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Photos of shark victim underscore threat from cell phone cameras

Experts say such actions are HIPAA violations

"Good people who exercised poor judgment" recently took cell phone pictures of a shark attack victim who later died in the ED at Martin Memorial Medical Center in Stuart, FL, according to a statement released by hospital officials. Although no staff members were fired, the hospital has disciplined several ED employees for taking the cell phone pictures and has asked anyone with copies of the photos to destroy them.

Unfortunately, with the rapid spread of cell phones equipped with cameras, such activities have become all too common. "A hospital client of mine recently experienced a [privacy] breach when a trauma nurse on the first day of work in the ED was texting and 'Facebooking' friends about her cool new job," shares **Gina Ginn Greenwood**, JD, of counsel, in the Macon, GA, office of Baker, Donelson, Bearman, Caldwell, & Berkowitz. Minute by minute, details of patient emergencies were posted "for all the world to see," says Greenwood.

The nurse was shocked to learn this was a prohibited activity, "and unfortunately her career was short-lived," she reports. She was under the impression that the disclosure was allowed because she did not use patients' names. "This is a common mistake," says Greenwood. "Health information that can in anyway be used identify a patient must be protected under Health Insurance Portability and

Executive Summary

The Health Insurance Portability and Accountability Act (HIPAA) might not specifically address cell phone cameras, but if your staff takes unauthorized photos with their cell phones, they (and you and your facility) likely will be in violation of HIPAA, say legal experts.

- HIPAA can extend to pictures taken of patients if the information on that picture identifies the individual.
- New laws on electronic personal health information increase penalties for violations.
- The surest way to prevent violations is to prohibit cell phone camera use in the ED.

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Accountability Act [HIPAA)] privacy and security rules."

Mary Jean Geroulo, JD, MBA, a health care attorney with the Dallas law firm of Stewart Stimmel, says, "This has come up in several facilities. We have had reports of staff — whether they are nurses, techs, or even physicians in a couple of cases — taking pictures of patients either with horrifying trauma in the ED or in surgery."

Geroulo says she has received reports of pictures posted by people on their Facebook pages offering accounts of "see what I did today" and others being e-mailed to patients who wanted to see what their gallbladder looked like. "Various kinds of pictures have been taken by cell phones when not authorized, and this is an issue many hospitals are struggling with," she notes. "It's more prevalent in the ED, considering that patients often come in with unusual conditions, and people think they are interesting and want to share them with people they know."

What does HIPAA say?

One of the potential causes for confusion among ED staff and leadership is that cell phone cameras are not specifically mentioned in HIPAA - most likely because when the law was created they were not so common.

"I reviewed the HIPAA standards, and while it does not say specifically that cell phone pictures are not allowed, it does say that photos without proper consent are not allowed," says **Scott Felten**, MD, FACEP, an emergency physician at St. Francis Hospital and an assistant professor at the University of Oklahoma, both in Tulsa. "Where the breakdown occurs is that people have a 'disconnect' when it comes to what they consider a 'picture.' A phone seems like a harmless thing, but a picture is a picture."

Felten's instincts are spot on, says Geroulo. "HIPAA has very broad applicability. It covers anything that qualifies as individually identifiable patent information," she explains. "Typically, we think of things like medical records or X-rays, but it can extend to pictures taken of patients if the information on that picture identifies the individual."

The example of a shark bite victim would fall into that category, Geroulo says. "In and of itself, a picture of a body part may not violate HIPAA, but if something unique and identifiable about that body part links it to an individual it is," she says. "So, in the case of shark bite victims, there is usually an article in the paper about surfer 'John Jones' being bitten in the leg, so when a picture of a leg with a shark bite is seen, the patient can be identified."

Protecting patient privacy became even more critical with the passage of the Health Information Technology for Clinical and Economic Health (HITECH) Act, which was part of the American Recovery and Reinvestment Act of 2009 and included strengthening of guidelines and greater penalties for HIPAA violations. There is a series of tiered minimum fines for individual claims and a $1.5 million maxi-

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Editorial Questions

For questions or comments, call Joy Daughtery Dickinson, (229) 551-9195.

Editor: Steve Lewis (steve@wordmaninc.com).
Associate Publisher: Coles McKagen (404) 262-5420 (coles.mckagen@ahcmedia.com).
Senior Managing Editor: Joy Daughtery Dickinson (229) 551-9195 (joy.dickinson@ahcmedia.com).
Director of Marketing: Schandale Kornegay.
Production Editor: Ami Sutaria.

AHC Media LLC

Sources

For more information about cell phone camera use in the ED, contact:
• **Scott Felten**, MD, FACEP, Emergency Physician, St. Francis Hospital, Tulsa, OK. Phone: (918) 520-9966.
• **Mary Jean Geroulo**, JD, MBA, Stewart Stimmel, Dallas. Phone: (214) 615-2012. Fax: (214) 752-692. E-mail: maryjean@stewartstimmel.com. Web: www.stewartstimmel.com.
• **Gina Ginn Greenwood**, JD, Of Counsel, Baker, Donelson, Bearman, Caldwell, & Berkowitz, Macon, GA. Phone: (404) 589-0009. Fax: (404) 238-9612. E-mail: ggreenwood@bakerdonelson.com.

mum fine when a group of employees are affected.

Hospitals are required by the HIPAA Security Rule to assess the risks associated with use and disclosure of electronic personal health information (ePHI), Geroulo explains. "Misuse of social media is a risk hospitals likely did not address during initial security compliance implementation, but in light of recent HITECH changes to the HIPAA rules, including the addition of breach notification rules and the enhancement of penalties, now is the time to address these risks and implement policies and training to mitigate the chances of misuse," she says.

It is important for hospitals to train their workforce members - especially the younger ones — on the proper use of PHI, Geroulo says. "Recent health provider/clinical graduates are part of a generation that has grown up telling the world, minute by minute, the details of their lives," she says. "Hospitals will need to train these and other workforce members about the proper use of PHI." *(For more on how to prevent potential HIPAA violations, see the story below.)* ■

Prohibit cell phones to ensure privacy

The surest way to prevent violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) involving the use of cell phone cameras is to prohibit the use of cell phones in the ED, say privacy experts.

"For our nursing staff, the nurse coordinator has gone to a policy that the use of cell phones is forbidden in the ED beyond use for reference, such as downloading medication guides," says **Scott Felten**, MD, FACEP, an emergency physician at St. Francis Hospital and an assistant professor at the University of Oklahoma, both in Tulsa. "Any texting, photography, or even speaking on the phone during work is forbidden and can lead to termination."

In addition, Felten says, all residents and other physicians obtaining privileges receive orientation about professionalism and behavior, and residents also receive annual online HIPAA training. "Every year the nursing and ancillary staff must do what the residents do," he adds.

The policy is not an empty one, Felten says. "There was an incident in the last 12 months," he says. "The individual using a cell phone for personal use has been terminated."

Mary Jean Geroulo, JD, MBA, a health care attorney with the Dallas law firm of Stewart Stimmel, says, "Having been on the operations side of things and been responsible for implementing policies, the only way to prevent violations is to prohibit the use of cell phone cameras by staff. Once a picture is taken and they hit the 'send' button, if they delete the picture, administration will not know if the picture that was sent out violates HIPAA."

The simplest way to avoid such a 'horrible proposition' is to prohibit taking pictures of patients with personal cell phones, Geroulo says. While she understands the educational need to take photos, Geroulo argues that cell phones shouldn't be used for those pictures anyway, because "the quality is not that good."

In addition to violating the law, "patients have a right to expect a certain level of respect of their person when they are unconscious and unable to speak for themselves," she says. People who work in the ED have to develop a certain level of casualness as to what has to occur to stabilize a patient as quickly as they can, Geroulo says. "Clothing comes off, body parts are treated in way that is hard for the casual observer," she says. "It's hard enough to know that as a patient, but to have one of those workers take pictures of your body when undergoing a life-changing experience and to have it used for someone's personal gratification — I find it to be the most horrifying violation." ■

Is the new health law a good opportunity?

[Editor's note: ED Management *issued an e-bulletin to readers on March 24, 2010, about health care reform's impact on EDs. We also described recent*

Executive Summary

Although many of the provisions on the new health care law will not take effect for several years, observers say that ED managers must begin to deal with this new reality immediately.

- Redouble your efforts for improving throughput via rapid evaluation units and other process changes.
- Educate patients with chronic illnesses about the benefits of regular primary care visits.
- Work closely with patients who are adapting to the new law, and encourage them to take more responsibility for their personal health.

studies on the impact of health care reform in Massachusetts on ED crowding. ED Management *issues such bulletins to keep readers informed of the latest developments in emergency management. If you wish to receive future* ED Management *bulletins, contact customer services at (800) 688-2421 or customerservice@ahcmedia.com.]*

Now that health care reform has become legislative reality, what does the future hold for EDs?

"I'm not sure anybody really knows," says **Don Lombino**, MD, FACEP, chairman and director of emergency medicine at The Stamford (CT) Hospital. "There will potentially be 32 million more people with insurance, and we do not have excess capacity as it stands today in the ED and among primary caregivers; this will really stress the system."

Angela F. Gardner, MD, FACEP, assistant professor, Division of Emergency Medicine, Department Of Surgery, at the University of Texas Southwestern Medical Center in Dallas and president of the American College of Emergency Physicians (ACEP), agrees. "I think the first thing people have to anticipate is that ED volumes are going to go up," Gardner says. "Our experience in Massachusetts saw a 7% increase across the board." ACEP cites two recent studies.[1-2] "The nation can anticipate a similar event to occur," Gardner says. *(When EDs become significantly crowded, remember the basics such as frequent vitals, she says. See Clinical Tip on p. 53.)*

Karen Rieger, JD, shareholder and director of the law firm of Crowe & Dunley in Oklahoma City, OK, and chair of its health care practice group, offered a different opinion in a recent interview in a local paper.[3] "Hopefully, what this will do, is with 30 million more Americans being covered, they will be able to get routine care earlier from their physicians or from a clinic before it becomes and emergency," she said.

However, a recently published study in the National Bureau of Economic Research looked at 19-year-olds who had just been dropped from their parents' coverage.(Reference 4) The researchers found that not having insurance resulted in a 40% reduction in ED visits.

Even if EDs see an increase in patients, that increase is not necessarily a bad thing, counters **Steven J. Davidson**, MD, chairman of the Department of Emergency Medicine at Maimonides Medical Center and professor of clinical emergency medicine, State University of New York — Health Science Center, both in Brooklyn, NY. "There will be more patients, which will be a great opportunity for EDs and emergency physicians," Davidson says. "As a specialty, it creates the opportunity to re-tool how our EDs work with streaming rapid evaluation units so that the many minor illnesses and injured patients we see get expeditious care and are turned around quickly."

On a positive note, adds Gardner, "Under EMTALA the ED has to care for people regardless of ability to pay, and many do not pay now, but five years from now those people will have some form of reimbursement. From that perspective, EDs should have a slight increase in reimbursement." *(For recommendations on how ED managers can adjust to the new law, see the story on p. 53.)*

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For more information on the new healthcare law, contact:

- **Steven J. Davidson**, MD, Chairman, Department of Emergency Medicine, Maimonides Medical Center, Brooklyn, NY. Phone: (718) 283-6030. E-mail: sdavidson@maimonidesmed.org.
- **Angela F. Gardner**, MD, FACEP, President, American College of Emergency Physicians, Irving, TX. Phone: (800) 798-1822.
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ED managers must take action now

While many aspects of the newly passed health care reform law will not take effect for several years, experts say that ED managers should waste no time in preparing for the changes to come.

"They need be thinking about those things now," says **Angela Gardner**, MD, FACEP, assistant professor at the University of Texas Southwestern in Dallas and president of the American College of Emergency Physicians.

"Many conditions are best treated by an ongoing relationship with the primary care physician, and we will have to gently lead our patients to that conclusion," Gardner says. For example, she notes, with conditions such as diabetes, hypertension, and asthma, the patient needs to see the primary care physician to have their disease managed.

ED managers should emphasize educating patients and have their staff tell such patients "We'll get you started on these meds, but do not come back to us for refills. Get seen by a primary care physician," she says.

In fact, that education should begin before these patients end up in the ED, via public service announcements and similar vehicles, Gardner says. "I think it's up to us as leaders to lead the way in helping people get to the best place for the care they need," she says. *(For examples, see resource box, below left.)*

Don Lombino, MD, FACEP, chairman and director of emergency medicine at The Stamford (CT) Hospital, agrees that patient education will become an even more important issue for EDs. "Hopefully [this law] will be the first step in a process, and as this process proceeds, we need to make sure our patients are part of that process — that they take some responsibility for their care on some level," Lombino says. "We should be there to guide them and help them as a partner."

Every time a patient is seen in the ED, there is an opportunity to educate them on safety and prevention, he says. "It can be simple things like using seat belts in a car, wearing bike helmets, or stopping smoking," Lombino says. "We need say in a non-dogmatic but strong way that we want to see them have an improved quality of life."

EDs and primary care will be inextricably linked as this new health care reality unfolds, predicts **Steven J.**

Resources

• The American College of Emergency Physicians (ACEP) regularly provides public information materials on when to seek emergency care. To access ACEP's Emergency Manual on the foundation web site, go to www.emergencycareforyou.org/EmergencyManual/WhatToDoInMedicalEmergency/Default.aspx and look under the Emergency Manual tab.

• An example of an ACEP public service announcement can be found at www.acep.org/pressroom.aspx?id=25890. Under "Add ICE' (In Case of Emergency) Entries to Cell Phones," click on any of the three options.

CLINICAL TIP

Don't forget vitals in crowded ED

If health care reform makes EDs even more crowded, as many predict, it will be critically important to remember to maintain the frequency of vitals, says **Angela Gardner**, MD, MD, assistant professor at the University of Texas Southwestern in Dallas and president of the American College of Emergency Physicians (ACEP).

"This clinical 'pearl' will help ED doctors stay out of trouble," Gardner says. "When crowding is at its worst, be sure the vital signs on patients get reassessed frequently because they tell you what's going on."

If you don't, she warns, on "crowded crazy busy" days, you'll inevitably discover that a patient who hasn't had vitals taken in four hours is "suddenly" worse, "You should take vitals at least every two hours," Gardner advises. ■

Davidson, MD, chairman of the Department of Emergency Medicine at Maimonides Medical Center and professor of clinical emergency medicine, State University of New York — Health Science Center, both in Brooklyn, NY. "In the next few years there will be a deluge of patients coming to us because of improved access, which we can address through rapid evaluation units and patient flow and processing techniques without spending much on bricks and mortar, while primary care improvements, if successful, will eventually draw the less urgent patients away from the ED, giving us the opportunity to appropriately respond to aging baby boomers who will be coming in sick and horizontal," Davidson says. ■

'Attitude adjustment' is key to ED success

Presenting patients get a bed in 3 minutes

In the face of steadily increasing volumes (13,000 between 2008 and 2009), the ED at Peninsula Regional Medical Center in Salisbury, MD, has improved all of its operating statistics, achieving a 'door-to-bed' time of three minutes and a door-to-doc time of 21 minutes.

While such a performance could not have been accomplished without more efficient processes, the ED leadership team insists that the single most important element in their success has been a change in the way physicians and nurses relate to each other.

Executive Summary

An attitude of cooperation and teamwork, rather than one of finger-pointing, was the key to success as the ED at Peninsula Regional Medical Center in Salisbury, MD, achieved a 'door to bed' time of three minutes and a door-to-doc time of 21 minutes, while facing steadily increasing volumes. Here's how they did it:
- Separate staff meetings for physicians and nurses were eliminated. Now there is a single meeting.
- When addressing staff, the physician leader and the nursing leader are consistently "on the same page."
- Decisions on care delivery processes became more patient-centered.

"We had some leadership changes 18 months ago with a renewed emphasis on our relationship and teamwork with nursing and the hospital," says **Clark Willis**, MD, medical director of the ED. "Most of the positive changes that have occurred, in my opinion, are process, structure and throughput changes that resulted out of that collaboration." Willis says it is "amazing" what can be accomplished when physicians and nurses link hands and work together, instead of blaming each other and pointing fingers.

Susan Castrignano, RN, BSN, nursing director, agrees. "A lot of it had to do with leadership," says Castrignano, who adds that she and Willis came to their positions about the same time. "When the staff saw we actually talked to each other and were on the same plan and shared the same ideas, and that we had support for each other, support from the physician group to nursing and vice versa, little by little people saw you as a leadership team and not me representing the nurses and he representing the physician team," Castrignano says.

One simple but important change involved the structure of staff meetings, she says. "Now we have one big meeting, whereas we used to have a staff meeting for nurses and a departmental meeting for doctors and some nurses," Castrignano says. "Now we are all in one big room together. We hear the same message at the same time."

Willis says, "We sat down and talked about what we thought made a difference." After an ED expansion, "we had more space, new servers to run the EMR [electronic medical record], but we both agreed that we had to make a renewed initiative of working together," he says.

In the past, there was much more division about who was responsible for different activities and whether errors were the doctor's fault or the nurse's, Willis says. "In trying to focus on how we could work better together, we eliminated job-title-specific details," he says. "Meetings were more about everybody seeing the bigger picture of where we were headed and what we were trying to do. The key questions became what was best for the patients and how

Sources

For more information about teamwork between ED nurses and physicians, contact:
- **Susan Castrignano**, RN, BSN, Nursing Director, Clark Willis, MD, ED Medical Director, Peninsula Regional Medical Center, Salisbury, MD. Phone:

we could best serve them, regardless of whose area it was." *(For more on the solutions this collaborative approach produced, see the story below.)* ■

'Line at the door' is tackled first

When the ED leadership team at Peninsula Regional Medical Center in Salisbury, MD, set out to improve throughput, the first thing they tackled was the line at the door, says Clark Willis, MD, medical director.

"Patients were lined up at one window trying to get registered and triaged," Willis recalls "The attitude was that we didn't 'own' the patient until they got past that wall."

Process changes to address this issue included putting a greeter in the waiting room to be sure patients with more urgent needs were seen first and streamlining the triage process so patients would get to treatment more quickly. *(The greeter also improves clinical care. See clinical tip, below.)*

Susan Castrignano, RN, BSN, the nursing director, says, "The ED had been expanded from 19,000 square feet to 41,000 square feet, but as much input as we had into the design, when our volume went up we still had issues. Instead of a full triage, if there was an open bed we started bringing the patients straight back. You could bring four or five people back at the same time, and it all happened in parallel."

To help make this possible, changes were made to the EMR screen to prevent nurses from performing a full triage and directing them to just do a "mini-screen," Castrignano says.

"The content of the triage was not changed, but the team felt it was important to separate the screens and have the triage nurses do the first initial screen and the primary nurse who would be taking care of the patient the second part, which contains the past medical history and medication reconciliation," she says.

The traditional culture of the staff was to do as much as possible in triage and not to dump the work on the primary nurses, Castrignano says. "But when the question came up as to what was best for the patient, and the goal is to have the patient see the provider, the majority of the nurses were supportive about the process change," she explains.

As with all of the changes made in this ED, teamwork was a critical element. Willis says, "We involved the nurses in the decision-making. We had a focus group process improvement, rather than just pronouncing the change."

The nurses received one-on-one training from other nurses. They walked through the new screening process and seeing how to get patients back to the bed more quickly. "The doctors were recipients of education, too, since they had to hop in and see those patients with the understanding that they may not have been completely triaged," Willis says.

The new attitude of cooperation manifested itself when a problem arose with the express care unit. "When we started to bring patients straight back, we had to protect express care, because staff tended to grab mid-level people to protect the doctors," Willis says. "They were poaching from express care to fill their own needs. We agreed to protect express care staff; that doctors would not pull mid-level staff, and nurses would not pull nurses or techs."

> "We involved the nurses in the decision-making. We had a focus group process improvement, rather than just pronouncing the change."

The result? Despite the fact that express care saw a 21% increase in volume, its throughput went from an hour and a half to under 60 minutes. ■

CLINICAL TIP

A greeter can avert waiting room tragedies

Want to prevent your ED from becoming one of those headlines blaring "Death in the waiting room"? Put a greeter out front, says **Clark Willis**, MD, medical director of the ED at Peninsula Regional Medical Center in Salisbury, MD.

"Having a physician's assistant or secretary there when patients first present make them our eyes and ears," Willis explains. "Without that you can literally have someone fall over in the corner. This way, they won't sit at the end of the line in failing health." ■

Overhaul of staff is done 'right, not fast'

Process takes more than 6 months

Taking nearly seven months to transition from an ED staffing model of a contracted physician group to one that involved a partnership with a neighboring medical school might seem overly long, but the leadership at St. Joseph's Hospital in Buckhannon, WV, says they wanted to "do it right." That process included bringing on properly credentialed physicians, as well as doctors who would relate well with the surrounding community.

It also meant keeping the ED running smoothly from the time the previous group's contract expired until the new doctors were fully onboard, while at the same time continuing with process improvements that had been put in place.

That ambitious goal was achieved, says **Amanda Jones**, RN, BSN, the director of the ED. "Our rate of patients left without being seen has held steady at 1% for the past three years, and during the transition it held steady at that level or even below," Jones says. *(For more on how the ED was kept running smoothly, see the story on p. 57.)*

"We have very high standards," Jones says. "In 2009 our average length of stay was 1.66 hours. This year it is at 2.07." High performance levels are maintained, she says, because when physicians are seen not performing at the desired speed, either Jones, the medical director, or the hospital CEO will speak with the physician in question. "And our nurses are very adamant that when a patient comes into a room, they do not wait for treatment," she adds.

When the decision was made in June 2009 to change from an ED management group to an external physician group, St. Joseph's chose the Department of Emergency Medicine at Charleston, WV-based West Virginia University (WVU).

"We worked toward a goal of a six- or seven-month period for the transition to be fully implemented," says **Sue Johnson-Phillippe**, RN, MS, FACHE, president and CEO of St. Joseph's. "We wanted to make sure we had the right physician providers in place we needed, not only in terms of numbers, but also credentials." In other words, all of the physicians had to be board certified in emergency medicine, Johnson-Phillippe says.

Jones says, "We never once discussed volume. It was more a case of a fit for the community. WVU is a major care center in rural West Virginia, and they already had physicians established within our community." The community's perception of WVU medicine is that it is "top of the line," so to bring them to St. Joseph's "is great for our patients," she says.

In terms of numbers, they did not really change. Pre- and post-transition physician staff was five FTEs, which could involve anywhere from seven to 12 doctors.

Integration of the new staff into the ED has been smooth, says Jones, "The nurses absolutely love them. They were well-picked, both by us and WVU," she says. In addition to Robert Blake, MD, who is a local physician, "We were lucky enough to be able to

Executive Summary

If you're about to overhaul your entire ED physician staff, there's no need to rush. It's better to take your time and do things right, say the leaders at St. Joseph's Hospital in Buckhannon, WV.

- A goal was established that the transition would take about 6-7 months.
- Contract physicians and locum tenens staff were used during the transition to keep the ED running smoothly.
- The nurse and physician leader were available

Clinical Tip

Choose your triage staff very carefully

One of the most important staffing decisions you can make is who to assign to triage, because it can impact patient safety in more than one way, says **Amanda Jones**, RN, BSN, the director of the ED at St. Joseph's Hospital in Buckhannon, WV.

"Your strong clinical providers should be in triage," Jones says, and not just because it is critical to determine the urgency of each patient's condition. "Without that staffing, your ED can be backed up very quickly for virtually no reason," which in turn leads to longer waits and a greater risk of complications, she says. ■

choose another doctor who was born and raised in our county," says Jones.

Johnson-Phillippe says the new physicians "can be very nice and gracious, but they also deliver quality care and the best outcomes possible." ■

ED fills the gap during transition

During the seven-month period when St. Joseph's Hospital in Buckhannon, WV, severed its relationship with an ED physician management group and formally began a new one with the Department of Emergency Medicine at West Virginia University (WVU) in Charleston, the department was kept running at full-speed without any drop in performance, according to ED and hospital leadership.

How did they do that? "In the beginning, we met about every other day," recalls **Sue Johnson-Phillippe**, RN, MS, FACHE, president and CEO of St. Joseph's. "Part of the strategy was that we employed a number of doctors to get us through and ended up using some [locum tenens staff].

In addition, without any guarantees a "carrot" was held in front of them: They might ultimately be employed by the university, says Johnson-Phillippe. "With that model we were able to use some senior residents from WVU, who also got exposed to our ED during the interim," she says.

The only physician from the previous staff who stayed was the long-time medical director, Robert Blake, MD, notes **Amanda Jones**, RN, BSN, the director of the ED. "He and I made it a point to either be in the department or to come in to see the new doctors when they arrived, to provide orientation, and give them time with the nurses," Jones says. The nurses "were more than willing to help any doctor adapt to our ED, and I and Dr. Blake were available pretty much 24/7 to make it work," she says. Many of the doctors who were able to come in and work a shift at a time eventually ended up with the department, she notes. *(Staffing is particularly critical in triage, says Jones. See the Clinical Tip, p. 56.)*

In addition, says Johnson-Phillippe, "The leadership for the department at WVU was intimately involved in seeing we were able to adequately staff the department. They did ongoing problem-solving with us when ran into a wall."

For example, ED managers from WVU would step in and take a shift if the St. Joseph's ED was short-staffed, Jones says. ■

Sources

For more information about staff transitions in the ED, contact:
- **Sue Johnson-Phillippe**, RN, MS, FACHE, President and CEO, St. Joseph's Hospital, Buckhannon, WV. Phone: (304) 473-2118.
- **Amanda Jones**, RN, BSN, ED Director, St. Joseph's Hospital. Phone: (304) 473-2000.

Will longer wait times mean more ED lawsuits?

Did a patient wait a long time in your ED, and did that patient have an adverse outcome? If these two events can be linked together by a plaintiff's attorney, it could result in a successful malpractice lawsuit against your staff or your institution.

It might not be too surprising that wait times are longer when EDs are more crowded. However, this occurs even for patients with life-threatening emergencies, according to a recent study. Researchers found that during crowded periods at four EDs, the adjusted median waiting room times of high-acuity level 2 patients were 3-35% higher than during normal periods.[1]

Andrew Garlisi, MD, MPH, MBA, VAQSF, medical director for Geauga County EMS and co-director of Chest Pain Center at University Hospitals Geauga Medical Center, Chardon, OH, was surprised by this statistic from a recent Centers for Disease Control and Prevention (CDC) report: Patients needing immediate care waited an average of 28 minutes to be seen by a physician.[2]

"These are obviously the critically ill or injured and unstable populations with the highest risk of death, and permanent disability," says Garlisi. "The CDC study did not expound on why these patients waited an average of 28 minutes or whether there were nurses, physician assistants, or nurse practitioners engaged in the care of the patient until the physician became available. Whether the physicians were otherwise engaged in the care of other critical patients is unknown. But certainly it would be worth investigating the reasons for delays on this subset of high-risk patients."

With "time-sensitive" issues such as respiratory distress, trauma, or myocardial infarction, the burden is on the emergency staff to see patients and make cor-

rect accurate decisions quickly, while performing a myriad of other activities, says Garlisi.

"If the physician is overwhelmed, or if the ED is understaffed or rendered dysfunctional for any of a number of reasons, the patient may suffer an untoward outcome, and liability increases exponentially," says Garlisi.

Sympathy Is unlikely

Sandra Schneider, MD, professor of emergency medicine at University of Rochester (NY) Medical Center, says, "Long waits make for unhappy patients, and unhappy patients are more likely to sue. Waiting room deaths have made national news. It is clear that society is not forgiving of long waits."

Once patients are seen, crowding still can cause delays that can lead to increased morbidity and mortality, adds Schneider. "If the attorney can create the sense that the staff did not care, or that they downplayed the patient's symptoms, it is easier to convince the jury of malpractice," she says.

Emory Petrack, MD, FAAP, FACEP, a medical-legal consultant and principal of Shaker Heights, OH-based Petrack Consulting, says, "We have all seen the major news stories where a significantly ill patient collapses in the ED, which of course, is a disaster. There is certainly concern about liability for physicians and perhaps even more for the institution."

Garlisi fully expects attorneys to take advantage of the pitfalls created by overburdened EDs, "especially since it is clear that hospital leaders realize there are delays, even for critically ill or injured patients. If we fail to apply some reasonable solutions in a coordinated fashion, with hospital teams working side-by-side with emergency physicians, we can only blame ourselves."

One such solution involves taking patient acuity into account for ED staffing. Garlisi says, "One critically ill or injured patient can tie up a physician and two nurses long enough to paralyze the ED," he says.

As waiting times increase, so do your medical legal risks, Petrack says. "So there need to be some systems put in place to handle those problems as they occur," he says.

Patients have come in right after one of the highly publicized waiting room deaths and made comments such as, "You're not going to make me wait and die like that other patient, are you?" says **Jonathan D. Lawrence,** MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

"So they are well aware of the problem of crowding," says Lawrence. "And if they are already sensitized that bad things can happen, and then something bad does happen, I am sure they are going to be quite inflamed. There is no question that it is a difficult problem and one fraught with legal difficulties."

Lawrence notes, however, that only a small minority of patients to whom bad things happen ever sue. "Most of the time, physicians and hospitals get away with malpractice without ever having a suit. Anything that increases the possibility that somebody would be more likely to sue increases your risk," he says.

If an adverse outcome occurs to a patient who was left sitting out in the waiting room, "it obviously wouldn't look good in front of a jury," says Lawrence. "These are difficult cases. It raises all kinds of questions as to the adequacy of your triage procedures, for example. Juries may or may not be sympathetic to the crush of other patients being seen at the same time. It's a little less problematic if somebody finally gets seen and then something bad happens. At least they were seen."

Linda M. Stimmel, JD, a partner with the Dallas-based law firm of Stewart Stimmel, says that "increased wait times in EDs will of course mean that some patients may suffer injury and death due to the delay. A good plaintiff's attorney will use that `delay' to prove causation in a lawsuit against a hospital, physician, or triage nurse." However, the plaintiff's attorney will have to show that the delay or increased wait time was unreasonable or that the ED didn't have a competent triage system to identify the more seriously ill patients.

"A jury will not be able to blame a hospital or physician if the only fault that can be shown is increased traffic due to a population without health insurance," says Stimmel.

References

1. McCarthy ML, Zeger SL, Ding R, et al. Crowding delays treatment and lengthens emergency department length of stay, even among high-acuity patients. *Ann Emerg Med* 2009; 54:492-503.

2. Centers from Disease Control and Prevention. Estimates of Emergency Department Capacity: United States, 2007. Accessed at www.cdc.gov/nchs/data/hestat/ed_capacity/ED_capacity.htm. ■

Wait time too long? Reduce risks this way

To reduce legal risks, the best strategy is to "show diligence," says **Linda M. Stimmel**, JD, a partner with the Dallas-based law firm of Stewart Stimmel.

Document your ED's efforts to provide adequate

staffing, and educate staff and physicians on improved triage techniques, such as attendance logs on inservices to improve triage.

Here are other risk-reducing practices:

• **Address concerns of a patient or family member by providing an immediate reassessment.**

Emory Petrack, MD, FAAP, FACEP, a medical-legal consultant and principle of Shaker Heights, OH-based Petrack Consulting, says, "When someone comes to a staff member, whether a physician, nurse, clerk or anybody, and expresses concern about their loved one, do not blow that off."

• **Post signage and verbally inform patients to let the nurse know if their condition worsens.**

"On some level, you are putting that responsibility on the patient," says Petrack. "I think it's fine to let people know that it's a busy ED, and you need to work with us to make sure you are taken care of."

• **Keep patients informed continuously. Jonathan D. Lawrence,** MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA, says, "From a consumer standpoint, people often don't mind waiting, as long as they know what they're waiting for. But when it's busy, usually the triage nurse doesn't have time to go out there and make nice. And those are exactly those times that are most tension-filled."

Instead, an administrator might tell patients that an ambulance just brought in additional patients from a motor vehicle crash, and the ED staff is doing the best they can but an exact wait time can't be given. ■

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 **September** 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*

7. According to Gina Ginn Greenwood, of counsel in the office of Baker, Donelson, Bearman, Caldwell, & Berkowitz, there are many misconceptions about what is and is not permissible under The Health Insurance Portability and Accountability Act (HIPAA) when photographing a patient. Which of the following is not incorrect?
   A. There is no violation if you don't show body parts.
   B. There is no violation if the patient is not identifiable.
   C. There is no violation if you do not forward the photo by e-mail.
   D. There is no violation if you do not use the patient's name.

8. Scott Felten, MD, FACEP, an emergency physician at St. Francis Hospital and an assistant professor at the University of Oklahoma, both in Tulsa, recommends adopting a strict policy governing the use of cell phones in the ED, such as the one the St. Francis ED nurse coordinator developed, to avoid potential HIPAA violations. The St. Francis policy forbids the use of cell phones entirely, except for:
   A. Texting.
   B. Downloading reference material.
   C. Personal calls.
   D. Educational photography.

9. According to Angela Gardner, MD, FACEP, president of the American College of Emergency Physicians (ACEP), many conditions seen in the ED are best treated by an ongoing relationship with the primary care physician. Which of the following is among those conditions?
   A. Diabetes
   B. Hypertension
   C. Asthma
   D. All of the above

COMING IN FUTURE MONTHS

■ ED uses digital billboards, texting to broadcast wait times

■ Throughput drive lowers discharge time, LOS

■ ED leaders study most effective intake systems

■ "Medical home" program cuts peds ED visits in half

10. According to Susan Castrignano, RN, BSN, the nursing director of the ED at Peninsula Regional Medical Center, what vehicle was used to determine the most appropriate options for recent process improvement initiatives?
    A. Focus groups
    B. Staff meetings
    C. Directives from ED leadership
    D. Online survey.

11. According to Amanda Jones, RN, BSN, the director of the ED at St. Joseph's Hospital, who helped temporary physicians become acclimated during the recent staffing transition period?
    A. The medical director
    B. The nursing director
    C. ED nurses
    D. All of the above

12. According to Pat Adamski, RN, MS, MBA, the director of the Standards Interpretation Group and the Office of Quality Monitoring for The Joint Commission, a woman who comes in with certain symptoms and does not reveal she had delivered within how many days might cause something potentially dangerous to be missed?
    A. 21 days.
    B. 30 days.
    C. 42 days.
    D. 60 days.

CNE/CME answers

Answers:7. B 8. B 9. D 10. A 11. D 12. C

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

Sentinel Event Alert issued on maternal deaths — ED plays important role in prevention

Specific actions spelled out for education, processes

In a new Sentinel Event Alert[1], The Joint Commission focused on an issue to which ED managers are no strangers. In fact, in listing three "Suggested Actions," it focused one squarely on the ED: "Educate emergency room personnel about the possibility that a woman, whatever her presenting symptoms, may be pregnant or may have recently been pregnant. Many maternal deaths occur before the woman is hospitalized or after she delivers and is discharged. These deaths may occur in another hospital, away from the woman's usual prenatal or obstetric care givers. Knowledge of pregnancy may affect the diagnosis or appropriate treatment."

"We want to make sure the providers that work in EDs have women of child-bearing age on their radar in terms of the potential for this event," says **Pat Adamski**, RN, MS, MBA, the director of the Standards Interpretation Group and the Office of Quality Monitoring for The Joint Commission. "When we think about pregnancy and having babies, it's usually a pretty positive event and many women sail through, so when problems do occur, it's something for ED staff in particular to be prepared for, as they deal with pregnant women on a regular basis, but they usually cruise through the ED on the way to labor and delivery."

Adamski says one of the goals of the alert is to raise awareness of certain complications and conditions that might cause potential for maternal deaths -- deaths that can potentially be avoided. "If you know the patient is pregnant, there are a lot of conditions EDs probably are used to seeing, but do not always consider that maternal death piece -- particularly post-delivery," she says. "A woman who comes in with certain symptoms and does not reveal she had delivered within 42 days might cause something to be missed."

Helene Connolly, MD, FACEP, chair of the Department of Emergency Medicine at Mercy Hospital and Medical Center in Chicago, says, "Our protocol is that any female of child-bearing age who presents with abdominal pain or vaginal bleeding will get a pregnancy test. As soon as they come to triage, the nurses have the authority to order the test, and they do so liberally."

In fact, one of the ED's quality indicators is that every woman with abdominal pain has to have a

Executive Summary

Maternal deaths are a serious enough issue that The Joint Commission recently put out a Sentinel Event Alert with several suggested actions, with one specifically addressing the ED.

- Educate your staff about the fact that any woman of child-bearing age, regardless of presenting symptoms, might be pregnant or might recently have been pregnant.
- Adopt a policy that any female of child-bearing age who presents with abdominal pain or vaginal bleeding receives a pregnancy test.
- Ensure that any patient with a complaint referable to pregnancy goes to labor and delivery for a stress test and continuous monitoring.

Financial Disclosure:
Senior Managing Editor Joy Dickinson, Author Steve Lewis, Nurse Planner Diana S. Contino, and Associate Publisher Coles McKagen report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Executive Editor James J. Augustine discloses that he is an employee of EMP Holding and is on the speakers bureau for Masimo Corp. and Dey Pharma.

pregnancy test, Connolly says. "We cover it at staff meetings, posted communication, and so on, so we do have continuing education," she says.

Also, during the past 20 weeks a new procedure has been instituted. Any complaint referable to pregnancy will go to labor and delivery for a stress test and will be monitored. "In addition, since EDs have gotten more familiar with ultrasound, maternal deaths from ectopic pregnancies have just dropped to the ground," Connolly says.

Lisa Hrutkay, DO, an attending physician in the ED at Ohio Valley Medical Center in Wheeling, WV, says, "If there is abdominal pain or vaginal bleeding, the patient will get an ultrasound to rule out ectopic pregnancies."

Adamski says, "In the ED you have doctors and nurses who are well-versed in diseases and conditions and the education that follows, but if you have a pregnancy discovered late in the term, it requires specialized knowledge. Of course, it's much easier if you have an OB/GYN."

When education is provided, remember that adult students have a variety of learning preferences, she says. "People need to be addressed in a variety of ways," Adamski says. "If you have 10 learners, a third of them may learn by hearing, another percentage by doing, and so on." In other words, she says, some members of the staff might be fine with an inservice or a self-learning module, while others might prefer a "robust clinical discussion" with staff members bouncing ideas off each other. "It's really a question of what works best for the members of your group," says Adamski.

Drills and protocols

Another Joint Commission suggested action with implications for the ED reads as follows: "Identify specific triggers for responding to changes in the mother's vital signs and clinical condition and develop and use protocols and drills for responding to changes, such as hemorrhage and pre-eclampsia. Use the drills to train staff in the protocols, to refine local protocols, and to identify and fix systems problems that would prevent optimal care."

Connolly, noting that vitals are the first step in triage, says, "We are very vital sign-driven already." If the vitals are normal, they might be checked once again before discharge. If they are abnormal, the frequency of repeats depends on how abnormal they are.

"Vital signs are particularly important in a pregnant woman -- especially blood pressure, which should be lower," says Connolly. "Where a normal 24-year-old would have 120 over 80, what's normal in a woman who is not pregnant might be a hypertensive sign in pregnant women."

Her ED does not run drills for such situations, "but I'm not saying it's a bad idea," she says. "We had a patient just the other night who was pregnant and hemorrhaging and almost died. It's not a bad idea to dissect a case like that." If it became apparent that there were delays occurring in the treatment of pregnant women, "We'd look for ways to improve," she says. "If you did do a mock drill, you could come up with things that bring you down the wrong path."

Hrutkay, however, isn't certain that mock drills are necessary. "Most of the hemorrhages we have are non-emergent," she says. Usually her staff will see spotting or spontaneous miscarriages, Hrutkay says.

ED managers looking to boost their knowledge and improve protocols might look outside their department for help, Adamski suggests. "If you have an OB department or a family birthing area, they'd be able to provide a wealth of information and help your staff better understand symptoms and sets of symptoms to be able to act on quickly," she says. "If the OB department conducts drills, perhaps they would give your staff the opportunity to participate."

Reference

1. The Joint Commission. Preventing maternal death. Sentinel Event Alert Jan. 26, 2010; Issue 44. Accessed at www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_44.htm. ■

Standard is revised for medical staff bylaws

Joint Commission: It provides more flexibility

The Joint Commission has approved revisions to Medical Staff (MS) 01.01.01, formerly known as MS.1.20. This standard, it says, "is designed to contribute to patient safety and quality of care through the support of a well-functioning, positive relationship between a hospital's medical staff and governing body."

Standard MS.01.01.01 addresses the medical staff's self-governance and its accountability to the governing body for the quality and safety of patient care. It recognizes that while a hospital's governing body is ultimately responsible for the quality and safety of care, the governing body, medical staff, and administration must collaborate to achieve this goal.

Executive Summary

In response to feedback from the medical community, The Joint Commission has revised its medical staff standard.

- If the medical staff wants to have the associated details of all elements in the bylaws they can, but they can also reference them in rules and regulations or policies and procedures.
- The medical staff's self-governance is maintained, and its collaboration with the hospital's governing body is enhanced.
- It makes clear that quality and safety are not just the hospital's responsibility. It is the responsibility of the hospital and medical staff working collaboratively and supporting each other.

The revisions are based on the unanimous recommendations of an 18-member expert task force representing the American College of Physicians, American College of Surgeons, American Dental Association, American Hospital Association, American Medical Association, Federation of American Hospitals, National Association Medical Staff Services, as well as hospital trustees and health care attorneys.

The revised standard goes into effect March 31, 2011, which provides a year for ED managers and other hospital leaders to come into compliance with the revised requirements. The deadline also gives officials with The Joint Commission an opportunity to answer any questions that might arise about the revised standard. They also say it will provide additional education to support hospitals and prepare them for implementation of the standard.

The medical staff bylaws issue has been a subject of interest from physicians and hospitals for several years, notes **Charles A. Mowll**, FACHE, executive vice president of business development, government, and external relations for The Joint Commission. Changes had been proposed in 2007, but hospital officials had thought they were overly proscriptive and they didn't really see a quality and safety impact, he says.

"The standard defines those elements that need to be cited in the bylaws, but when we put the standard out we also said all the attendant detail and descriptions of those items had to be in the bylaws as well, and that was just not reality in many hospitals; many have them in policies and procedures and rules and regulations," Mowll explains. "If we had let it stand in its old form, hospitals would have had to go in and move a lot of material around from rules and regulations to bylaws, and bylaws require joint endorsement of both medical staff and the governing body."

Under the revised standard, if the medical staff wants to have the associated details in the bylaws they can, but they can also reference them in rules and regulations or policies and procedures, he says.

For ED managers, says Mowll, the revised standard might not require many changes at all. "It is our hope that this change will not have any dramatic impact on well-functioning staff in terms its relationship with the governing body," he says. "We don't want to fix what isn't broken."

Michael R. Humphrey, MD, the chief clinical officer at St Rita's Medical Center in Lima, OH, agrees. "Everything they're saying should be changed, we have had in the form of written bylaws," Humphrey says. "Maybe we're unique or fortunate, but there's not one line-item we would have to change."

Collaboration means safety

Another key aspect of the standard is its emphasis that the medical staff's self-governance be maintained and its collaboration with the hospital's governing body enhanced, says Mowll.

"We want to emphasize the goal here is safe, high quality care," says Mowll. "When these three [medical staff, the medical executive committee, and the governing body] work together collaboratively, the patient benefits."

This change led to a change in the standard concerning communication. "What we all assume is that when the medical executive committee acts on behalf of the medical staff, it lets them know what changes it is making in advance," Mowll says. "That was never written down before, so we added it into the changes — that there needs to be pro-active communication between the med-exec committee and med staff and vice versa — so if the medical staff makes changes and takes it to the governing body, that is communicated beforehand with the medical executive committee."

That active communication builds trust and a more positive working relationship, he says. In addition, Mowll says, the features that are required in the bylaws, such as the credentialing process, ensuring a fair hearing and appeals process for doctors under scrutiny, and formal processes such as history and physicals "have a direct impact on patient safety." That's why the various leadership groups must see eye to eye in these key areas, he emphasizes.

The ED at St. Rita's has a clinical director and an administrative director, notes Humphrey. "They are

the ones who build all the policies and procedures applying to the department itself," he says. It is usually the clinical director who makes bylaws recommendations, Humphrey says.

In terms of quality improvement, there is strong communication with the medical executive committee, he says. "We operate on a 6-point quality assurance level," Humphrey says. "Any case rated 3 or above gets referred to the med-exec committee, and they will determine what needs to be done."

Another thing the revised standard accomplishes is a sense of shared responsibility for patient safety and quality, Mowll says. "The new emphasis in the way we rewrote the standard is that you can't point fingers," he explains. "It's not just the hospital's responsibility. It is the hospital and medical staff working collaboratively and supporting each other." (Editor's note: Detailed information about revised standard MS.01.01.01 can be found on The Joint Commission Web site, www.jointcommission.org. On the right-hand side of the page, under "Joint Commission News," click on "Joint Commission approves revised medical staff bylaws standard MS.0.01.011.) ■

Comments sought by Joint Commission

The Joint Commission is seeking comments in two areas of concern to ED managers: candidate performance measures for inpatient and ED care of sudden cardiac arrest patients, and its revised National Patient Safety Goal (NPSG) 03.07.01, which addresses medication reconciliation.

The Joint Commission also is seeking abstracts describing effective community-based programs, program implementation methods, or practices related to the prevention or treatment of sudden cardiac arrest for potential inclusion in an educational monograph. The submission deadline for candidate performance measures is April 30, 2010, and the deadline for abstracts is May 23, 2010. For instructions and how and where to submit the performance measures and abstracts go to www.jointcommission.org/performancemeasurement/callsforparticipation.

There are separate links on this page to click on for the performance measures and for the abstracts. For more information, contact Kathleen Domzalski at kdomzalski@jointcommission.org.

In response to complaints from accredited organizations that the 2009 version of NPSG.03.07.01was difficult to implement because it was too detailed and too broad in scope, The Joint Commission researched the implementation challenges and subsequently revised the goal. "The revised NPSG places a spotlight on specific risk points in the process that are critical and readily achievable," says The Joint Commission. "The remaining components of the medication reconciliation process are covered in standards."

Go to www.jointcommission.org/Standards/FieldReviews/fr_npsg030701.htm and click on the appropriate program. There you will find a copy of the proposed standard/NPSG as well as instructions on how to offer your comments. The Joint Commission would like to receive comments by April 30, 2010, but this field of engagement will remain open until May 11, 2010. ■