YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

HPR HOSPITAL PEER REVIEW®

Accreditation • Credentialing • Discharge Planning • Medicare Compliance • Patient Safety • QI/UR • Reimbursement

**June 2010:** Vol. 35, No. 6
Pages 61-72

## IN THIS ISSUE

■ OIG report: Hospitals still underreporting adverse events . . . . . 61

■ Shore up your incident reporting system. . . . . 64

■ Color: A safety catch or a safety curse? . . . . . 65

■ Accreditation Field Report: Use priority focus report as 'road map' for survey . . . 68

■ Best practices among high-performing systems. . . . 70

■ News briefs . . . . . 71

Also included
*Patient Satisfaction Planner*
CNE evaluation

Financial Disclosure:
Managing Editor and Writer Jill Robbins, Executive Editor Russ Underwood and nurse planner Paula Swain report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

# OIG 'state of the union': Hospitals still underreporting adverse events

*Report also finds inaccurate or absent diagnosis codes*

Hospital reporting on adverse events is still lacking, according to a report from the Department of Health and Human Services Office of Inspector General (OIG), released in March.

"I don't think any of us were terribly surprised by the OIG report. I think it was carefully done, but I think it's a cautionary note because it indicates that there are more things happening to patients than get reported," says **Bill Munier**, MD, MBA, director of the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality (AHRQ).

In 2008, the OIG began a case study to "determine the incidence of adverse events" and has now released its report — "Adverse Events in Hospitals: Methods for Identifying Events." As part of its study, the agency reviewed a random sample of 278 Medicare beneficiary hospitalizations. The objective: to evaluate the use of various methods for identifying harm to Medicare beneficiaries. The OIG used five screening methods to identify events — nurse reviews of records, interviews with beneficiaries, two types of billing data analysis, and reviews of hospitals' internal incident reports. It uncovered shortcomings in screening methods for Medicare payments and federal initiatives to identify, track, and monitor events. Analysis of billing data showed inaccurate or absent billing codes and insufficient internal incident reports. With the former, the report says, hospitals could be receiving overpayments. For the latter, there were no incident reports for 112 of 120 events identified "including some of the most serious events involving death or permanent disability to the patients."

Among its recommendations, the OIG has suggested that:

- CMS and AHRQ "explore opportunities to identify events when conducting medical record reviews for other purposes";
- CMS "ensure that hospitals code claims accurately and completely to allow for identification of hospital-acquired conditions [HACs] affected by Medicare's payment policy";
- CMS "provide interpretive guidelines for state survey agencies to assess hospital compliance with requirements to track and monitor adverse events";
- AHRQ "inform PSOs [patient safety organizations] that internal hos-

AHC Media LLC

pital incident reporting may be insufficient to provide needed information about events to PSOs."

"I think a lot of people think that the incident reporting systems are picking up what they should be picking up," Munier says, adding that AHRQ thinks the report was sound. CMS also has stated it agrees with the recommendations made in the report.

"What I would say is that the report is sort of a clarion call that adverse event reporting systems, as they have been done historically, aren't getting the job done," Munier says.

The report also shows "that there is no one system that really has the answer for this. And doing a chart review the way they did, which I think was the most accurate method [the study found for identifying events], is very labor-intensive."

**Henry Fader**, attorney with Pepper Hamilton LLP, says he had heard from multiple sources before the publication of the report "that people were putting multiple conditions down even if it was something minor so they wouldn't be flagged for having a hospital-acquired condition. And I know the state reporting agencies have also noticed a lot of underreporting on infections." Fader recalls a recent article that suggested that light reporting on HACs is linked to overreporting of present-on-admission (POA) indicators.

Hospitals are going to have to have policies on how to deal with HACs, he says. "I think what this is showing is very quickly after there's an incident or a suspected incident, you have to make a decision about, 'What are we going to here? Are we going to bill it? Are we not going bill it? Are we going to talk to the family or not talk to the family?'"

**Jill Rosenthal,** MPH, program director at the National Academy for State Health Policy, says there are many important takeaways for quality managers. One message, she says, is that it's difficult to identify these events. "[OIG] used various types of strategies to identify the events and found quite a bit of variation in what turned up."

She suggests that hospitals go back and review how POAs should be coded and "make a concerted effort to improve the coding of POAs."

"I was surprised at the number of events that turned up through hospital review. It's pretty low. And given that in many states it's required that those events be reported, and given that it's required that they be coded by POAs, I think that looking at improving hospital incident identification is a big message here," she says.

She suggests using the Institute for Healthcare Improvement's tools on incident reporting and says that many states that require reporting of this sort do training sessions and "provide information to facilities on how to identify and report root causes of events."

"I also think with the emphasis on health information technology and medical records, I hope there will be improvements in how those kinds of events get identified," she says. She thinks the move to electronic systems and more information

**Hospital Peer Review**® (ISSN# 0149-2632) is published monthly, and Patient Satisfaction Planner™ is published quarterly, by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

**POSTMASTER:** Send address changes to Hospital Peer Review®, P.O. Box 740059, Atlanta, GA 30374.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for Hospital Peer Review® is hospital-based quality professionals.

Opinions expressed are not necessarily those of this publication.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcmedia.com. E-mail: customerservice@ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)



Executive Editor: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).

Managing Editor/Writer: Jill Robbins, (404) 262-5557, (jill.robbins@ahcmedia.com).




Editorial Questions

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

on how to improve POA coding will help ease the burden of tracking events. "I think it also gets back to [the fact] that you need various mechanisms to identify the events because none of them work perfectly on their own."

She thinks variation in state reporting requirements also will become more standardized with time. "More states are adopting the NQF [National Quality Forum] list of serious events. The CMS hospital-acquired condition payment policy incorporates a lot of the NQF events. And I think with the patient safety organizations, the efforts to develop common formats, I think it's all coming together slowly but surely," she says.

"I think given that there's a nonpayment policy for Medicare and there are a number of states that have that same policy through Medicaid, and given that our new health reform legislation requires Medicaid to do that in the future, it's going to become increasingly important that facilities are able to code accurately and that they're able to identify those events."

Just how CMS and AHRQ will follow up with the recommendations remains to be seen, "but given that there's increased attention on it at the national level, I think that we'll see more happening to improve identification of events in the future," she says.

Munier points out that information gathered and reported to patient safety organizations is protected and cannot be used against hospital staff, as fear of reprisal remains one of the biggest barriers to voluntary reporting. AHRQ is refining its common formats to help hospitals report in a "more scientific and structured ways" when working in concert with a PSO.

"If everyone [reports] differently, you never get smarter about it. So we're also issuing the specifications for turning these common formats into electronic form... By specifying not only the definitions on paper, but also electronically, we are getting to a level of specificity that's necessary in order to really know that we're collecting valid information in the same way in different hospitals." *(To get more information on AHRQ's common formats and PSO engagement, visit www.pso.ahrq.gov.)*

In May, AHRQ had its second annual meeting of PSOs and also met with software developers to evaluate "the technical specifications, which we hope will be very helpful in expediting the development of software to automate the AHRQ common formats."

Munier acknowledges the disparities among different regulating bodies and reporting requirements. "A lot of well-meaning organizations, ours included, of course, have developed lists of events or definitions to meet the needs of their own constituencies. And this has happened over time, and there's no one overall agent that has the authority or the sway to say, 'This is what you're going to be collecting,'" he says.

Moving forward, AHRQ will meet with CMS, NQF, the Centers for Disease Control and Prevention, and state regulators on collecting information on hospital adverse events. "Now, that won't solve [the problem of disparate requirements], but I think getting together and beginning to discuss how we can begin to come together in terms of what we're reporting is the first step," he says.

He says "as PSOs begin to get operational and work with hospitals, we're going to see whether they've made a difference or not, whether working with a PSO encourages more reporting, and whether, over time, patient care is delivered more safely."

Fader says the report is a "wake-up call." With analysis showing that HACs "were being underreported either from a present-on-admission situation or the incident reports were being underreported" and with the recommendation that "state surveyors be trained to look for underreporting and that they look for the lack of incident reports in certain areas and then that they were going to continue to study why this underreporting was going on," hospitals should heed the call.

He says hospitals can no longer work in silos. "You no longer can isolate the billing department, the risk managers, the medical staff, and everybody goes about their own function without having cross-fertilization of ideas and dealing with problems as they've arisen," he says.

Munier also highlights the need for cross-discipline communication. "If you want to talk about high-level concepts that are important to this whole endeavor, the other big one is teamwork, which has to do with patient safety and quality. Too often I think the professionals in hospitals have worked in independent silos — the nursing silo, the doctor silo, the pharmacy silo, the medical records silo, and we're finding increasingly that teamwork can make it a safer and better place for hospitals."

AHRQ has tools to help hospitals both gauge the culture of safety from the employee's perspective (*http://www.ahrq.gov/qual/patientsafetyculture/hospsurvindex.htm*) and to encourage teamwork as part of its work with the Department of Defense called TeamSTEPPS (*http://teamstepps.ahrq.gov/*).

Beyond building the culture of safety that supports more transparency and reporting of events, some states have been successful in building that culture on a statewide-basis, he says. "In the state of Pennsylvania, where they're getting a very high number of near-misses reported, where they do have protection of information, and where it's being used only for educational purposes and not to sue people, they're getting an awful lot of near-misses and they are helping that state learn how to make care safer."

Munier says establishing the culture can make the difference.

"I think it's a project that's going to take a number of years. It's certainly not something you're going to snap your fingers and have improvement right away. We're doing everything we can. We have our culture surveys, surveys of patient experience, all which are aimed at finding out whether what's going on at the hospital level is conducive to the kind of culture that would encourage reporting and improvement. So I think we're doing everything we can to push things in the right direction," he says.

"The [OIG] report does two things. It lays out a quantitative assessment of the job that needs doing, and it also provides objective evidence that everybody can look at why they need to do a better job, and I think that's a good thing," he says.

(To view the OIG report, go to: *http://oig.hhs.gov/oei/reports/oei-06-08-00221.pdf*.) ■

# Shore up your incident reporting system

According to experts *Hospital Peer Review* spoke with, the two biggest barriers to a robust reporting system are employees' fear of punitive action and a burdensome policy that requires a lot of work.

"The starting point is for hospitals to develop a system that makes it easy for staff to report adverse events," says **Kurt Patton**, CEO of Patton Healthcare Consulting in Glendale, AZ, and former executive director of accreditation services at The Joint Commission.

"Sometimes in hospitals people report an adverse event and somebody in a position of authority — the quality department or whomever — starts to ask you so many follow-up questions and asks for so much additional data that you just regret ever having reported it," he adds.

Many hospitals are moving to Web-based reporting systems, but Patton says whatever the system, you must make it simple to encourage compliance. He says oftentimes with Web systems, each page asks a question that must be answered to move on. "If I get a website that asks me one question per screen, I'm never going to want to use it again. And a lot of systems are like that," he says.

"One I've seen hospitals use that's nice is you can call a number and say, 'This is Kurt from 4 South and we have a patient up here that's developed a skin ulcer. It's the patient in 429B, Mr. Smith.' And then quality or risk goes and investigates it. And that's a really easy technique for staff to use."

**Jim Conway**, senior vice president at the Institute for Healthcare Improvement (IHI) and senior consultant at the Dana-Farber Cancer Institute, concurs. "The first thing I'm saying is we have to simplify the systems. The second is not every one gets an RCA [root-cause analysis]. That there are some issues that get resolved in the ongoing communication among clinicians with their patients. There's some stuff that requires an incident report. There's some stuff that requires a root-cause analysis, and what we really need to understand is what's the most appropriate methodology."

Patton, too, says not every report begs an investigation and that even the smaller incidents can be used for improvement. "That minor incident may not be worth sitting down and spending thousands of dollars of staff time doing an RCA, but somebody in the quality department should certainly be analyzing the frequency of the occurrence," he says. By tracking the smaller incidents and knowing the frequency, you can uncover areas that need improvement.

Conway says many facilities spend a lot of time on capturing the information but not using it to facilitate improvement, and that, he adds, does not motivate staff to report. What motivates staff is not being punished for reporting and seeing that something is done about what is reported.

"I go to some organizations where staff report stuff and nothing happens. And it's not that anybody is bad, it's not that leaders are bad, but there's so much stuff coming in, there's not a good process to do that, there's not appropriate levels of delegation. So one of the ways to really stimulate reporting is, part of the culture, when you report something there's a mechanism to do something

to drive change and improvement. If you do that, then people will say, 'Wow that worked. I'll do another one of those.'"

Conway says, too, hospitals should move away from blaming an individual when an incident occurs. "We have done an awfully good job in health care of expecting people who are great people who suffer from being human to be perfect 100% of the time. And they can't be. So when we begin to understand when is it about individual responsibility, when is it about shared responsibility, and when is it about system responsibility — when we begin to understand that and practice that — then people will be far more willing to come forward and enter the system.

"That's all part of moving from this compliance focus [and asking] 'Who caused the pressure ulcer?' to 'Where do we have a problem with pressure ulcers and then how do we sit down at a table to figure out how we make this go away?'"

Patton says there are other, "passive" ways to uncover incidents. "As people screen medical records, there are clues that come through, and those clues can be triggers to say, 'Maybe there's an adverse event here of some sort.' You see that a lot of times with medication errors. When an order comes through and it says d/c [discontinue] all meds, Benadryl stat, that doesn't take a whole lot of brain power to say, 'Oh wait a minute, maybe this patient is having some kind of allergic reaction to their meds.' And that doesn't necessarily require an employee to fill out an incident report, but that by itself should trigger people to investigate that case." He says seeing "d/c all meds" in a chart would be a "dead clue" that a patient is having an allergic reaction. That issue, being a medication-related one, you may want to delegate to the pharmacy to investigate.

He suggests looking for other "passive triggers." "If you look from a medical record/coding perspective, there may be things that they can identify at the hospital that aren't being reported but they ought to be analyzing. The patient that comes in without a skin ulcer, when that gets coded a few days later and the patient now has a skin ulcer, that should somehow be culled from the hospital's computer system and reported to risk management or quality for people to review that," he says.

Conway says, "The OIG is very, very concerned about the amount of preventable harm that happens in the United States that nobody appears to be doing anything about. So they have put a tremendous focus on governance and governance responsibility for quality and safety. They've been a major supporter of IHI's work in getting the board on board."

Both Conway and Patton say evaluating your hospital's culture is integral in understanding barriers to reporting. The Agency for Healthcare Research and Quality's tool on evaluating staff perception of culture is useful here, too. Conway suggests also looking at IHI's self-assessment tool to see if you have systems in place for proper crisis/disclosure management (*visit http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/DisclosureToolkitCultureAssessment.htm and select "IHI Disclosure Culture Assessment Tool"*).

Disclosure, he says, is part of a process. First, when a practitioner forgets, for instance, to order a lab test or to give a patient medication, do you tell the patient then? And then how do you support people after a disclosure and how do you resolve a crisis after it's reported?

"And the last piece is ongoing learning and improvement. What we're finding is organizations are remembering to do the disclosure, and they're really working hard to do that right, but then the case gets referred to the malpractice carrier and nobody follows up with the family," he says.

"Do you have a policy in place on patient communications? Do you have a documented flow of how communications flow when an event happens?" he says. Because there should be a policy in place to follow immediately after an incident occurs. ■

# Color: A safety catch or a safety curse?

*Some experts say 'no' to color*

Color is everywhere in our world. Think of all the colors we use for navigating traffic and the unrest it would cause if those signs were taken away. But experts say beware of color in health care; they can cause indelible harm, even death.

Color "works with traffic signals because it ties color and location consistently. But health care can't do that. It's got too many moving parts," says **Debora Simmons**, RN, MSN, CCRN, CCNS, research scientist at Texas A&M Rural and Community Heath Institute and associate director at The Patient Safety Education Project. And just as color is used in multiple ways — armbands, IV tubing, medication labels, enteral feeding tubes, infusion pumps — it has been the cause of mul-

tiple errors, Simmons says, citing that there is no evidence or literature supporting its use an indicator or differentiator.

"The sad part about it is that cognitively the driver for us for color is very strongly ingrained in our working memory, so you will hold that in your head and you'll keep that and then you'll make that association without even consciously thinking about it," she says.

In health care now, "people rely on color and just overall appearance. Unless there's something else to differentiate the products — like really bold labeling of the name in strategic locations on a container, for example, that helps to differentiate the product — we see the kinds of things that get reported to [our national reporting database]. And that is, they pick up the wrong container thinking they have the right one," says **Michael Cohen**, RPh, MS, ScD, president of The Institute for Safe Medication Practices.

"I think people do develop a picture of what the container is supposed to look like in their mind's eye, and that's what they're looking for, and unless they see any disconfirming evidence that proves to them that what I have in my hand is not what's in my mind it's just very, very easy for us to overlook that," he says.

Anecdotes of errors caused by hospital staff relying on color as a sole identifier are endless, Simmons says. Some, such as the heparin overdose with actor Dennis Quaid's twins, reach the mainstream media. But many don't. Simmons recalls a recent case in a hospital. Typically, she says, red has been used for arterial lines and blue for venous lines. A patient had come into the hospital for dialysis, and one of the ports became clotted and needed to be replaced. "They needed to pull the venous port but after dialysis the last time the techs accidently recapped with the wrong color. So they put the red cap on the venous and the blue cap on the arterial line. And so they removed the wrong line," Simmons says.

She points to the use of color for feeding tubes. "We've got orange lines, orange oral syringes so you will start to associate orange with oral or GI systems," she says. But one company is coming out with a purple feeding tube, "and now we've got purple PICC lines that are out there... What you're doing is you're making the association with a purple feeding tube to a triple intravenous line. That connection is fatal. That will kill a patient," she says.

Multiple layers of problems with using color as a safety "catch" exist, Simmons says:

- There's no standardization of colors in any setting or use.
- There are no standards regarding color from any regulatory body or the FDA.

She suggests looking at the use of color in other high-risk industries: Color is never used as the sole identifier, she says. With traffic lights, color is tied to position. With stop lights "it's the position of where those lights are that is supposed to cue us forward. If you mixed them up, then people would get all confused. So it's color and location. Well, you can't do that on patients because patients are all over the place and we move them from area to area. So you can't tie location and color."

Also in health care, she says, "You've got all these products that have universal connectors so they can connect to each other, and you've got people that are working fast in risky situations and they're busy and they're interrupted and they're used to doing things and they're making these associations with color, which is the wrong thing to do."

And using color with IV lines as a sole safety protector, she says, just doesn't work. "If you've got this colored IV line and you stock them and you run out of one, what you're going to do is use the other IV line. That's it. So now if you identified everything as say red is vasoactive and you run out of red lines, well you're not going to stop using that on patients. You've still got to use the drug and so what people will do is substitute those. So now you've got something that was supposed to be in a color and supposed to tee people off to the color but they're out of something so they're using something else," she says.

Simmons says using color seems an easy solution, but looking at it in terms of human factors engineering or cognitive psychology, it doesn't hold up. Good systems use redundancies, multiple layers of preventing errors, and force functions to prompt the correct action.

"If you look at other industries, when they do use color, what they do is they put color with a tactile cue and another visual cue such as shape. So they want something to feel different and be shaped differently and have color," and together those are used to decrease risk of an error. Color alone doesn't do that, she says.

There are many initiatives under way to try to stop companies from using colors in their marketing, and Simmons says in California there is legislation that prevents the use of universal colors on feeding tubes after 2013. "I'd be willing to forego the attractiveness of the label for safety reasons, and that's what I would like to see knowing that it will never happen," says Cohen.

Simmons suggests looking at your purchasing and join with others to stop companies from using color on their labeling. Beyond that, with the system as it is, and companies using marketing and colors and different fonts to distinguish themselves and compete with others, she admits there are not many great interventions to overcome errors.

One safety check she suggests is using independent double-checking by staff, for instance, when a nurse moves or reconnects a line. However, this not only disrupts workflow, but it can be burdensome for staff. For now, though, it can be helpful. She acknowledges the fact that now hospitals have to try to create others layers of safety and workarounds around things that were created with safety in mind but just don't work.

Another suggestion she makes is to "stop beating people up for errors so they'll tell you about them. The second thing is, you can make people aware that if something looks alike or sounds alike, that should be a huge red flag to your staff that an error might happen. And they should recognize that. The only way to do that is to put emphasis on it and make them aware of their environment. Say, 'If you see something like this, we need to move it. If you see something that looks alike, sounds alike next to each other, we need to move it.' So we've got to start teaching people to do that."

Both Cohen and Simmons favor hospitals using internal labeling — black and white labeling. "I would avoid things like asking nurses to use color tags to add to the IV line to differentiate them. I understand why people want to put a tag on it, but I would just use a black-and-white label. If you start putting colors on it, it could mean different things to different people. You could increase the rate of an infusion pump on the wrong line unintentionally," Cohen says. He would like to see labels that emphasize the drug name and strength rather than an attractive, marketable, and colorful label.

**Peggi Guenter**, PhD, RN, CNSN, director of clinical practice, advocacy, and research affairs for the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) also notes the flaws with using color as an indicator. She says A.S.P.E.N. has joined an international task force to redesign enteral connectors.

"What's happening is that some companies are claiming that purple is the standard when a standard color has actually not been set by a standards organization. The whole premise is that color in and of itself does not prevent a misconnection and our safe practices for enteral nutrition actually say that it should serve as a trigger for the nurse to think maybe this shouldn't be connected to something else. Color does not actually prevent the misconnection. Only a connector redesign will prevent the misconnections," she says.

"So what's happening is that some enteral equipment manufacturers are claiming that purple is the color and they're all fighting with each other about what color is the standard color even though a color has not been set. But they only work in their little realm. And they're not realizing that there actually are purple IV lines, PICC lines, on the market," she says.

She relates a conversation with a nurse at an Iowa hospital who works with the purchasing agents. This nurse "has had a terrible time trying to educate the nurses about color, and she's in this dilemma because they have a contract with the purple IV people and a contract with the purple enteral people and she's really having to go through a tremendous educational endeavor in order to prevent these from being hooked up with each other. So the problem with color is that all of these systems are being developed in silos and there's no overseeing body that looks at the color," Guenter says.

She says for the most part, there are no enteral systems on the market that don't use color "at least in their administration sets." She also promotes looking at your purchasing options. Her suggestions. "It's checking the bags. It's working down the tubing system so that before you take the end of an administration set, you need to make sure that what you're hooking it to is not an IV. There are some intravenous lines that are white and made of silicone and look very much like what an enteral feeding tube might look like. So tracing that feeding tube back to its origin to make sure that that's not an IV line and is indeed a feeding tube is really probably the most primary thing to do," she says.

She also suggests looking at your supply room and creating force functions to help nurses locate the correct tubes. She recommends packaging the tubing with the enteral feeding bag in a central supply room. "There's a way the correct tubing can be packaged with the bag using a rubber band. The correct tubing can be packaged with the bag coming up versus the nurse just running into a local supply room and pulling tubing out and pulling indeed the wrong tubing and priming the bag and then hooking into an IV."

She also favors internal labeling systems. "For instance, on a patient's abdomen, who is a surgical patient, we might have three or four different tubes on their abdomen. Some are drainage tubes, some

are feeding tubes. And to make sure that you label those so that when you go to hook the feeding in, you're putting it in the right kind of tube." ■

**ACCREDITATION**
***Field Report***

# Use priority focus report as 'road map' for survey

**Kathleen Rauch**, RN, BSN, director, Center for Clinical and Operational Performance Analysis, Risk Management & Infection Control at Princeton Healthcare System, felt pretty good coming out of a recent Joint Commission survey. Because she knew what to expect and what was needed to get ready.

Her takeaway from the experience: "We had certainly been hearing plenty that the focus was going to be more on that consultative basis versus just really looking to home in on compliance, and I think that we felt very much that there was a different experience when they came out."

## Survey prep: Tools and suggestions

The first thing she says she would share with others in preparing for a Joint Commission survey is using the priority focus report for guidance. "They really do use that as a gauge. Certainly when we had our opening meeting, our orientation with the surveyors and leadership, our lead surveyor brought that to the table... He said certainly this is going to be a starting point for us to look at these areas to see how are you doing," she says.

She suggests looking at the report to identify areas for improvement. "At least for our experience, they absolutely used those reports as part of their road map for starting their tracer activity."

She says for hospitals accredited by The Joint Commission, the priority focus process summary report, which comes out quarterly, is available on their internal site. The report culls data from various sources, including the Centers for Medicare & Medicaid Services, any complaints filed against the hospital, pre-survey information taken from the hospital's application, past survey findings, information from The Joint Commission's quality monitoring system database of complaints and non-self-reported events, core measure data, and external data from sources such as MedPAR and HCAPS.

The report "gives you the top three or four priority focus areas such as communication, assessment, patient safety, staffing," she says. "It also then gives you some information as far as clinical service groups, where there's opportunity there. So for an acute care hospital, it could be general surgery/psychiatry/oncology/general medicine. Because they're trying to give you some insight based on this information they've put together where they're seeing possibilities that should be explored. And that's what it's meant to be. It's meant to be a tool."

Rauch also looked to The Joint Commission's survey guide, survey planning tools, and activity guide to help preparedness. One surveyor, she says, "articulated many times that [the activity guide] was exactly what he was going to be using for the systems tracers. When he facilitated the environment of care, emergency management, and competency tracers, the surveyor stayed true to his word and followed the system tracer criteria in the activity guide."

Rauch followed the survey activity guide to create binders with the appropriate documents and kept those regularly updated. "Most everything they needed was in the binder, which made the document review process easier for both the surveyor team and us," she says. "The binder contained our PPR measure of success dashboard, our organizational PI plan, as well as other documents, which also served as guides to their survey activities. I really felt that by having the right documents available upon the surveyor team arrival that things flowed much better for us in our discussions with them, and that when they were out surveying, they were really able to see what we had in that binder is really what we do in practice. I think that that was a real strength for us in this survey."

## And the survey begins....

Rauch says the system had Joint Commission Resources (JCR) consultants visit last fall who had said some surveyors prefer PowerPoint presentations, while others don't. The PowerPoint presentation, used for the surveyors' orientation session, "wasn't too much. It wasn't too little. What it did was just gave them a quick snapshot of our organziation. It clarified for them what are our inpatient services, our outpatient services, and it wasn't heavy. We tried to keep it somewhat lean... It gave our leadership team prompts of the things we thought were important, that we wanted them to know. And it helped us to open up some dialogue."

The presentation also included organizational PI priorities and what the system was doing for quality and safety. Rauch also had prepared a presentation for the data system tracer based on JCR's suggestions, but the surveyor preferred an open-table discussion.

"My recommendation to folks who are getting ready for systems tracers: Make sure you have people who can really have that conversation at the table, rather than one person owning the conversation." She says the institution had been rehearsing system tracers, which she says prepared staff and helped them work off each other and know what input each could make individually. "One of the surveyors said when we did our medication management tracer, he was really impressed between how pharmacy was able to really be engaged and how nursing could speak to certain components and it really didn't just sit with one person or one practice," she says.

Rehearsals also were done with leadership and physicians. She says The Joint Commission likes to see physicians in the leadership session to see their engagement in the organization's goals. Beyond physicians, the CEO, a member of the board, the president of the medical staff, and the vice president sat in on the meeting.

"It was really significant to the surveyors that we had a board member who came and sat and who was able to articulate what is happening in our organization, what we're doing for quality and safety. He could speak to sentinel events and quality data. It really sent the message that we have good communication and that there is engagement on all levels," she says. "There wasn't one person who sat at the table who didn't contribute something, and it was because we had done the practices."

For the leadership session, Rauch pulled together information on the culture of safety, disruptive behavior, conflict management, and sentinel events. One recommendation she had received was that it wasn't value-added to just have a room full of people. "Have folks who can really work with each other and demonstrate that it's very collaborative."

For infection control, she says the surveyor offered a choice — either to sit down with the entire infection control committee or to meet with just the infection control coordinator and epidemiologist and then to move on to do the tracer. "We opted for the latter because that's really what he said they're looking to move toward. They're looking to move away from the group infection control systems tracer. He looked through our planning and our risk assessments, and that was the bulk of his evaluation."

She says surveyors want to know the reasons behind the way you do things. "They want to hear that you're not just arbitrarily doing or not doing things, that there's actually thoughtfulness, that you sit down and look at it and say, 'Well, this does have risk, but when I look at the benefits I have to say I think that it's still the better thing to do.' That wasn't certainly something we heard last time," she says.

She says, in some ways, The Joint Commission has become more similar to DNV. "They're trying to really get us to think more about evaluation, analysis, really using data, not just sitting on data. Because that was a big focus, too. 'So tell me how did you come to that conclusion? Tell me how you used data.' That was really very commonly asked during any of the tracers," she says.

## Surveyor focus

Rauch says surveyors looked at dating, timing, and signing of H&Ps, as well as legibility and timeliness. "They asked almost every person that I can think of when I was with the lead surveyor about handoff communication." The system uses the SBAR (Situation-Background-Assessment-Recommendation) technique, even though Rauch says The Joint Commission wants you to have a format but doesn't specify which one.

Surveyors also looked at patient identification — "what are your identifiers and when would you do it?" They looked at the med rec process, though it is not yet being scored.

They evaluated the patient assessment process, specifically skin, by asking staff if they use the Braden score and how frequently it's used. They looked at pain — pain assessment — and nutrition, as well as the system's policy for falls.

When surveyors were walking around, they also looked for expired equipment or materials and medication storage. Environment of care issues, such as documentation for dampers and having a call bell in the visitor bathroom adjacent to the emergency department, were discussed.

Asked if surveyors focused on the National Patient Safety Goals, Rauch says, "No. I didn't find that. I found that the priority focus report was really the roadmap for them. At least for those first couple days. That they really were looking to see what those topics were, how were we doing with those?

"I think that we were able to pretty consistently demonstrate to them that we don't just wake up in the morning and say, 'Oh, this sounds like a

good thing' and just throw it up in the air. That we really sit down and look at things to determine what we should be doing and how we should be doing it," she says. ■

## Best practices among high-performing systems

What distinguishes high-performing multi-hospital health systems from the rest? With support from The Commonwealth Fund, that's what the Health Research & Educational Trust (HRET) set out to uncover in a yearlong research project.[1] And their findings? Co-author **Maulik S. Joshi**, DrPH, president HRET and senior vice president for research at the American Hospital Association, says it isn't that simple. There is not one single characteristic that makes the difference but rather a confluence of systemwide communication of goals and priorities, linking a "perfect care" model with short-term goals, leadership's commitment to improvement, and incentivizing quality care.

"[C]ulture and leadership were clearly the two foundational elements for high performance — having that culture of performance excellence, accountability for results, and leaders really being able to implement and execute on these things were really, really major themes," Joshi says.

Another element common to high-performing systems was clear alignment of plans across the system "so that everything was clear from the top of the health system down to each individual hospital," he says. Other consistent practices seemed to hold true: "Incentives were really built in to do performance improvement and achieve the results. High-performing systems really used data robustly in terms of how they were doing, how they can improve, what to do, and then I think one of the more emerging areas is the standardization and spread [of data]," he says.

Some systems have salaried physicians who receive financial incentives for meeting specified quality and safety goals. Regarding incentivizing staff, Joshi says it is an "enabler" and "definitely plays a factor. [I]t's one of those you call necessary but not sufficient. It enables, but it's not the answer."

Alongside communication throughout the system, articulating and prioritizing goals is integral to high performance. "You need to focus on those vital few things that are most important. Those will vary by organization, but they'll probably have some association with patient satisfaction, clinical quality, access,

## CNE QUESTIONS

21. How many screening methods did the OIG evaluate for uncovering adverse events?
A. 1
B. 3
C. 5
D. 8

22. According to Kurt Patton, every incident reported should undergo a root-cause analysis.
A. True
B. False

23. According to Debora Simmons, RN, MSN, CCRN, CCNS, there is no evidence supporting the use of color as an error prevention tool in hospitals.
A. True
B. False

24. The Joint Commission has moved the National Patient Safety Goal on abbreviations into standard IM.02.02.01 as ____.
A. EP2
B. EP3
C. EP4
D. EP5

Answer Key: 21. C; 22. B; 23. A; 24. 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 **this issue**, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

and other things. So absolutely every organization needs to figure out what's that priority list and stay focused on delivering the best care for those areas and acknowledging that you're not excluding everything else but that you need to always have those few things that are your priority," Joshi says.

Using robust data was one consistent theme among high-performing systems, but Joshi says in many ways being able to access appropriate and useful data is still difficult. "We all are just really in our infancy of having more data and information used, and electronic health records will get us there," he says. "It's just we don't have real-time or near real-time information in health care to help us to decide the best care for our patients sometimes, and so we go on proxies. So I think part of it is, again, the data may be there, the skills are there, but we as a field need to have it readily accessible and usable so we can do something with it, and that's nobody's fault."

Another theme was holding to the quality principle of "all or nothing" or "getting to zero" and creating milestones or shorter-term goals of getting there.

*(To download the full report, go to http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Mar/A-Guide-to-Achieving-High-Performance-in-MultiHospital-Health-Systems.aspx. Also see Appendix A: High Performing Health System Survey, page 21.)*

REFERENCE
1. Yonek J., Hines S., and Joshi M. A Guide to Achieving High Performance in Multi-Hospital Health Systems. Health Research & Educational Trust, Chicago, IL. March 2010. ■

NEWS BRIEFS

# Joint Commission clarifies IM.02.02.01

As part of its Standards Improvement Initiative, The Joint Commission has moved the National Patient Safety Goal on abbreviations into the information management standard IM.02.02.01, element of performance 2. The wording also was clarified as The Joint Commission says organizations thought they had to create lists of approved abbreviations, acronyms, symbols, and dose designations, which was not the intention. Effective July 1, the language will return to the 2009 language stating: "The organization uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations." ■

# Most challenging requirements in '09

According to The Joint Commission, these five requirements were most frequently cited for noncompliance in hospitals.

• RC.01.01.01: The hospital maintains complete and accurate medical records.

• LS.02.01.10: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

• LS.02.01.20: The hospital maintains the

## 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

■ Getting certification for chronic kidney disease

■ Revisiting medication reconciliation requirements

■ Improving care during 'off-peak' hours

■ Suggestions for a conflict of interest policy

integrity of the means of egress.

• EC.02.03.05: The hospital maintains fire safety equipment and fire safety building features.

• RC.02.03.07: Qualified staff receive and record verbal orders. ■

# MOS requirements on several EPs deleted

A Joint Commission spokesman says, "The Joint Commission periodically reviews elements of performance (EP) categories and measures of success (MOS) as part of the normal process of updating and revising the standards." And as part of that, several MOS requirements were deleted effective April 26, 2010. While compliance with the EP is still required, you will no longer need to relay MOS data for the following EPs:

**Environment of Care (EC)**
- EC.02.01.01 EPs 7, 11
- EC.02.01.03 EP 6
- EC.02.02.01 EPs 7*, 8
- EC.02.03.01 EP 1
- EC.02.03.05 EPs 3, 4, 7*, 9*, 12*, 16*, 17*, 18*, 19*, 20*
- EC.02.04.01 EP 3
- EC.02.04.03 EP 1
- EC.02.05.01 EP 3
- EC.02.05.05 EP 1
- EC.02.05.07 EP 2

**Information Management (IM)**
- IM.02.02.01 EP 1*
- IM.02.02.03 EP 2*

**Leadership (LD)**
- LD.04.01.07 EP 3*

**Medication Management (MM)**
- MM.05.01.17 EP 2*

**Medical Staff (MS)**
- MS.02.01.01 EP 5*

**Provision of Care (PC)**
- PC.02.02.03 EPs 3, 4, 6, 9, 11
- PC.03.05.17 EP 3

**Performance Improvement (PI)**
- PI.01.01.01 EPs 3*, 16*, 17*, 18*, 19*, 20*, 21*

**Record of Care, Treatment, and Services (RC)**
- RC.01.01.01 EPs 11, 19
- RC.01.04.01 EP 2
- RC.01.05.01 EPs 2*, 3*
- RC.02.03.07 EP 4

* The EP is changing to the "A" scoring category effective July 1, 2010. ■

PATIENT SATISFACTION PLANNER™

# Center dedicated to patients over age 65

*Staff are trained to provide geriatric care, support*

The nation's first senior emergency center, opened by Holy Cross Hospital in Silver Spring, MD, is specifically tailored to meet the needs of a growing population of adults and provides care that goes beyond the typical emergency department assessment and treatment.

The Seniors Emergency Center at Holy Cross is an eight-bed, separate, enclosed area of the main emergency department and is dedicated to the care of patients over age 65, says *Susan Spivock Smith*, RN, CRNP, PhD, geriatric nurse practitioner at the center. The center is staffed by two nurses, an emergency center physician, a geriatric social worker, and a certified nurse assistant.

"We operate on a model similar to a pediatric emergency department. Just as children are not small adults, older adults are not the same as younger adults. Having geriatric specialists who can recognize atypical presentations in this specialized population can help speed the plan of care and treatment and result in better outcomes," adds *Marcella Smith*, MSW, social worker at the center.

For instance, a younger adult who is having a heart attack will have symptoms of mid-sternal crushing chest pain, sweating, and nausea. In the older adult, the atypical presentation of a heart attack may be manifested as abdominal pain, change in appetite, or altered mental status.

"In the younger adult, when you hear hooves, you think horses; but in the older adult, you must thing zebras," Spivock Smith says.

The center opened Nov. 6, 2008. In its first year, the hospital provided care to more than 12,000 seniors in the emergency center, and more than 50% of them were admitted.

Among respondents to a patient satisfaction survey sent to patients three weeks after a visit, 98% say they would recommend the center to friends and families.

"The emergency department is a frequent point of entry into the health care system for seniors. Holy Cross Hospital has always been senior-friendly, but we wanted to expand the services we provide to older adults," says Smith.

Patients over 65 who are not experiencing an acute event such as a heart attack or a stroke are triaged to the senior emergency department or Express Care, Spivock Smith says.

About 75% of seniors who present to the emergency department meet the criteria for the senior emergency center, she adds.

Spivock Smith and Smith also see senior patients in the main emergency department.

Almost half of the patients seen in the emergency department have had a fall. The most common conditions seen in the Senior Emergency Center include abdominal pain, shortness of breath, diarrhea and vomiting, dehydration, urinary tract infections, or change in mental status.

"We assess problems that older adult patients may be having beyond the reason they came to the emergency department. For instance, if someone tells us they can't pay for their blood pressure medicine or can't afford groceries, we help them access the appropriate resources that can help. As a social worker, I have the expertise to provide support, compassion, and respect to these vulnerable elders," Smith says.

When the patient arrives at the emergency center, the RN on duty conducts a comprehensive assessment that includes the patient's living conditions, support at home or in the community, mobility issues, and whether they have been in the emergency department during the last 72 hours and the last 30 days, or have been hospitalized in the past three months.

As part of the assessment, the RN records family concerns, caregiver stress, or other issues that may affect a safe discharge.

"We look at the potential for readmissions from the get-go so we can take measures to make sure they can transition safely into the community and prevent them from coming back," Spivock Smith says.

If patients are taking five or more medications, the staff alert the pharmacist, who assesses the medication to determine if there is an inappropriate drug or dose. The pharmacist communicates the information to the physician so he or she can

make changes to the medication regimen.

"A lot of times, medication can contribute to falls. The patients may not be taking the right dosage or the right class of drugs. In those cases, the pharmacist makes a recommendation to the physician to prescribe a more appropriate drug," Spivock Smith says.

The Senior Emergency Center staff have access to all the resources the hospital provides.

The team of Spivock Smith and Smith team is able to help avoid unnecessary hospitalizations by identifying proactively what issues might be a roadblock to discharge.

For instance, if a patient has fallen, they can request a physical therapy evaluation in the senior emergency center. A physical therapist can assess the need for equipment and make recommendations for home care services to assist the older adult with transitioning home safely.

"We've also helped facilitate admissions for patient who were not safe to go home. We are involved with discharge planning for these patients so when they do leave the hospital, it's to a safe environment," Smith says.

If patients are admitted to the hospital, Smith and Spivock Smith follow up with the case manager and social worker on the unit, alerting them of any issues they have observed.

"This means they are a step ahead in the discharge planning process because they already have the information we have gathered on their living situation, caregiver availability, and any mobility or cognitive issues," Spivock Smith says.

When patients are being discharged from the senior emergency center, Spivock Smith takes an active role in making sure they understand their discharge instructions and get an appointment with their primary care physician for a timely follow up.

"We take a holistic approach to the care the patient receives through the entire continuum of care. We found that sometimes patients come back to the emergency department because they don't understand their discharge instructions and they don't get the appropriate follow up after discharge," Spivock Smith says.

Smith calls the patients the day after they are discharged from the emergency department to make sure they have everything they need at home.

"Home may be a nursing home, a group home, an assisted living center, or the patient's own home," she says.

She asks if they've gotten their prescription filled, whether they have an appointment for follow-up care, and answers any questions.

If there are any barriers to care, Smith works with the patient and family to meet those needs.

For example, when patients tell Smith that they couldn't get an appointment with their doctor for several weeks, she asks for permission to call the doctor and see if she can get the appointment in a more timely manner.

"We know that if patients are not seen in a timely manner, symptoms may not be well controlled and they'll end up back in the hospital. We work to get them an appointment with a doctor in one or two days," she says.

The Spivock Smith-Smith team facilitates care along the continuum. They have a collaborative relationship with the doctors in the community.

"The physicians trust our judgment and are very receptive to our requests," Spivock Smith says.

Sometimes the team provides help and support for someone other than the patient and looks beyond his or her physical complaints, Smith reports.

For instance, a man who came in complaining of abdominal pain is the primary caregiver for a wife with cognitive issues and was experiencing a lot of stress related to caregiving.

"While the staff took care of the patient, I met with the daughter, who agreed that something needed to be done to relieve her father. We arranged for adult care to get relief for the father," she adds.

*Kevin J. Sexton*, president and CEO of the hospital, came up with the idea of the special emergency department for seniors because of the growing senior population in Montgomery County.

"Within the next 10 years, the senior population is expected to grow five times faster than everyone else. The growing number of seniors in this country presents a tremendous challenge to our health system, and it is our responsibility to respond in a way that is both sensitive and sustainable," Sexton said.

The hospital formed an advisory committee that included clinicians as well as a focus group of seniors and worked closely with Bill H. Thomas, MD, an elder care expert, and his team at The Erickson School at the University of Maryland to design the area and create a senior-friendly space.

The Holy Cross Hospital auxiliary earmarked the money from its gala in 2007 for the senior

program.

Patients in the focus group said they wanted to be kept warm, kept comfortable, and kept informed during their emergency department stay.

The hospital modified what had been an overflow area for the Express Care department to include six bays, two private patient rooms, and a room for family consultations.

The environment was designed to reduce anxiety, confusion, and risk of falling.

"We focus on making the experience as pleasant as possible. The patients often are here for several hours," Spivock Smith says.

Features used throughout the senior center include soft colors; noise-abatement features; non-slip, non-glare floors; non-glare lights with dimmers; hand rails; and grab bars. The area has a blanket warmer and a nursing station designed for increased visibility.

The rooms have pressure-reducing mattresses, clocks, calendars, telephones with large buttons, a dry-erase board, a flat-screen television with a speaker that can go under the pillow for patients who are hard of hearing, and comfortable chairs for family members.

"We encourage family members to stay with the patients. We strive to keep them informed. We let them know what tests are being performed and when we expect the results back. It has been our experience that patients and family members become less anxious when they know what to expect," Smith says.

*(For more information contact:*
*Marcella Smith, MSW, social worker, Senior Emergency Center, Holy Cross Hospital, e-mail: smithmarc@holycrosshealth.org.)* ■

# ED cuts LWBS from 5% to 0.5%

*Input required from several departments*

Recognizing that ED wait times and throughput are affected by the entire hospital, the leaders at King's Daughters Medical Center in Ashland, KY, engaged all the departments that interface with the ED and slashed the rate at which ED patients leave before treatment from 5% to 0.5%. This accomplishment is all the more remarkable because the ED sees 76,000 patients a year and volume has not declined during the implementation period.

During that same time period, turnaround time for admitted patients decreased by 22%, from 312 minutes to 242 minutes, and turnaround time for patients discharged from the ED fell by 9%, from 183 minutes to 166 minutes. "We still have a long way to go," says *Mona Thompson*, MBA, RN, CPHQ, CENP, vice president of patient services and chief nursing officer.

*Brandi Boggs*, RN, MSN, director of emergency services, says, "Throughput is a high priority for us for lots of reasons: patient satisfaction, quality of care, overall decline in length of stay."

Senior leaders outlined the goals and methods to achieve them. "We had a goal of reaching best practice in terms of left without being seen as defined by The Advisory Board — which is 0.55%," says Boggs. *(Editor's note: The Advisory Board, based in Washington, DC, is a provider of performance improvement services to the health care and education sectors.)*

Thompson says, "Brandi and her team came up with this plan. She involved radiology, bed placement, doctors and nurses, housekeeping, the pharmacy, the customer satisfaction team, the laboratory, case management, social workers, and IT — all the stakeholders." These stakeholders worked on actions specific to their discipline needed to achieve the 0.55% goal, she says.

"That's really important," says Thompson. "Teamwork is important to us, and the team members who do the work know how to make things better." So, for example, ED charge nurses and triage nurses accept responsibility for patient-left-without-being-seen rates and actively interact with patients to explain the benefits of receiving a medical screening exam, she says.

After several months of meetings, the plan was implemented in February 2009. Boggs says that in the ED itself, "one of the things we do differently now is triage patients directly to the back when there is an open bed. Triage is a function, not a location. If there is an open bed, and you bring the patient straight back, it increases quality of care and customer satisfaction."

This step eliminates the "funnel," Thompson says. "Most ED teams will tell you that patients arrive at triage in clusters, not in a steady stream, so if you funnel all of them through one or two triage nurses, it makes it slower for the last person in the cluster," she says. Now if there is a bed open, the patient can be triaged by the bedside

nurse, Boggs says.

"We also do hourly throughput assessments in the ED," she says. "We developed a worksheet where we can look at things that define throughput — patients in the lobby, current wait time, boarders" who are waiting more than two hours for a bed. Based on the worksheet, the charge nurse will assign a color (green, yellow, orange, or red) to indicate throughput status.

If there is a problem, all of the departments will swing into action. This team approach has led to steady progress, says Thompson, who notes that the 0.5% figure was first achieved in January 2010. "In the last two fiscal years [which end in October], we averaged 4.55% and 3.49%, respectively," she reports. "Year to date, we are at 1.33%." ■

# ED makes lemonade out of lemons

*Inadequate intake system vastly improved*

An adverse event in the ED at University Medical Center (UMC) in Las Vegas might have drawn negative media coverage and state and federal investigations, but it also led to process changes that the ED managers say have made a world of difference in patient satisfaction and quality.

"The problem was an incident that began at one of our outlying clinics, which we call Quick Cares," says *Dale Carrison,* DO, MS, FACEP, FACEOP, chairman of emergency services at UMC. He adds that ongoing legal action prevents him from going into too much detail. "They called the ED and advised us that a patient — a female with abdominal pain — was coming in her own vehicle. She had chosen not to come by ambulance."

There are varying versions on what happened once she arrived in the ED, says Carrison, "but she waited for a significant period of time — for too long," he notes.

An aggravating factor was that the woman was pregnant. However, the outlying clinic had not detected the pregnancy, and in fact, according to Carrison, the woman herself did not know she was pregnant. There was a delay in seeing the triage nurse, and the patient left on her own. According to local press reports, she tried another hospital but was told the wait there would be a long one, was given pain medication, and went home, where she delivered a premature baby girl. Paramedics failed to revive the baby, say the reports. The patient and her fiancé subsequently filed a complaint alleging that she was ignored in the ED so long that she and her fiancé returned home.

Following the investigations, including one by the Centers for Medicare & Medicaid Services, and the request for corrective actions, Carrison put together a team and conducted a root-cause analysis on all that had happened. "We looked at every portion of the system to determine the best odds of preventing this from happening again," he says.

One of the changes already had been under way, but the team decided to further modify it. "In the real old days, a patient took a number and sat down. We realized that was not good, and [we] went on to have a CNA get an initial chief complaint, put the patient's name in the computer, take vitals, and then forward the information to a triage nurse," says Carrison.

More recently, however, the department had implemented a rapid medical assessment (RMA) process, with a doctor in triage from 9 a.m. to 6 p.m. When this event occurred after 6 p.m., the team decided to extend the RMA hours until 3 a.m.

During those hours, the patients are now seen by a nurse "meeter/greeter," says *Evelyn Lundell*, RN, MSN, the clinical manager of the ED. In addition to performing the "mini-medical" initial assessment, "they can offer an extra eye that is trained to pick up a patient that might be deteriorating and cause an unfortunate death, such has been seen EDs across the country," she notes. The nurse enters the patient information into the computer and obtains a pain level and chief complaint. A rapid registration is performed. The patient is seen by the RMA doctor, who orders treatments and tests.

"He may be able to discharge the patient or expedite them to the back, during which time the nurses initiate the testing, get labs drawn, and finish the triage from the nurse's perspective," says Lundell.

Carrison says he is collecting data to evaluate those changes, which have been in place only a few months. However, he says, "Anecdotally, I can tell you that adding RMA hours has absolutely made a difference in this 53-bed ED." UMC, he adds, has completed its corrective actions. ■