fed Reg* 60,551 (Nov. 20, 2009)].

• "Triage-only" visit.

ED coding staffers continue to question how to bill ED services when the patient is seen only by a nurse for triage but leaves prior to being seen by a physician. CMS does not specify the type of hospital staff who may provide services in hospitals, as OPPS makes payment for services incident to physician services — that is, for the services and resources used to support physician services. Remember, OPPS is for the ED staff support, not the ED physician services, which are billed separately. Hospitals may choose their own staffing configurations to provide services as long as the following also are taken into account:

- state and local laws;
- hospital policies;
- federal requirements (EMTALA and Medicare conditions of participation for hospital staffing).

CMS clarifies that billing a visit code in addition to another service because the patient interacted with hospital staff or spent time in a room for the service is inappropriate. However, here's where it gets specific to the facility: "A hospital may bill a visit code based on the hospital's own coding guidelines which must reasonably relate the intensity of hospital resources to different levels of HCPCS codes." CMS published a visit FAQ that further clarifies: "Providers should work with their local FIs regarding the medical necessity for these visits." Thus, it would seem that if facility nursing criteria specify the type of staff support required to triage a patient and rule out the presence or absence of a

Resources

For assistance with monitoring recovery audit contractor (RAC) auditors for hot spots, contact:

- **Region A:** Diversified Collection Services. E-mail: info@dcsrac.com. Web: www.dcsrac.com
- **Region B:** CGI. E-mail: racb@cgi.com. Web: racb.cgi.com.
- **Region C:** Connolly Consulting. E-mail: RACinfo@connollyhealthcare.com. Web: www.connollyhealthcare.com/RAC.
- **Region D:** HealthDatainsights. E-mail: racinfo@emailhdi.com. Web: racinfo.healthdatainsights.com.

medical emergency, a low-level visit level might be appropriate. ***[Editor's note: The quality data reporting program for hospital outpatient care, known as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), generally has been modeled after the program for hospital inpatient services. See the story, below.]*** ■

HOP QDRP modeled after inpatient program

By **Caral Edelberg**, CPC, CCS-P, CHC
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The quality data reporting program for hospital outpatient care, known as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), generally has been modeled after the program for hospital inpatient services. Both of these quality reporting programs for hospital services, as well as the program for physicians and other eligible professionals, known as the Physician Quality Reporting Initiative (PQRI), have financial incentives for reporting of quality data to CMS. In 2009, CMS required that hospitals paid under the OPPS submit data on seven measures for hospital outpatient services furnished on or after April 1, 2008. For 2010, CMS has added four new measures for reporting. **(See list of HOP QDRP measures for 2010, below.)**

More measures in 2011

In addition to these measures, CMS is considering additional measures for 2011 reporting that will affect the ED and will include two measures that address overutilization of CT scans, which have implications on patient safety due to radiation

HOP QDRP Measures — 2010

Measure Number	Description	CY 2009 Designation
OP-1	Median Time to Fibrinolysis	ED-AMI-2
OP-2	Fibrinolytic Therapy Received Within 30 Minutes	ED-AMI-3
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention	ED-AMI-5
OP-4	Aspirin at Arrival	ED-AMI-1
OP-5	Median Time to ECG	ED-AMI-4
OP-6	Timing of Antibiotic Prophylaxis	PQRI #20
OP-7	Prophylactic Antibiotic Selection for Surgical Patients	PQRI #21
OP-8	MRI Lumbar Spine for Low Back Pain	N/A
OP-9	Mammography Follow-up Rates	N/A
OP-10	Abdomen CT-Use of Contrast Material	N/A
OP-11	Thorax CT-Use of Contrast Material	N/S

Source: 42 CFR Parts 410, 416, and 419. Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Final Rule.

exposure. Additional information on proposed criteria for ED CT scans for headache, as well as other measures under consideration, can be found at www.imaging measures.com. ■

If providers apologize, will there be a lawsuit?

A few hours after a chest pain patient was worked up and discharged with a noncardiac diagnosis in a Virginia ED, he was brought back dead on arrival. According to the family, the ED physician got down on his knees in front of the man's wife and begged for forgiveness for missing the diagnosis. The family sued the ED physician, and the case was settled out of court.

The above case happened years before "I'm sorry" legislation was enacted in the state. Interestingly, however, had the law been in existence, it might not have made any difference whatsoever.

"It's possible that we might have been able to keep that out of evidence under the statute, but I am not optimistic," says **Joseph P. McMenamin**, MD, JD, FCLM, the attorney who defended the ED physician. McMenamin is a partner at Richmond, VA-based McGuireWoods and a former practicing emergency physician.

"The statute has to be obeyed to the letter. You have to be very careful with what you say and how you say it," explains McMenamin. "I suspect the physician still would have been faced with admissible evidence, and that was pretty damaging."

If the apology is brought in as evidence, and it is exaggerated or distorted by the patient or family, the defense attorney can challenge the accuracy of their account. "I can put my guy on the stand to say what really happened. But if the jury decides to disbelieve what Doctor X has to say, you're stuck with that. The mere fact that the family says it means the jury gets to consider it and might believe it," says McMenamin. "And a jury hearing that the doctor said he's sorry may think he's basically admitting he was wrong. That may be what they hear."

Are risks really reduced?

Massachusetts is among the states providing statutory protection for providers apologizing for an unfortunate patient outcome. The statute says that such statements are inadmissible in civil cases.

J. Peter Kelley, JD, a health care attorney with Cambridge, MA-based Foster & Eldridge, says, "My office routinely files a motion in limine at trial to preclude any statement of apology or sympathy. These motions are routinely allowed. Having this protection, we advise providers in certain circumstances to express sympathy and/or apologize to the patient and family for unfortunate medical results."

Kelley adds that in his experience, disclosure doesn't make the defense more difficult. "Motivation for litigation is fueled by a patient or family feeling the provider is uncaring or dismissive of the bad outcome," he says. "Appropriate disclosure and expressions of sympathy, if properly communicated, can reduce the likelihood of a claim."

Richard C. Boothman, chief risk officer at the University of Michigan Health System in Ann Arbor, says that "I'm sorry laws," in his opinion, haven't been around long enough to be tested. "I don't think that they offer guaranteed protection against the potential abuse of an apology," he says. However, Boothman says that being honest in these situations can reduce your liability in many ways, including diffusing anger. "It can allow the parties to move toward reasonable compensation and emotional closure without the expense, both financial and emotional, of litigation," he says. "When an apology is owed, every day that passes without one causes a new injury. The price to resolve the dispute only rises as time passes."

On the other hand, if in fact an apology is not owed, failing to discuss this with the patient can cement misunderstandings and misconceptions. This situation can lead to unfounded litigation. "It is always better to avoid a lawsuit than to win one that never should have been filed in the first place," says Boothman.

However, McMenamin isn't convinced the situation is so clear-cut. "As a defense guy, I don't mind admitting that these statutes give me the willies," he says. "Understanding what the law is on a topic might not necessarily be a walk in the park. Sometimes it's very difficult to figure out what the legislature had in mind. After all, why do we have judges? And if it's a statute that's pretty new, we don't have a lot of case law to point to."

McMenamin adds that even if an ED physician is a scholar of the law, at 2 a.m. when he is trying to figure out what to say to somebody about a maloccurrence, he's unlikely to take into consideration any case law that has interpreted the meaning of a statute.

Emory Petrack, MD, FAAP, FACEP, president of Cleveland-based Petrack Consulting, says that while ED physicians frequently apologize about minor issues such as delays in X-ray results, apologies for more serious issues are uncommon in his experience. "However, I have made apologies myself for medication dosing

errors," he says. "Fortunately, while the error was significant — a nurse giving an excessive dose of ibuprofen — there were no expected clinical manifestations."

Petrack says that whether error disclosure to patients can, in fact, prevent a lawsuit is "the $64,000 question. In general, I do believe that honesty in communication, which includes acknowledging errors made, is the right thing to do," he says.

With a serious error that is likely to be discovered anyway, failing to be clear about what happened, including a possible apology, might make the situation worse. "That said, if it were a very serious error, after the clinical concerns are handled, I'd probably contact risk management to bring them quickly in the loop," says Petrack.

If you do apologize, do so with another health care provider in the room. "If it ends up becoming an issue, and there's a deposition or other investigation, the hospital now has two 'witnesses' to the discussion," says Petrack. **(For an examination of whether mistakes should be hidden, see story, below. For specific strategies to reduce liability risks when apologizing to a patient, see story, below right.)** ■

Should mistakes ever be hidden?

"I think it's pretty clear that if you hide a mistake and then somebody finds it, you are probably at much greater risk of losing a case," says **Peter Viccellio**, MD, FACEP, vice chairman of the Department of Emergency Medicine at the State University of New York at Stony Brook. "A classic example of that would be somebody doctoring a chart. It is seen as proof of guilt," he says.

Rather than training everyone in the ED in how to disclose mistakes to patients, Viccellio recommends designating individuals in the department or hospital. "If someone came to harm in my department, I would feel it most appropriate for me to sit down and talk to them," he says.

Viccellio points out that anytime a patient is called back for a misread CT scan, it constitutes an admission of error. However, other mistakes would never be known by the patient, unless they were told. "Some things you can bury," he says. "So the question becomes, if I did something that harms a patient and I can hide it, then should I? I meant to give you dexamethasone and instead you got a high dose of methotrexate, that may not give you any manifestations now. But it may increase your risk of cancer down the road."

Viccellio says in his ED, "if we believe we did something to a patient where there was actual harm and it was our fault, as far as not disclosing it to the patient, I don't think we consider that as an option. We would feel compelled to inform the patient."

With error disclosure, the question isn't whether or not it influences juries, he says. "The question is whether or not your actions influence whether it ever becomes a malpractice suit to begin with," Viccellio says. "Most people, in fact, don't sue after a medical mistake. The statistics are in your favor. But most studies suggest that an angry person is more likely to sue. And if I hide something from them and they find out, I think it's much more likely that they would sue, or try to sue."

He acknowledges his frustration with the lack of legitimacy of many ED malpractice cases. "But because that's a problem doesn't mean that therefore we're entitled to lie about what we do," Viccellio says. "The fact is, there are terrible problems with the system of litigation. But does that excuse us for being dishonest with our patients about errors that we make? To me, the answer is no."

Even mistakes that have no consequence are a "slippery slope," according to Viccellio. He gives the example of a patient who was in cardiac arrest for 30 minutes before they arrived in the ED. It's later discovered that the endotracheal tube placed in the ED, long after the patient had any chance of survival, was in the esophagus instead of in the airway, Whether there is a legitimate purpose in informing the family of such events, which had no chance of altering the outcome, is a matter of controversy. However, the situation is different for a child who was intubated with the endotracheal tube in the esophagus, received no oxygen for about 10 minutes, and is severely disabled, possibly as a result of the mistake.

"That's an example of something that the family might not ever know unless you told them," says Viccellio. "And if you do tell them, it does introduce the possibility of a $10 million payout. Still, how is it right not to tell them?" ■

Avoid a bungled apology: First, get all the facts

Are you about to apologize to your ED patient? Before you do so, be sure you have a thorough understanding of the facts.

"There is no substitute to knowing the difference between a true medical error and simply an undesired

outcome of reasonable care," according to **Richard C. Boothman**, JD, chief risk officer at the University of Michigan Health System (UMHS) in Ann Arbor. "We work hard to know the difference. Until we are reasonably sure we have gathered all relevant information and scrutinized it carefully, we do not advocate jumping to conclusions either way."

After UMHS adopted an "I'm sorry" policy in 2001, Boothman says malpractice claims against his health system fell from 121 in 2001 to 61 in 2006. The average time to process a claim fell from 20 months to eight months, and costs per claim are half as much.

Boothman says, however, that, "We do not advocate insincere or uninformed apologies. When we apologize, we are reasonably sure our staff acted unreasonably in the provision of medical care. We are prepared to compensate for the impact of any injury that flowed from that mistake."

In Boothman's opinion, no amount of training would prepare an ED physician involved in an unanticipated outcome to handle this situation alone. "Even the most emotionally intelligent caregiver is too involved personally to do this without help," he says.

In part, this is because few incidents turn out to be what they initially appear. It takes a careful and thorough investigation to understand what happened and why. "A badly handled disclosure is worse than no disclosure at all," says Boothman. "Our approach is to address the patient and family's medical needs first. We promise full disclosure, but only after we complete our investigation. This always entails listening to the patient and family, and promising that we will act in a principled, honest way."

If a true medical mistake was made, Boothman advocates disclosing it without excuses, but with an explanation. "It can actually be harmful to a patient to deliver an apology without providing context. The patient and family need to make sense of the mistake, so they understand that the caregiver never intended to hurt them," says Boothman. "We emphasize the difference between an excuse and an explanation."

If apologizing, be prepared to address the consequences of the mistake and what it will take to "make it right."

"If your health system is committed to a principled approach, the likelihood is very high that cases of true medical error lead to quick settlements and decreased risk of finding yourself uncomfortably in front of a jury," says Boothman.

According to **Peter Viccellio**, MD, FACEP, vice chairman of the Department of Emergency Medicine at the State University of New York at Stony Brook, "It's good for all of us as physicians, to sit down in a chair for a few hours and think through how we're going to deal with terrible things when they happen. Overall, it's just a lot easier to be honest than not to be."

Take these steps before apologizing to your ED patient:

- If your state has an "I'm sorry" law, have a full understanding of what it covers.
- Involve senior administrators for difficult cases.
- Learn what your insurance company would expect of you, before you find yourself in an acute crisis.
- Find out how an apology will affect your malpractice coverage. ■

ED uses test site before going live

(Editor's note: This is the second article in a two-part series. In the first article, we discussed the decision of the leaders of the EDs at Sacred Heart Medical Center in Eugene, OR, to begin posting their waiting times on the Internet. In this installment, we examine the process they used to make sure the system was running smoothly before they officially started.)

Before the two EDs of the Sacred Heart Medical Center began posting their wait times on their home page, a test web site was set up for the department so that the staff could become acclimated to it and leadership could be sure everything was working correctly.

"We worked out the bugs in the system," explains **Gary Young**, MD, the ED medical director. For example, he says, during some of the initial trials, wait times mistakenly showed up as 1,000 minutes.

"We have RFD [radiofrequency device] badges that patients wear so we know where they are and how long they've been there," Young says. "But if the electronic system is incorrectly getting the numbers, then what we post will not be accurate."

Joy Cresci, RN, assistant administrator of emergency

Sources

For more information on posting waiting times online, contact:

- **Joy Cresci**, RN, Assistant Administrator of Emergency and Critical Care; **Gary Young**, MD, ED Medical Director, Sacred Heart Medical Center, Eugene, OR. Phone: (541) 686-7300.

and critical care for Sacred Heart, says, "Our registration staff keeps the web site open, and if they see something that does not make sense, they go in and double-check on the patient. Usually what happened by mistake was that a badge was not discharged to a patient, but this hardly happens anymore."

Now that the site is up and running, the patient tracking system automatically uploads wait times every five minutes. "It would have been very different if we had to have the staff manually figure out the wait times and populate the site," notes Young, who adds that the Sacred Heart IT people had called the IT professionals at Scottsdale (AZ) Health System, which posts their wait times online, to find out how they tracked their own wait times.

Registration clerks trained

There was not much training required of the staff, except for the registration clerks, says Cresci. These clerks, who are situated in the lobby, had to learn how to monitor the web site to make sure there aren't any glitches, she says. For example, if a patient tracking badge is left in the lobby by mistake, it would continue to count as a patient. "For the rest of the staff, they just needed to know that they would be getting questions from the public," Cresci says. "Some people will still call and ask how long the wait is."

Even though wait times have gone down "dramatically," from 30 minutes to under 15 minutes, Cresci can't point to the wait time postings because many process improvement initiatives have been going on at the same time. Young says, "Psychologically, it may have had a small impact. Doctors and nurses know they're being measured and looked at by the public."

Cresci says that the charge nurses, who originally had objected to the program, "have been totally fine. They're glad we did it," says Cresci. ■

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity with the **March** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/CME objectives

1. **Apply** new information about various approaches to ED management.
2. **Discuss** how developments in the regulatory arena apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■

CNE/CME *questions*

25. According to AnnMarie Papa, MSN, RN, CEN, FAEN, president-elect of the Emergency Nurses Association, which of the following topics represent important core competencies for pediatric ED nursing care?
A. Airway management
B. Dehydration
C. Sepsis
D. All of the above

26. According to Julie Carrigan, RN, BSN, CEN, patient care coordinator in the ED at Catawba Valley Medical Center, how is she alerted when there is a radiological discrepancy?
A. She receives a call from the radiologist.
B. She is paged by the treating ED physician.
C. She performs a search on the Patient Archives and Communication System (PACS).
D. She is informed by the ED nurse manager.

27. According to Caral Edelberg, CPC, CCS-P, CHC, president of Edelberg Compliance Associates, hospitals may choose their own staffing configurations to provide services as long as several factors are also taken into account. Which of the following is *not* among them?
A. State and local laws

COMING IN FUTURE MONTHS

■ Are uninsured trauma patients more likely to die?

■ Patient referral program will link patients, community physicians

■ Nurse training in safe handling procedures reduces injuries

■ ED slashes waiting time from two hours to 30 minutes

B. ED policies and procedures
C. Hospital policies
D. Federal requirements

28. According to Joy Cresci, RN, assistant administrator of emergency and critical care for Sacred Heart Medical Center, only one group of staff members had to be specially trained in preparation for posting the ED's wait times online. Who were they?

A. The registration clerks
B. The triage nurses
C. The physician assistants
D. The nurse practitioners

29. According to George Mills, MBA, FASCHE, CEM, CHFM, CHSP, a senior engineer with The Joint Commission, how wide a path of egress is required in the ED?

A. Three feet
B. Four feet
C. Five feet
D. Six feet

30. According to Margaret VanAmringe, MPH, vice president of public policy and government relations, The Joint Commission, which of these factors should be examined when seeking opportunities to improve readmission rates?

A. Disease category
B. Population
C. Age
D. All of the above

CNE/CME answers

25. D; 26. C; 27. B; 28. A; 29. A; 30. D.

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

Compliance rates are low on egress, fire safety, says Joint Commission

For the first time in several years, The Joint Commission standards and goals with the lowest compliance rates are not directly related to the delivery of health care. In its annual listing of the standards or goals with the highest rates of noncompliance for the first six months of 2009, The Joint Commission listed the following:

- **Life Safety (LS) 02.01.20:** The hospital maintains the integrity of the means of egress, 45% noncompliant;
- **LS.02.01.10:** Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat, 43% noncompliant;
- **Record of Care, Treatment, and Services (RC) 02.03.07:** Qualified staff receive and record verbal orders, 40% noncompliant;
- **Environment of Care (EC) 02.03.05:** The hospital maintains fire safety equipment and fire safety building features, 38% noncompliant;
- **National Patient Safety Goal (NPSG) 02.03.01:** The hospital measures, assesses and, if needed, takes action to improve the timeliness of reporting and the timeliness of receipt of critical tests and critical results and values by the responsible licensed caregiver, 38% noncompliant.

Executive Summary

Egress and fire safety goals and standards are among those with the highest noncompliance rates, according to The Joint Commission.

- Recognize that egress exceptions that are made for the ED do not apply to other units in which you might wish to "board" patients.
- Designate a specific individual in your department to review fire safety standards and make sure the department is in compliance.
- Educate the staff on evacuation procedures, including what they must take with them.

With ED managers often playing a key role in disaster planning, and with EDs particularly susceptible to the spread of fires due to their design, observers agree these are important areas on which to focus. This focus is particularly needed for the standard on egress, because there might be some misunderstanding about what constitutes compliance. **(See the story about the importance of fire standards for ED managers on p. 2.)**

The egress standard is a double-edged sword for the ED, notes **George Mills**, MBA, FASCHE, CEM, CHFM, CHSP, a senior engineer with The Joint Commission. The good news is that most EDs are considered "suites" by The Joint Commission, he says. "As a suite, the egress corridor is considered an 'intervening room,' so the criteria we normally use for egress corridors do not apply," Mills says. "That's why in the ED, you can do patient care in what looks like a corridor." So, for example, if you walk through this intervening room, he explains, you might see several triage bays on one side, with sliding door for entry. "That is not compliant in a normal patient care unit, but in a suite, it's OK," says Mills.

The 8-foot-wide clearance requirement also does not apply, he says. "If you have a Pyxis machine or a food cart in that area, it's OK. The only thing we ask is a requirement to maintain a 3-foot path of egress, so you can always get out of the area from all the different rooms," says Mills. Normally in the ED, most of

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these things are kept to one side of the space to provide a path of egress, he says.

The other requirement is that there must be two "separate and remote" doors in and out of the suite. "Most EDs are shaped in a horseshoe, so the two ways to get out are separate and remote from each other," Mills says.

Where EDs can run afoul of the standard, he warns, is when they arrange to have patients boarded in hallways [in other departments] to manage patient flow. "It's not compliant to be treating patients in hallways, say, in the med/surg area, because you have corridor clutter," says Mills. "If you have a separate observation area, then that's egress to an intervening room, but if you push them out of the ED early and board your patients in the hallways [in other departments], you have to be aware that's a violation."

The only exception is in an emergency situation, says **Kathy John**, MSA, ARN, CHSP, CHEP, chairwoman of the Atlanta Metropolitan Medical Response Healthcare Section. "If they activate their surge capacity plan, it's just like converting other spaces such as outpatient spaces, auditoriums, and conference rooms to short-term usage for surge capacity," John says.

Mills concurs. "If there is a surge situation, you have no options," he says. "If you have to board patients upstairs as part of surge response, that's acceptable."

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Mills concurs. "If there is a surge situation, you have no options," he says. "If you have to board patients upstairs as part of surge response, that's acceptable."

Some EDs aren't 'caught'

If boarding patients in other departments is a violation of Joint Commission standards, why are so many EDs doing it?

"They get around it because they haven't been caught," says **Mike McEvoy**, PhD, REMT-P, RN, CCRN, EMS coordinator, Saratoga County, NY.

"Here's the problem: What The Joint Commission is telling you is that there are two different standards, and they do not treat the ED as a 'floor,' but it's important for ED directors to know that what's perfectly acceptable for them is *not* acceptable when a person goes to a floor," McEvoy says.

It's quite natural for ED managers to reason that if it's OK to do it in their department, it must be OK to do it upstairs in another department, he says. "Unfortunately, they don't think of the ED as being any different from the rest of the hospital, but if a Joint Commission person tells you it is, then, oh yeah — it is!" McEvoy says.

Probably the most important consideration when you think about egress and evacuation is that typically you evacuate "at the wall," he says. "So, keep in mind when you think about emergency planning to remove the curtains from your 'picture' of your department and use the walls as borders beyond which you have to move everybody," McEvoy advises. ■

Fire standards are key for EDs

The fire safety standards set forth by The Joint Commission, which have low compliance rates, should receive special attention from ED managers. Observers note that the ED is a frequent site for unexpected fires, especially when set by patients. In addition, smoke moves quickly through an ED because of the open architecture, and many of the patients are very sensitive to smoke, so it is not tolerated well.

"That's an accurate statement," says **George Mills**, MBA, FASCHE, CEM, CHFM, CHSP, a senior engineer with The Joint Commission. "There is much less 'compartmentation' in the suite-like ED. If there is a fire in a room with four walls, it will be contained." If patient rooms are not defined, you lose the ability to compartmentalize, he says.

Given this added danger, what are the responsibilities of the ED manager? **Mike McEvoy**, PhD, REMT-P, RN, CCRN, EMS coordinator in Saratoga County, NY, says, "I would say two things are important to do: One, have someone in the ED who is responsible for surveying these sorts of compliance issues — what are the standards, are the fire extinguishers where they need to be, are exits blocked?" This individual should check these items on a routine basis, he adds.

"The second thing, which is really hard to do — but very important — is to periodically conduct a drill where you actually practice evacuation and move large

numbers of patients," he says. McEvoy recognizes this practice is difficult to do with live patients, but says all EDs have quiet times when there are opportunities to practice moving simulated patients with ventilators and multiple IVs. "When you do that, you gain comprehensive appreciation for what would happen," he says.

Even the ICU had a drill

For ED managers who question the practicality of doing this type of drill, McEvoy has the following response: "We even did it in an ICU. We evacuated an entire portion onto another floor just to see if we had the equipment and supplies available to do that."

Kathy John, MSA, ARN, CHSP, CHEP, chairwoman of the Atlanta Metropolitan Medical Response Healthcare Section, says, "You may be able to reduce supplies in the hallways if there are too many, so there's less in the way if you need to quickly evacuate." In addition, she notes, "It's a requirement that the fire extinguishers be checked monthly and annually, so the ED manager needs to be aware of the location and who is responsible to test the equipment according to the [standards of the] National Fire Protection Agency."

The ED manager "needs to know and understand what the requirement is and who is responsible for it," John says. "They also need to understand the storage requirements around sprinkler heads. For example, they must make sure not to store anything too close to the sprinkler heads, because it makes them less effective."

Finally, she says, the manager needs to educate staff about the hospital fire plan as well as the evacuation plan: meeting places inside or outside the department in case of a fire; who turns off the medical gases; what to bring with them in case of evacuation (i.e., charts, medications); and how to do it. "I'm big on the team approach and everybody knowing their role, such as taking a head count when everyone gets outside, because the fire department will need to know if everyone got out," John says. ■

Executive Summary

With The Joint Commission making 30-day readmission rates public for heart attack, heart failure, and pneumonia Medicare patients, and with the possibility that health care reform legislation will add penalties for high readmission rates, the pressure has increased for improved performance in these areas.

- Review your readmission data to uncover opportunities for improvement.
- Put a case manager in the ED, to optimize the discharge planning process.
- Look to your observation or clinical decision unit as sources of important data.

Quality Check measures added by Joint Commission

As of January 2010, The Joint Commission has incorporated into its Quality Check web site (www.qualitycheck.org/consumer/searchQCR.aspx) the Centers for Medicare & Medicaid Services' (CMS') 30-day readmission rates for heart attack, heart failure, and pneumonia Medicare patients.

Quality Check displays data on National Quality Improvement Goals for hospitals on selected performance measures in six treatment areas: children's asthma care, heart attack, heart failure, pneumonia, pregnancy, surgical care, and pregnancy. The ED's performance in all of these areas becomes part of the hospital's data submission to Quality Check. That information then can be accessed by consumers as part of their search for hospital care.

Bruce S. Auerbach, MD, FACEP, vice president and chief, emergency and ambulatory services at Sturdy Memorial Hospital in Attleboro, MA, says, "Once a person has been admitted to the hospital, the ED really has no further involvement in what goes on while in they're in the hospital or upon discharge." However, he notes, "Some EDs have instituted programs that process or provide more care in the ED or through which patients are overseen in adjacent areas — like observation or clinical decision units — as a means to manage those individuals they think they can take care of within a 24-hour-period and not admit them." These patients, he continues, will be discharged from the ED or the other units, in which case the ED staff that oversee that unit will provide discharge instructions, he says.

In addition, he notes, some institutions will put case managers in the ED. "Because they have so much to do with discharge planning, they will use them in the ED even for patients who are being admitted since they can start work early on discharge planning so that when they're discharged there are no obstacles in the way of going home," Auerbach explains. **(For more information, see the story on p. 4.)**

Margaret VanAmringe, vice president of public

policy and government relations in the Washington, DC, office of The Joint Commission, says that in addition to accreditation status and performance data, the Quality Check site also indicates "merit badges" for organizations that meet certain criteria for recognition, such as the Malcolm Baldrige National Quality Award. That annual award recognizes U.S. organizations in the health care, business, education, and nonprofit sectors for performance excellence.

Why were these particular measures added? "We're trying to follow what is going on at the Hospital Compare web site [www.hospitalcompare.hhs.gov] so that people who got to ours do not have to go to another site just to get a couple of measures that are part our core measures set," VanAmringe explains. "We really had to be careful about these three because they are *only* for Medicare patients, while all the others are for all adult patients." That presents the need to identify for consumers that the cohort is narrower, and that by and large it only represents the elderly, she says.

The need to show "good" numbers in these areas has taken on increased importance with the emphasis placed by national organizations on limiting preventable readmissions. The need for positive numbers might increase soon, warns VanAmringe. "Everybody right now, from a public policy and quality and safety standpoint, is looking at preventable readmissions, and if Congress passes a health care reform bill and it has a penalty for high readmission rates, then it becomes a monetary incentive as a quality and safety issue," she notes. ■

Data hold the key to low readmit rates

With The Joint Commission incorporating the Centers for Medicare & Medicaid Services' (CMS) 30-day readmission rates for heart attack, heart failure, and pneumonia Medicare patients into its Quality Check web site (www.qualitycheck.org/consumer/searchQCR.aspx), the performance of individual facilities will come under greater scrutiny. Additionally, health care reform legislation might include penalties for poor performance.

As a first step toward decreasing readmission rates, examine your data, says **Margaret VanAmringe**, MPH, vice president of public policy and government relations in the Washington, DC, office of The Joint Commission. "Look at readmissions and discern whether there are opportunities to reduce the number," she advises. "That will, of course, depend on disease category, population, age, and many different factors."

It will behoove you "to really analyze readmissions, assess these data, use a random sample of charts, and look to see if there is a certain group of patients in these three areas where you feel there could be the potential to prevent readmissions," VanAmringe says.

Michael C. Choo, MD, MBA, FACEP, FAAEM, ACHE, president and CEO of Clinton Memorial Hospital in Wilmington, OH, says, "It's always been very important to evaluate the data on a monthly basis and find solutions." Choo, who served for 10 years as the ED medical director at Dayton Heart Hospital, is bringing what he learned there to his new position. "Congestive heart failure is the most difficult of the three because it's especially problematic in [the Medicare] population," he says. "Initiatives we've used include trying to identify at the time of discharge those patients who need extra support at home or additional education." For those patients who are identified as high-risk, arrangements are made for intense home health care followed by outpatient therapy sessions, he says. His current health system has Congestive Heart Failure clinics, where patients' status is monitored to make sure they stay stable and don't return to the ED or the hospital, he says.

Myocardial infarctions and pneumonia are much easier, he says. "At the time of discharge, we make sure to assess the risk for return, such as home situation compliance probabilities, and communicate those risks with the primary care physician," Choo says. If the patient qualifies, he adds, home health care is recommended.

In the end, says Choo, "it comes down to how well you work with case managers. They identify the risks and coordinate discharge planning, education, and follow-up so the condition does not exacerbate." He has become "much more aggressively proactive in managing these issues," and, in fact, has begun placing case managers within the ED. **(For additional information on case managers in the ED, see "Preparation pays off for EDs in DC as millions visit for inauguration," *ED Management*, March 2009, p. 25, and "Emergency department managers warned of 'catastrophic' crowding due to elderly, *EDM,* February 2008, p. 13.)**

With sites such as Quality Check and hospitalcompare, VanAmringe adds, there also is a definite opportunity for benchmarking and for contacting facilities that are performing well and comparing notes. "Health care providers are very interested in comparing how they're doing, and what percentile they're in, compared either with similar facilities or those, say, in the same state," she says. "Being able to benchmark and compare is a very important aspect of quality improvement." ■