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Fall prevention takes 'constant attention,' comprehensive interventions

Hospital keeps fall rate low with continuous reinforcement

Preventing patient falls is a constant struggle for hospitals. And as Medicare has cut reimbursement for falls as a "never event" and patients are getting increasingly older and sicker, it will continue to be a challenge. According to Joint Commission statistics, in 2008 patient falls ranked as the fifth highest sentinel event; reported falls have become increasingly more frequent since 2000, when The Joint Commission first labeled them as sentinel events.

Falls represent not only a significant cost to hospitals, but a greater length of stay for patients. In a 2009 study, "Medicare nonpayment, hospital falls, and unintended consequences," the authors write: Falls are "high-cost and high-volume, and they result in the assignment of a case to a higher-paying DRG. Some 3 to 20% of inpatients fall at least once during their hospital stay; these falls result in injuries, increased lengths of stay, malpractice lawsuits, and more than $4,000 in excess charges per hospitalization."[1]

Sentara Healthcare began working on its fall prevention program in 2000, when it added falls as a quality indicator on its executive quality report. It began its initiative by reviewing the literature available at the time and selecting a fall risk assessment scale, the Conley scale, published in *MedSurg Nursing* in 1999.[2] **Stephanie S. Jackson**, DNP(c), RN, ACNS-BC, manager, patient care services, education department, diabetes program & enterostomal therapy services at Sentara Norfolk General Hospital, says the system also participated in a number of collaboratives. In a collaborative with the Institute for Healthcare Improvement, the system became one of the top 10% national performers in the area of falls with injuries in 2006.

"I can tell you that falls is certainly something that takes constant attention. When you take your eyes off of it for a little while, it begins to slip. We're always looking at our program to see what can we do different. What can we enhance? What have we done in the past that maybe we're not doing now?" Jackson says.

The hospital's comprehensive program has seen success over the years. In 2009, Sentara Norfolk General Hospital had 0.12 overall serious injuries per 1,000 patient days. The overall system rate is 0.10.

Besides the risk assessment procedure, Sentara's fall prevention program also includes what it calls "job aids," designed to help nurses, with

interventions for "all the patients who come into our hospital" as well as high-risk and special patient populations, Jackson says.

Universal, patient-specific interventions

The risk assessment is completed for every patient every 12 hours. The hospital also has what it calls universal fall prevention interventions that can be used for every patient:

- having a call bell that the patient can easily reach;
- putting beds in low positions;
- using appropriate lighting in patient rooms;
- offering nonslip footwear;
- arranging furniture for safe patient access.

Then there are patient-specific precautions. Perhaps a patient has already fallen. Should that patient be moved closer to the nursing station so he or she is more visible? Does the patient need an assistive device or a consult with a physical therapist? Does the patient need a bedside commode? In some cases, the hospital places what it calls safety partners, or sitters, in rooms to monitor the patient's risks. Or a pharmacology review is done with a pharmacist if the patient is on a combination of high-risk medications, is overly sedated, or is new to narcotics.

If a patient is known to be at risk for a fall or injury, a low bed can be ordered from the equipment room with a floor mat. Jackson says it's important to make sure the hospital is always equipped with things you may need for patients. For instance, "a few patients have required helmets. And we stock those on our rehab unit." If a patient is on an anticoagulant or had some sort of surgery where a part of the skull was removed "and we think they're at risk for falls, we have a helmet we can put on them," she says.

Interventions for high-risk patients

In 2006, the focus shifted to patients at high risk for harm, Jackson says. Sentara uses the Institute for Healthcare Improvement's ABCs High Risk To Harm assessment tool to identify those patients. For that population, five interventions are in place, and staff are expected to follow these if a patient rates as high risk based on the Conley scale.

• Identify high-risk patients with a colored armband.

Each high-risk patient is identified with a pink armband. And all staff — from environmental services to catering — are educated on what the armband signals. The armband is used, Jackson says, because it identifies the patient throughout the hospital stay. A pink sign also is placed outside the patient's room with a symbol of a patient falling. The hospital now is looking at changing that to align with the national and statewide

Continued on page 28

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Fall Risk Assessment Procedure

Purpose: To prevent patient falls/falls with injury through appropriate assessment of fall risk and implementation of appropriate fall/injury prevention interventions.
Definitions: Fall — An unplanned descent to the floor.
Performed By: Registered Nurse or Licensed Practical Nurse
Procedure:

Required Action Steps	Supplemental Guidance
NOTE: All medical record documentation shall be completed on the patient care flowsheet, nursing notes, and/or in the Electronic Computer Documentation System according to unit-specific documentation procedures.	
Fall Risk Assessment & Prevention Interventions	
1. Assess and determine a fall risk score for each new patient admitted or transferred to the unit using the Conley Fall Risk Assessment Scale.	• The Conley Fall Risk Assessment Scale is found in the Electronic Computer Documentation System or on the nursing flowsheet. • See Conley Scale Job Aid. • Fall Prevention Patient Care Protocol/Intervention may also be implemented based on nursing judgment including risk associated with medication regimen.
2. Document the fall risk score and indicate the fall risk criteria in the medical record.	
3. Review "Fall Prevention Tips" with the patient, family, and/or significant other.	
4. Instruct all patients — regardless of fall risk — on universal fall prevention interventions.	• Universal fall prevention interventions are found on the "Fall Prevention Interventions" job aid.
5. Implement Fall Prevention Patient Care Protocol or Fall Prevention Template for patients who have a Fall Risk Score of 2 or higher.	• High-risk fall interventions are found on the "Fall Prevention Interventions" job aid.
6. Implement any additional patient-specific interventions deemed necessary to prevent a fall, based on the patient's fall risk score, condition, or mental status.	• Patient-specific interventions for consideration are found on the Fall Prevention Interventions job aid.
7. Document all interventions considered and implemented in the medical record.	• Educate the patient and family regarding the fall prevention program.
8. Reassess the patient twice daily or as the patient's condition changes. Monitor for changes in fall risk status and appropriateness of fall prevention interventions.	
9. Document reassessment findings in medical record.	
10. Practice clear communications and effective handoffs of fall risk status and precautions during shift reports and transfer between departments and/or procedural areas.	
Responding to a Patient Fall CAUTION: Respond immediately to any patient injury sustained in the fall by contacting the patient's physician and proceeding with diagnostic orders or treatments.	
11. Document the patient's post-fall vitals signs, injuries, education, and fall interventions implemented.	• Refer to Post Fall Algorithm Job Aid for instructions and expectations about fall documentation.
12. Notify the nursing supervisor (or designee) and the patient's physician and family of the fall and document all notifications.	
13. Document the patient vital signs and neurological status within one hour after the fall.	• Reassessment should occur sooner than one hour if the patient experienced a change in vital signs, pain, or neurological status as a result of the fall. • In the Electronic Computer Documentation System, document any changes in the patient's fall risk assessment criteria as a focus note.
14. Complete a Sentara Tracking and Reporting System (STARS) report.	
NOTE:The Sentara Tracking and Reporting System (STARS) report is not a part of the medical record and should not be referenced in medical record documentation.	
15. Check to ensure that all necessary fall documentation was entered into the medical record.	<u>Required Medical Record Fall Documentation</u> • Immediate post fall assessment documentation • Documentation of notifications made after fall • 1-hour post-fall reassessment documentation
16. Send the STARS report along with a copy of the documentation, if appropriate, to risk management.	

Continued from page 26

color of yellow.

• EMR system also identifies patients at high risk.

"There is a precaution in the documentation system that travels with the patient," Jackson says. For instance, if the patient is scheduled for an X-ray, the radiology department will get a transmittal prior to the procedure alerting clinicians there that they are getting an at-risk patient; they know they can't leave the patient unattended and extra caution needs to be used getting the patient on and off the table.

• Beds are equipped with alarm devices.

Beds are outfitted with alarm devices. When patients are in the ED on a stretcher for an extended amount of time, a portable alarm device is used.

"We know that alarms don't prevent falls, but we know that if a patient were to fall that that alarm would be an indication to us and we could get to the patient right away. And technology has improved a lot with alarms over time so they do send off a lot more quickly than they did say five or 10 years ago. So we're having a lot of success with those as well," she says.

• Toileting schedules are prepared.

A major risk for patient falls is when the patient goes to and from the bathroom, Jackson says, pointing to literature and what she's seen at the hospital. Patients have unique toileting schedules per unit. For example, in the rehab unit, it may be every two hours. The surgical unit may use an every four hour schedule. Nursing assistants round on the patients and take patients to the bathroom vs. asking them if they need to go. "It's more of an encouragement," Jackson says, and it's been quite successful.

• Beware the three Ps — pain, potty, and position.

"We try to focus on that type of rounding, especially in some of our units. We have an orthopedic trauma neuro unit that had a lot of falls in the past... we've encouraged a lot of rounding, frequent rounding on that unit. And that's really helped with that population," Jackson says.

One of the biggest challenges, Jackson says, was encouraging awareness among staff — "from the person who waxes the floor who sees that a patient with a pink armband is trying to get out of bed unassisted and they can request the nurse, all the way through to our physicians. And so we have the full gamut, the full spectrum of our employees is involved. That overcomes a big hurdle."

Each of the eight hospitals in the system has its own fall prevention task force in addition to a systemwide group. Representatives from the task forces come together for a monthly phone call in which they discuss interventions that are and are not working.

"The other thing that has been so important for us is our administrative support. Really keeping them in the loop. We have a quality department that tracks our data for us monthly," Jackson says.

But she prefers using a weekly report, so the data are more up to date. "If you're six weeks downstream, you can't huddle with your staff on your unit and say we've got to do something different. That's 10 falls ago. But if you know, 'Oh my gosh, we had a fall every day on our unit last week. We really have to buckle down. We've got to have some more frequent rounding.'"

Every Monday morning, all the inpatient nurse managers, the clinical nurse specialists, the nursing directors, the nurse executive, and the vice president of medical affairs get this report. The report is unit-specific, with goals for each.

"So if your unit goal was to have only two falls with injury for the year and you've already had one, then you know your staff have to be really focused on that. And tied to those goals is a performance plus incentive program that all the staff participate in. So that works really well to keep it in the forefront," she says.

She also receives all of the incident reports. "So if I see anything in those that I have a question about, I have a really quick timely follow up with the manager. So if it happens today, I get the report around midnight and so tomorrow morning first thing I'll do is follow up on all those, and if I need to follow up with any of the managers I'll do that if I have any questions or if I think something may have been coded wrong or it's just not clear."

Another important element is timeliness of intervention if a fall does occur. Patient care supervisors are available 24/7 and function as leaders. They are called if a patient has fallen and immediately respond. They complete a "mini-debriefing," which goes out to all leadership to let them know a fall has happened.

Jackson tries to round weekly with staff to ask questions such as: What are the barriers? What don't you have available for fall prevention? Someone may answer with a very specific need. For example, one nurse said she needs activity aprons, which are not regularly stocked on her unit.

A physical environment assessment of all

patient rooms is done annually. "All the beds are built in with night lights under the beds, but sometimes they go out and the staff might not know the correct mechanism for reporting that. So we help with that. We look at all the IV poles and do they still roll well? Do they need to be lubed, or do they need to go out of service? So things like that; and when we do that, we always send staff from a different unit so that you have some really objective eyes looking at the physical environment," she says.

Falls are categorized at Sentara as no harm, minimal, moderate, major, and death. "So we track moderate harm and above," she says.

Jackson reports actual numbers rather than fall rates to staff, as they seem to understand those better. So in 2009, Sentara Norfolk General Hospital had 0.12 overall serious injuries per 1,000 patient days. She would explain that to staff as the hospital has 12 falls for every 100,000 patient days. "We had some hospitals that were as low as three falls for every 100,000 patient days. So definitely some admirable statistics," she says.

"What we find is we need constant reinforcement back to those interventions that will prevent patients from falling," she says.

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Reference

1. Inouye SK, Brown CJ, Tinetti ME. Medicare Nonpayment, Hospital Falls, and Unintended Consequences *NEJM*. 2009 Jun 4;360(23):2390-3.
2. Conley D, Schultz AA, Selvin R. The challenge of predicting patients at risk for falling: development of the Conley Scale *Medsurg Nurs*. 1999 Dec;8(6):348-54. ■

Standardizing withdrawal of life support

How a QI process can help patients cope

When a dedicated nurse and a quality improvement consultant come together, beautiful things can happen. It starts with an idea, a problem that begs for a solution, and then the work on finding the answers begins.

Lindsey Robertson, BSN, RN, is a staff nurse who has worked in the surgical intensive care unit at Vanderbilt University Hospital for eight years. She saw that oftentimes the decision to withdraw mechanical ventilation had been made and once everything is turned off, the patient typically dies within five minutes. "In some cases, the ventilator, certain drips, and countless other machines are the only reason they have not died," she says.

The shift from curative measures to compassionate ones, she notes, is a difficult thing for clinicians to deal with. She also noticed there were no real models or standardized processes for patients who are taken off support and die less than 24 hours later. By creating guidelines, she thought she could make the process easier for the clinical team, including physicians and nurses, and in turn help interns, residents, and new nurses who may be experiencing their first patient death. She also wanted a team approach for all the disciplines involved.

Robertson engaged the help of **Barbara Gray**, BSN, RN, quality consultant, to create an improved standardized system and to help guide it through the various committees it would have to pass muster with before becoming a unit-based hospital policy.

Gray says initially they looked at guidance from the American Association of Critical Care Nurses and the Robert Wood Johnson Foundation. But a lot of what they found was more about palliative or long-term care. "In our work, it's just more about, 'OK, once the decision is made, how do we do this? What do we do?'" she says.

One option that was suggested to help increase ICU bed availability was moving patients upstairs to complete the dying process, once the decision to withdraw was made. However, Robertson says, "My concern with moving the patient is that the family has developed rapport with the nurse in the ICU and with the ICU medical team, and if you send them upstairs to a new nurse and a different medical team, they will lose that compassionate continuity. Also, the majority of our withdrawals happen quickly, and most patients die within a 30-minute period of turning everything off.

"My preference is to educate the nurses in our ICU to deal with these situations and keep it in-house where we can deal with it compassionately, with a family who knows us and has been deal-

ing with us," she says.

Once a patient and his or her family decides to withdraw support, the physician initiates the comfort care order set and nurses print the guidelines for withdrawal of life support as a reference. Robertson says the discussion between the nurse and the patient and family involves a lot of questions, and because it's a stressful time, nurses can get overwhelmed or forget the myriad details. The guidelines serve as reminders of all the questions that need to be touched on, including:

- Does the family want a pastor or religious leader there?
- Would additional family members like to be there?
- Would the family like to be present when the patient passes, and would they like to see the patient after he or she expires and is cleaned?
- What the family should expect as far as physical changes as the patient dies.

"We have things like that outlined so that a nurse can follow the process and make sure that everything is covered for the comfort of the family and patient so that things will go as smoothly as possible. There's no such thing as a good death. But it can be without conflict and be a peaceful memory," she says.

The guidelines include every member of the team who needs to be present and prompts to ensure everything that is needed, such as drugs, is in the room.

"We can even turn off the monitor alarms and turn off the monitor screen in the room to remove the stress of watching a dying heart. Some of our patients are in isolation, which means the family members are wearing gloves and gowns in the room. The guidelines remind the nurse to tell the family to remove their gloves, lower the bedrails, and touch their family member. These are simple things that can be forgotten that need to be implemented," Robertson says.

Robertson and Gray also revised an existing order set to assist in the management of sedation and ventilation. The guidelines are part of the surgical critical care manual, so physicians have become familiar with them. New residents are introduced to the guidelines when they arrive each month. And every six months, Robertson sends out a staffwide email to remind people that the guidelines are available and where they are located electronically.

Providing a comfortable space for family is at the helm of the initiative, which includes reminders that:

- privacy is provided;
- patients are monitored for pain or discomfort;
- liberalized visitation;
- ensuring the family is comfortable — that chairs are provided, gloves are removed, and the bedrails are lowered;
- all unnecessary equipment is removed;
- doors are closed to keep the room as quiet as possible;
- the cardiac monitor is turned off.

Robertson and Gray say they have received positive feedback from both families and the clinical team including the nurses, respiratory therapists, residents, fellows, and attending physicians.

The guidelines that were developed "give everybody kind of a sigh of relief if you will. 'OK, there's a process for doing this. We don't have to create something. If we don't know what to do, here it is written down for us.' And so that's really helped a lot," Gray says.

She says the support from each committee the guidelines passed through was there. "But [leadership has] so many irons in the fire so many times it takes someone with a real special interest to just kind of keep nudging or pushing forward," like Robertson, she says. ■

Applying reliability to improve infection rates

CCHMC reduces VAP rates

When staff at the Cincinnati Children's Hospital Medical Center (CCHMC) began working on reducing ventilator-associated pneumonia rates, they armed themselves with more than a bundle. The work was informed by the theory of high reliability — how to make progress and how to sustain improvements.

Uma Kotagal, MBBS, MS, senior vice president for quality and transformation at CCHMC, says they came across a framework that the Institute for Healthcare Improvement (IHI) discussed as part of its Pursuing Perfection initiative. The framework was developed by University of Michigan researchers Karl E. Weick and Kathleen M. Sutcliffe, who

had studied other highly reliable industries such as aviation and recorded the characteristics therein. The IHI recognized that this framework could be applied to the health care industry, Kotagal says, "and we found it to be extremely useful to getting great results."

"If you want 99% reliability in a process, then training and reminders won't get you there," Kotagal says. "You'd have to use checklists, force functions, and default functions, etc. So that learning really helped us a lot to think about how do we get ourselves to a place of very high performance.

"When we started to work on the ventilator pneumonia bundle, we worked on understanding those concepts and designing our interventions — for example, using the every-four-hour nursing and respiratory huddle to check on whether we applied all components of the ventilator bundle and hard wiring some of our safety indicators into routine nursing documentation, as well as using alerts to remind us about important components. Those kinds of tools that we used allowed us to get to very high levels of performance on the processes that we were interested in," she says.

They began by adopting the IHI bundle for ventilator-associated pneumonia (VAP) prevention. Of course, that was developed for adult patients. So Kotagal says CCHMC had to modify some of it for its specific patient population. "For example in the NICU, the kids that are on radiant warmers or on incubators couldn't have the head of the bed elevated to the same level. Or some of the medications were not appropriate for prescribing a newborn," she says.

The team researched evidence-based synthesis, systematic reviews, and expert consensus to adapt the bundle to the pediatric world. The program began as an internal collaboration between the hospital's three ICUs — the pediatric ICU, the neonatal ICU, and the cardiac ICU. Each team tested the intervention and came together as a group to learn from each other's experiences. "So what could be learned at one place could be accepted by the other. And that moved us much faster," she says.

Double checking

Kotagal says a number of interventions were implemented to ensure that the bundle was being followed.

Frequent huddles are now a part of everyday work for the hospital's nurses and respiratory therapists. Often, they meet every four hours but might meet more frequently. And the purpose is to crosscheck the use of the bundled components. They verify that the position of the head of the bed is correct or that a mouth cleaning was performed. "When we first started to do the improvement, we did use these naturally occurring huddles to create force functions that allowed us to be sure that things were going well," she says.

Another built-in check, she says, for respiratory therapists and nurses is that a set of six prepackaged mouth kits is located above each patient's bed to ensure that the kits are being used.

"At the beginning we had a checklist and a separate sheet for documenting all of this. Now we've gone through a fairly extensive sustainability checklist or a control plan and so all of the components of the bundle are incorporated into daily work. It's part of people's evaluation. We also have a mechanism for alerting us if something is out of the ordinary. Statistical signals allow us to pick up something if there's a problem," she says.

"For example, if we run out of a particular kind of tubing because the company stopped making that tubing, then we have a process to notify us that the tubing has changed. So right now it's all part of our work. It's been a couple of years since we hard-wired the changes, and we've sustained very low VAP rates for a very long period of time." Their target this year is to reach 0.5 infections per 1,000 ventilator days. So constant reinforcement and preoccupation with failure, a key characteristic of the high reliability model, have enabled the hospital to anticipate and prevent infections as part of everyday practice, Kotagal says.

Now when an infection occurs, Kotagal says, an abbreviated root-cause analysis is completed. "So now if we have a signal that something is different, we're trying to find out what the cause is. So it's generally not due to deterioration of processes but rather an aberrant cause." Last year they established that a problem occurred with patients being transported off the floor. In one case, the problem was due to running out of the correct ventilator tubing. "So every time we learn something, we put a new process in place to address that," she says.

She references Atul Gawande's new book, "The Checklist Manifesto." "I think that the idea

that you get down to sufficient level of detail, that you're not relying on memory, is important. And that is a step up from fuzzy [messages such as], 'Consider treating the patient' or 'You might want to consider this if a patient exhibits these findings,'" she says.

Improvement eliminates the reliance on memory alone. For example, Kotagal explains, clinicians are expected to give antibiotics prior to incision based on evidence. If that doesn't happen, there should be a particular reason, such as the patient is crashing or the patient was already on antibiotics and the surgeon decided not to give an additional dose.

Multiple teams track and report daily and weekly failures. Kotagal says because they are working now at a high reliability rate with the bundles, they can isolate and analyze daily failures. "So we could say today in the ICU a kid didn't get his head elevated and let's figure out what the problem is. And maybe it is that the incubator bed only goes that high or maybe somebody ordered the wrong bed for this patient, not realizing they would be on a ventilator. Always legitimate reasons. And if you're honest and willing to tackle those legitimate reasons without individual blame, then everybody is part of the process solution."

If the team finds a case in which a child wasn't given antibiotics prior to incision, they can go to that particular surgeon and say, "Our records show the patient wasn't given antibiotics. Why was that?" And he or she might say, "We elected not to give antibiotics because the patient already was on antibiotics and I didn't want to give an additional dose."

"By looking at daily failures and sorting them out, we find that we can get to much higher levels of performance, both because the individuals can remember the case and so it builds accountability. And because they can identify problems that we didn't think about that improve our process," she says.

The concept of high reliability also looks at anticipating failures so you can work to solve them beforehand. Kotagal says the hospital is working to apply the high reliability concepts at an organization-wide level through systematic escalation processes, huddles, algorithmic predictions of patient deterioration, analyzing daily failures, and mitigating those failures to reduce harm. ■

Engaging your board is a must: Here's how

You know just how complex your job is. How can you get your board on board with quality and not overwhelm them?

Susan L. Cresswell, MHA, CPHQ, director, quality resources at Providence Medford Medical Center in Medford, OR, says she gives her a board a foundation. When new members come on board, she has an orientation for them in which she explains the various regulatory agencies and public reporting data sources. They might not understand, for instance, why the hospital is paying The Joint Commission for accreditation.

"We kind of give them the historical background so that they understand why we're using The Joint Commission and how that relates to our local state department of health and that they come in for surveys as well as for patient complaints," she says.

She also shows them where publicly reported data are shown. "I think the show and tell is really important. If they don't see it, they don't realize the impact of it actually being out there on the web," she says.

Then, once the board has that foundation, she tries to keep their reports at a higher level and classifies things as green, yellow, or red. So if the hospital is working on hand hygiene, green signifies that the hospital may not be at a 100% but there is an action plan in place, no barriers have been identified, and the initiative is pro-

gressing or the standard is being met. Yellow signifies that there is a problem and the QI team may have had to go back to the drawing board and rework its action plan. Red signals there are issues or barriers that have not been addressed yet.

She says the board is a community board that doesn't have much fiscal responsibility, so one of its main charges is quality. She sits on the board as a quality director and runs a monthly report. In that, she provides the national benchmark for the measure at hand and then the hospital's performance. "I think giving them the benchmark instead of just a target is very important because then they can relate our organization to other organizations, and once again, the more that they can put things into a more regional or national perspective, the more engaged they become," she says.

She doesn't include everything but focuses on the QI priorities. "We try to keep it focused on what our priorities are. We always keep them updated on grievances because. . . Medicare states, particularly in the Conditions of Participation, that the board has to have a role in that."

The board has delegated the responsibility to the quality improvement committee, which in turn produces a report that looks at the timeliness of response to grievances and how many grievances have been received within the median time rather than the average. "We produce the report for them that looks at timeliness of response to grievances and how many did we get within the median time. We look at the median time rather than the average because if you have one complaint that for some reason has a real long time frame to resolve and may go outside policy range etc., that one may skew the average. We tend to look at the median time to response and see if that's within the time frame that's required in our policy."

She also informs them about core measure performance. She tries to keep the level of data high. For instance, if she were reporting on throughput, she wouldn't include time frames such as from time of admit to time into the ED. "We're going to look at the total turnaround time," she says.

Avoid using acronyms

"I would say that I think the most critical thing in engaging your board is communication and it's an ability to take the scientific and put it into a layperson's language," she says. One thing she knows confuses her board is acronyms such as DRGs, AMIs, CoPs.

"Part of their orientation is we give them an Excel spreadsheet that's got over 300 acronyms that are commonly used in health care. They get a big laugh out of that. But whatever report we give them, we always make sure we give them the full name and then we'll put the acronym in parentheses so we can use it to refer to in the discussion," she says.

Kathy Helak, RN, MSN, administrator, clinical performance support at Henry Ford Wyandotte Hospital, finds that acronyms frustrate and confuse her board as well. "The first thing you have to do is be disciplined enough to get rid of the acronyms, get rid of the abbreviations, and put the information that you're sharing in terminology that others will understand. I think that's difficult oftentimes for the medical staff to do with the board, and so I think it becomes really critical that the people in my type of position who are actually providing the information and oftentimes generating the presentation for people to respond to. That's something you have to be very cognizant of."

The second most important thing, Helak says, is to "be very clear on whatever you're talking to the board, what is it in it for them, and what you expect them to do with the information. And sometimes it's informational and sometimes it's decision making that you need. So I try to go with some guidance from the board of trustees quality committee chair. What is it that they feel is important to report up to the full board? So that's always one thing I look at."

She also looks at what her CEO feels is important for the board to know, "especially if it relates to anything from a regulatory or governmental perspective. For example, things that are going on with the hospital's accreditation. It's coming up, they're here, here were the deficiencies, here's our action plan. So that's always something that's important."

A sentinel event signals the need for "an automatic report, and so we work together and complete our root-cause analysis and so forth in a timely manner so we can report that up. But that's another absolute that if that occurs, we report that."

Cresswell tries to give the board a synopsis in lay language of whatever issue is on the table. "They don't remember necessarily from month to month. So if we're looking at the AMI readmission rate we'll have a little paragraph that says

we're looking at readmissions for patients who suffered a heart attack. We want to know if we gave them the appropriate discharge instructions, etc. So [the report tells them] here's what the issue is and here's why it's important to us in lay terms. And then that frames up for them the whole report about that particular item," she says.

One of the board members sits on the quality improvement committee and becomes a part of the discussion of prioritization of tasks. So that individual can speak up at the board meeting. "I come to the board with the report and I give the report but then that individual can chime in to say, 'Yes, that was a very lively discussion and here's my perspective on why the hospital chose this' or 'I feel comfortable that even though we aren't performing as well as we want to in this particular area, I actually heard that team report out and I think that where they're going is appropriate,'" Cresswell says.

Another thing she says is important is making the quality report interesting. "Sometimes that means kind of telling the story and explaining to the board members, if we're working on throughput, well what does that mean to an individual patient? Well, what that means is that if your mom comes in and we decide she needs to be admitted for observation that she's not going to be sitting down in the emergency department maybe not getting as much attention as she could or would if we got her right up to the floor. So sometimes it's personalizing it for them... I think that's really where you get your biggest bang for the buck with them is if you can connect with them on their level. "

You know you've got them if…

"Too many times, I've seen reports given and it's so high level, their eyes just glaze over. They're not paying any attention," Cresswell says. "So if I start getting questions from them then I know I've been successful. Because they aren't going to ask a question unless they feel somewhat comfortable that they aren't going to appear stupid. So if they ask me questions, that to me means they've got some basic level of understanding of what I've presented and they feel confident and comfortable enough to be able to ask me about it and to solicit more information. Where if I don't get any questions, sometimes I think I went over their head." ■

CNE *questions*

9. What is Sentara Norfolk General Hospital's current fall rate?
A. 0.12 per 1,000 patient days
B. 12 per 1,000 patient days
C. 0.5 per 1,000 patient days
D. 50 per 1,000 patient days

10. Which of the following are discussed in Vanderbilt University Medical Center's guidelines for withdrawal of life support?
A. patients are monitored for pain or discomfort
B. ensuring the family is comfortable — that chairs are provided, gloves are removed, and the bedrails are lowered
C. the cardiac monitor is turned off
D. all of the above

11. Which elements are a part of the Cincinnati Children's Hospital Medical Center initiative to reduce VAP rates?
A. use of evidence-based practice bundle
B. force functions
C. huddles
D. all of the above

12. The North Shore-Long Island Jewish Health System was able to improve hand hygiene compliance by 81% using LED screens, remote monitoring, and constant feedback.
A. True
B. False

Answer Key: 9. A; 10. D; 11. D; 12. A.

CNE instructions

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

North Shore-LIJ wins NQF quality award

North Shore-Long Island Jewish Health System based in Great Neck, NY, was awarded with the National Quality Forum's 2010 National Quality Healthcare Award.

Asked what the indicators of a high-quality institution are, **Karen Nelson**, RN, vice president of the institute of clinical excellence and quality for the North Shore-Long Island Jewish Health System, lists:

- leadership prioritization with clearly set expectations;
- using evidence-based best practices;
- an interdisciplinary approach across the continuum;
- a consistent message from administrative and clinical leaders;
- staying focused;
- engaging frontline staff and physicians;
- rewarding successes;
- sharing best practices and lessons learned;
- providing regular feedback utilizing data and benchmarks.

"We've set our benchmarks at the top decile of performance nationwide. Being at the national average is not good enough, and we don't limit ourselves to being the best in the state. We're striving to reach top decile performance across the nation in every one of our quality indicators," Nelson says.

In 2008, the health system developed a three-year strategic plan for clinical excellence "to clearly articulate our strategic imperatives, actionable initiatives, and measures of success. The plan aligned with the NQF national priorities and the markers of success on the system dashboard." Along those lines, she says, the strategic imperatives for the system are reducing unnecessary variation and overuse, improving care coordination and patient safety, integrating the continuum of care, population health improvement, and increasing stakeholder trust by engaging patients and families.

Nelson says the organization also has a culture of both internal and external transparency and posts data publicly including infection rates, CMS appropriate care scores, and use of evidence-based care for stroke on its web site.

As far as methodologies, "physician and

CNE objectives

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

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

COMING IN FUTURE MONTHS

- ■ Managing timing of H&Ps
- ■ Keeping it quiet in the hospital
- ■ Additional coverage on preventing readmissions
- ■ More stories direct from your peers about surveys

nursing leaders partner to co-chair our clinical initiatives, utilize data to review performance, reduce variation in care through use of evidence-based guidelines, and ensure patient safety," she says. "We developed tools for the improvement of care coordination, and through our collaborative care model, we engage patients and their families."

Internally, hospitals within the system share adverse events, lessons learned, and best practices. "Adverse events and risk reduction strategies are shared among institutions, enabling leaders to perform a risk analysis at their own site to make sure that appropriate processes are in place to prevent an adverse event from occurring," she says.

"People want to do the right thing. They want to provide the best care to their patients — physicians as well as frontline staff at the bedside. And I think that involving caregivers in any process that you're looking to change, being a voice at the table... helps give you the buy in and results. It cannot be a mandate from leadership to say, 'This is the way you need to do it.' You need to engage the stakeholders," Nelson says.

One area of focus was the system's rates of central line-associated bacteremias (CLABs), which were examined to improve patient care and safety in 22 intensive care units encompassing more than 330 ICU beds. Work included standardizing evidence-based infection control practices, policies and procedures, reporting, and training modules. When an infection occurs, a root-cause analysis is conducted to assess opportunities for improvement.

"The message of zero tolerance was spread to all employees through these surveillance efforts, as well as through the intranet, collaborative care councils, and newsletter articles. The outcome of this targeted intervention has resulted in a 60.3% decrease in the CLABs rate from 2004 to 2008. In addition, central line days decreased by 8.7%," Nelson says.

The system also has improved its hand hygiene compliance by 81%, through technology and innovation, Nelson says. Compliance is observed through a remotely monitored video camera. The camera "is used to assess and calculate compliance with hand hygiene events. Real-time performance feedback is transmitted every 10 minutes and displayed on two separate LED boards in the unit." The purpose of the "real-time performance feedback," Nelson says, is not punitive for noncompliant individuals. It's about creating enhanced awareness and constant feedback. ■

PATIENT SATISFACTION PLANNER™

Throughput drive lowers discharge time, LOS

ED time drops, patient satisfaction soars

When Henrico Doctor's Hospital in Richmond, VA, launched a hospitalwide initiative to improve patient throughput, the team was able to shave 2.5 hours off the average discharge time and decrease the average length of stay on the medical unit from almost 10 days to five days in the first six months of the project.

Before the project was initiated, the hospital's emergency department was frequently on diversion, says **Patrick McGrady**, RN, MBA, director of med-surg services at the 767-bed hospital with three campuses.

At that time, Henrico's average emergency department length of stay was 270 minutes. Patients who were admitted to the hospital stayed in the emergency department for more than 470 minutes. Bed-hold hours for patients waiting for transfer to an inpatient bed were about 1,500 a month. The percentage of patients who left without being treated was at 4%, twice the national average.

"We knew we had to change the way we were doing things and improve emergency department throughput. The hospital administration enlisted the help of a consulting firm to develop a plan to deal with the issue," McGrady says.

At the end of the improvement process, arrival to treatment time in the emergency department dropped from 77 to 21 minutes and patient satisfaction increased 563%.

When beginning the project, the hospital assembled a process improvement team of more than 90 people including hospital administration, physicians, case managers, bedside nurses, ancillary unit directors, and housekeeping staff.

When the team drilled down to look for the cause of emergency department delays, it determined that one of the biggest issues affecting throughput and bed availability was length of stay on the medical-surgical units, McGrady says.

The team began its initiative to decrease length of stay by investigating the discharge process from various points of view and outlining the roles that physicians, nurses, case managers, patients, and their family members play in the discharge process, looking for barriers to a timely discharge and ways to overcome them, McGrady says.

The team examined physicians' role, including what time of day they make rounds and what kind of communication they need to support the discharge process.

They looked at what kind of rounding the case managers were doing with the staff nurses or charge nurses on each unit or if they were making rounds at all.

"We considered what would be the best time to make rounds, the charge nurse role and how it impacts the length of stay, and the link between the physician and the case manager," he says.

The team also scrutinized what kind of communication various members of the treatment team had with patients and family members about discharge plans from the day of admission to the time of discharge.

One of the goals was to improve communication between the case managers and the charge nurses so both were on the same page about patients being discharged.

Now the case managers meet with the charge nurses in the morning and update them about potential discharges. They look for barriers that might slow down the discharge, such as home health referrals or durable medical equipment, and collaborate to ensure that services are in place and that the barriers are overcome.

The charge nurse team makes regular rounds to keep family and friends of the patient informed about the patient's condition.

The hospital's average discharge time was 5 p.m. when the initiative started. The team set a discharge goal of 11 a.m. for all patients on the medical and surgical units and almost immediately moved the average discharge time up to 2:16 p.m.

"We're still moving toward the 11 a.m. goal, but it's not set in concrete. If patients have extenuating circumstances, we're not going to push

them out on the street," he says.

The team put up signs in the patient rooms informing patients and family members about the target discharge time.

"This helped facilitate the conversation about discharge with patients early in the stay. It alerts the patient and family members that they need to start planning their transportation and other discharge needs," he says.

The team also created a flier to educate patients about what they can expect during their stay, including that the discharge target time is 11 a.m.

The nurses give patients the flier and talk with them about what they may need when they go home and what discharge services are available. They can determine from the conversation whether patients need a case manager or social worker to help them prepare to go home.

"The flier helps open up the discussion about discharge planning and helps us plan for the patient's post-discharge needs early in the admission process instead of waiting until the day of discharge to set it up," McGrady says.

The case managers review the charts of patients who exceed the geometric mean length of stay on a case-by-case basis and drill down to find out why patients stayed longer than the expected length of stay.

"Some patients stay longer than expected because of complications or change of DRG. But sometimes patients stay because it's convenient for the family or because the post-acute services are not in place in a timely manner. We looked at all the reasons for the delays and ways we could speed up the process. We did a lot of communicating with physicians and a lot of work instituting culture change," he says.

The case management department tracks patients who have longer stays than expected and follows up with the physicians to address the issue. If the patient is ready to be discharged, they try to make sure the patient is discharged within two hours after the physician writes the discharge order.

"We have been looking at physician-specific data and having a conversation with physicians who might have been keeping patients in the hospital longer than necessary to find out why," McGrady says.

For instance, in the past, lab work for med-surg patients typically was the last drawn and the last to be completed.

"The physicians knew this so they came in late to check on the results and determine if the patients were ready for discharge," McGrady says.

The team created a process that notifies the labs in advance if the patient's discharge or transfer is pending.

"Now physicians get the labs in a timely manner, and patients are not waiting to go home because the lab results aren't in the chart," he says.

When the process began, case managers were seeing the patients only if the physician wrote orders for a consultation. Now, the nurses can call the case manager or social worker in when needed.

(For more information, contact: ***Patrick McGrady****, RN, MBA, director of med-surg services, Henrico Doctors' Hospital, e-mail: Patrick.mcgrady@hcahealth care.com.)* ■

Patient-centric care decreases hospitalizations

Program combines face-to-face, case management

A combination of face-to-face and telephonic case management has resulted in high patient satisfaction ratings and a significant decrease in health care utilization for patients with complex medical needs.

The care management program, provided by Alere, an Atlanta-based health management firm, resulted in a 38% decrease in hospital admissions, a 36% reduction in hospital days, and a 30% decrease in emergency department visits for patients who are members of one health plan, according to a 2007 study.

Alere's care management team provides care coordination for patients with life-limiting diagnoses or significant chronic disease.

About 60% to 70% of patients in the program have advanced cancer. Others have multiple comorbidities, such as heart failure, diabetes, chronic obstructive pulmonary disease, coronary artery disease, and hypertension.

Care managers live in the same community as the majority of the patients they support and carry a caseload of about 22 patients at a time.

"We limit the caseload because of the intensity of resources patients in the complex care manage-

ment program need and the amount of attention they require," says **Albert Holt**, MD, MBA, senior vice president and senior medical director for case management and disease management programs for Alere.

The care managers conduct an initial assessment in the patient's home or hospital room and follow up by telephone. If there is a change in the patient's status or the patient is going to another level of care, the care manager makes another home visit.

If there isn't an Alere care manager nearby, the company sends a nurse case manager to that area to complete the in-home assessment.

The key to the success of the care program is taking a personal approach to care coordination and building a relationship based on face-to-face contact and working with the patients on goals that they identify as important, Holt says

"When the care managers go into the patient's home, they get patients' perspectives on illness and what they want to achieve. They collaborate with the patients and family members to set goals based on what patients want to do and develop a plan to help them meet their goals. Because patients are engaged in their own health care, they are able to keep their conditions from getting out of control and avoid hospitalization or visits to the emergency department," he adds.

Alere identifies patients eligible for the program by screening claims, precertification, medical information, and other data from their insurance plan and employer group clients.

"We concentrate on precertification and immediate hospital data, because we want to get patients when their illness is new to maximize our assistance to them," Holt says.

The organization's triage enrollment nurse calls eligible patients and completes an assessment to determine the client's clinical status and need for case management and enrolls interested patients in the program.

The care manager who is assigned the case sets up an appointment for a comprehensive in-home assessment that typically lasts several hours, says **Linda Alden**, RN, CCM, a complex care manager based in Southern California.

"We always encourage family members to be present when we meet with the patients. We're collecting and offering a lot of information, and it's always good to have more than one set of ears listening," Alden says.

The care managers already are familiar with the patients' medical history, but they also find out the patients' perceptions of their disease process.

'Perception is reality'

"Perception is reality. We often have cancer patients who are recovering from surgery and don't expect to have to have chemotherapy or radiation because the surgeon told them they removed the tumor and the margins were clear. If we know what they perceive, we can start the educational process there," Alden says.

During the initial visit, the case manager completes an in-depth assessment of the patient's symptoms, resources, and support system, says **Nancy Messenger**, RN, CCM, a care manager based in Northern Michigan who coordinates care with indemnity patients, often traveling throughout the country to meet them in person.

"We want to get a full and total picture of the patients and their needs during the face-to-face visit. One of the joys about this job is the flexibility we have to give our patients personal service and do whatever is needed to meet their specific needs, whether it's financial assistance, education, transportation, or help with meals or housekeeping," Messenger says.

After the initial assessment, the care managers develop a dynamic care plan and discuss it with their nurse supervisor, called a clinical support manager, and their medical director.

All of the complex case management cases are reviewed twice a month by the medical director to provide additional support and keep the clinical guidance on track, Holt says.

"The medical directors keep on top of chronic diseases and oncology regimens and can call on specialty experts when needed. For instance, if a patient has a complicated diabetes regimen, they can call on a diabetes specialist for advice," he says.

At the time they open a case, the care managers send a letter to each of the patient's physicians introducing the case management program to them.

The care managers identify one physician who is the primary physician and collaborate with him or her. For instance, if the patient is undergoing cancer treatment, the oncologist is likely to be the primary physician.

"Our relationship with the treating physician is very important," Alden says. "Patients are on the phone with us for an hour at a time and talk to

the doctor's office for five minutes. They tell us things that they don't share with the providers. We give them additional information to help them make clinical decisions."

Facilitate communication among physicians

Most of the patients in the program are being treated by multiple providers, most of whom do not regularly communicate with each other, Messenger adds.

"We facilitate communication among the treating physicians to make sure the patient's care is coordinated," she adds.

The nurses take a patient-centric approach to coordinating care, Holt says.

The complex care team treats the whole patient, not just the issues they are called in to address, Alden adds.

"We may be working with a cancer patient, but when we conduct the assessment, we find out he or she has hypertension. We incorporate education on managing hypertension, such as diet, exercises, and medication compliance, into our care plan for cancer," she says.

The care managers call their patients at least once a week and encourage them to call any time they need help.

"Because we're not a family member, a friend, or a physician directing their care, patients often feel more comfortable speaking with us. We can find out what's going on with them and alert their health care providers if needed," Messenger says.

That first face-to-face visit helps the care managers get to know the patients and their families and start to build a relationship.

"We become more than just a voice on the phone," Alden says. ■

Emergency departments post wait times on the web

Marketing pushes idea, but ED had to approve

Several months ago, the two EDs of Sacred Heart Medical Center in Eugene, OR, began posting their waiting times on their home page (www.peacehealth.org/shmc). There was a good deal of hesitation at first, say the ED leaders. However, patient satisfaction has risen from 96% to 100%, and the "peaks and valleys" of patient flow seem to have leveled out, they say.

"It was initiated by our marketing department," recalls **Joy Cresci,** RN, assistant administrator of emergency and critical care for Sacred Heart, which has EDs in its RiverBend facility in Springfield and at University District in Eugene. "They found out that the Scottsdale [AZ] Health System has their times on their web site." As it turned out, one of Sacred Heart's hospitalists had come from that system and said that it had been helpful, she says.

The move made sense to the marketing department from a competitive standpoint. Rival McKenzie-Willamette Medical Center in Springfield had been boasting about its short ED wait times on billboards and on its web site for months. Initially, however, there was lot of push-back in the ED, especially from charge nurses. "They felt we would be setting up false expectations," explains Cresci, who ultimately led the effort to post the ED wait times.

Gary Young, MD, the ED medical director, says, "It's something we struggle with all the time. There were times recently when we had record numbers of patients coming to the EDs, even though many had H1N1 and were able to go home."

Hospital administration left the decision up to the ED, and the department leadership began meeting to discuss the idea. "The competition of the other hospital changed many peoples' perspectives," says Cresci, "So I called the hospitals in Scottsdale to talk to their ED charge nurses and see if any of the issues raised by our charge nurses had materialized, and they said they hadn't."

The other reason the move made sense, says Cresci, is that one of the Sacred Heart hospitals had been open only for about a year, and the newer hospital was being overwhelmed with patients. The older facility had more capacity and could have taken more patients.

"Part of what we did to pave the way was to educate the community," adds Cresci. "We let them know that both EDs were staffed by the same doctors and the same level ED nurses." When they "went live" in September 2009, she adds, news releases were issued and interviews were conducted on local TV stations.

Young says, "We've been getting the word out through the media and mailings for more than a year, and it's still hard to make sure everyone understands what's happened with the two EDs. It will probably take another year or two." ■