YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

HPR HOSPITAL PEER REVIEW®

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

**August 2010:** Vol. 35, No. 8
Pages 85-96

## IN THIS ISSUE



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.

# Quality of care during off-peak hours: Are you monitoring this?

*Research shows deaths, complications more likely in off-peak hours*

From about 7 a.m. to 7 p.m. Monday to Friday a hospital is a busy place — with a host of clinical and administrative staff and department chairs and chiefs. But on nights and weekends, it's often quite different. It's quieter. Hospital leaders are not there, senior managers are off, and nurse/patient ratios are lower, says **David Shulkin**, MD, president of Morristown Memorial Hospital, part of Atlantic Health, and previously president and CEO of Beth Israel Medical Center in New York City. In an article in the *New England Journal of Medicine*, Shulkin wrote, the results of such "service deficiencies" in off-peak hours include increased mortality and readmission rates as well as additional surgical complications and medical errors.[1]

The disparity between these "two hospitals" is getting a lot of attention these days. With funding from the Robert Wood Johnson Foundation, **Patti Hamilton**, RN, PhD, has been studying the discrepancy in care as co-lead of the interdisciplinary nursing quality research initiative. **(See www.nursingopen247.com.)** Hamilton, formerly a nurse, is now dean of graduate studies, John and Nevils Wilson Professor at Midwestern State University in Wichita Falls, TX.

Hamilton's research began with neonates and mortality in off-peak shifts. The team "found that your biggest off-peak increase in mortality didn't happen in your big hospitals or it didn't even happen in your tiniest hospitals. The hospitals most likely to have differences in mortality rates were the middle-sized hospitals." She hypothesizes that bigger hospitals have more staff 24/7. The smaller hospitals can transport high-risk patients to tertiary care centers. "Those middle-sized hospitals tended to maybe hold on to patients they should have referred elsewhere or got into trouble because they didn't have enough staff to staff with equal expertise and skill 24/7. They put all their resources in the peak periods and were left a little bit deficient on the off-peak period," she says.

## Assessing patient safety during off-peak hours

Her research has included discussions with nurses about their workflow and concerns on off-peak hours. "When you add together all of the night shifts and the weekend shifts, that's the majority of the week. So really 64% of [nurses'] work hours are off-peak, meaning they're at a hospital doing

AHC Media LLC

something when the staffing and the resources are at the lowest ebb, which surprised me. I at first was thinking of it as being a minority of time, but it is not. It is the majority, and I just never have thought of it that way."

Complications and other untoward events are not the only price to pay for inadequate staffing, communication, and clinical evaluation seen during off-peak hours. Often, Hamilton says, patients admitted during these times have longer lengths of stay, incurring greater costs for the hospital.

Both Shulkin and Hamilton urge quality improvement directors to begin to look at discrepancies in care between peak and off-peak shifts.

"The very first thing I would recommend that people do is become sensitive to the fact that so much of what happens in hospitals happens at night and on the weekend. And plan accordingly... [W]e come up with policies and plans and workflow plans that work well during the day when everyone is there or the physician can be reached readily through their office, and we forget that it doesn't work that well the rest of the time," Hamilton says.

She suggests including staff who work off-peak hours — nurses, radiology technicians, respiratory therapists, occupational therapists, and physical therapists — on the decision-making team for any workflow or operational initiatives.

"One of the best suggestions I can make is for people to become aware that the majority of care delivered is delivered during off-peak periods. So that's No. 1," she says.

"The second one is that we don't gather data in a way that would allow us to know how we're operating differently — peak and off-peak. Very often, our core measures or our nursing-sensitive indicators or those things that we're measuring, we aggregate either over an entire day, an entire week, or an entire month. And when you do that, when you start talking about the average nurse/patient ratio, that may give you a picture that is not the same as if you had gathered the data and said, 'Now here's my peak nurse/patient ratio and here's my off-peak nurse/patient ratio.'"

She says it's important to gather the data that can answer the question: Are there differences between peak and off-peak hours?

Shulkin recommends that you look at your hospital's sentinel event and serious event data to see if an event occurred at night or on the weekend. "Just beginning to look for this issue and see whether lack of communication, lack of availability of staff or equipment contributed to the event, I think is important," he says.

He says oftentimes when you trace an event, you'll find the error actually occurred during an off-peak time. For example, if a patient has a cardiac arrest at 11 a.m., when you trace the event you might find that a critical lab value was missed at 3 a.m. or staff failed to note the patient's blood pressure began to drop at 4 a.m.

"From a quality improvement perspective, bringing that into the formal root-cause analysis

**Hospital Peer Review**® (ISSN# 0149-2632) is published monthly, and Discharge Planning Advisor™ and Patient Satisfaction Planner™ are 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).



AHC Media LLC

Editorial Questions

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

and the formal evaluation of the way care is evaluated will be eye-opening to many people," he says.

And off-peak hour vulnerabilities are not solely staffing issues. "There's so many more systems that are functional in regular hours than off hours that you really need to look at it from a clinical perspective. How was the situation handled on off-hours versus how it would be handled on regular hours?" he says.

Hamilton suggests hospitals use the SWAN tool, developed by Shulkin while he was at Beth Israel to assess their weekend and night care delivery. (**You can find the tool at http://davidshulkin.com/swan.asp.**)

Shulkin says QI directors can play a big role in looking at hospital functions and the problem of "off-peak" care. "[B]y letting people understand how this particular issue impacts their hospital with data and real events that could potentially be prevented, I think that's very powerful. I think the quality director has a lot of opportunity to share that information and to get decisions made upon that," he says.

### Work on handoffs, communication

Improving handoffs between day and night staff and strengthening communication among off-peak staff can make a "big difference" in quality of care, Shulkin says. He and Hamilton have had multiple discussions with nurses about their workflow and concerns. Shulkin says often seemingly small but consequential things can be uncovered.

"I think being aware of the communication problem is hugely important. We've known in health care that communication is a problem. But it becomes a very big problem off-peak, especially in those hospitals where say it's not a teaching institution and there's not a hierarchy of residents and interns and fellows and those sorts of things somewhere around 24/7. Community hospitals where the nurses are working and the physicians are off-site run into lots of problems with communication," says Hamilton.

One easily fixed problem Shulkin found in talking to off-peak staff was that they felt the person in the pharmacy was unresponsive to calls. At night, one person staffs the pharmacy, and it turned out there was no phone in the room where that person mixed chemicals. In the daytime, it wasn't a problem, but at night if he was the only one staffed and he was in the back, he didn't hear the phone.

"You find all sorts of small issues that frankly you wouldn't think about when you work in the hospital during the day but if you take the time to really look at the issues at night and talk to people, you find all sorts of things that you can begin to start doing to make it a better place," he says.

Shulkin is beginning to employ "nocturnists" as in-house night staff. He says many hospitals are used to 24/7 coverage within OB/GYN, anesthesiology, trauma care, and in the emergency department. "So those are the five areas where the standard really is to have 24-hour physician care. But I think that we're moving toward that in a broader way. It's a challenge because not many physicians look for jobs that keep them up all night, but I think that if you have a sensitivity around this issue and you're looking to improve from your current performance, this is certainly an area that's worth looking at."

REFERENCE
1. Shulkin DJ. Like night and day — shedding light on off-hours care *N Engl J Med*. 2008 May 15;358(20):2091-3. ■

# Improving quality on off-peak hours

*Some hospitals are changing care delivery*

The traditional hospital system in which physicians are staffed during the day and on call at night is not the only model. And certainly, as the health care industry becomes more aware of the quality of care for the traditional off-peak shifts, that model could change quite radically in the future.

There are some things hospitals can do now, and some challenges that cannot be overcome, says **David Grace**, MD, FHM, area medical officer for the Schumacher Group's Hospital Medicine Division and a hospitalist at Southwest Medical Center in Lafayette, LA. Among the latter, he says, is the fact that people sleep at night. During the day, patients have problems and can alert clinicians. "But very often if the patient is asleep, they'll sleep right through that event. So you lose your early warning system, which is the patient being able to tell you something is not right. And that I don't think we'll ever improve," he says.

Also, too often, nurses are uncomfortable calling physicians on call, when they know they are at home sleeping. "I've worked overnight shifts at hospitals over the years, and I've seen nurses discussing a bad lab result that came back missing. 'Hmm. I know that doctor who's on. I'm not calling him. He's going to yell at me. I'm going to wait

til 7 a.m. when his partner comes back,'" thus delaying care that could be critical.

He's tracked data and found nurses are less likely to page a doctor who is at home versus a doctor who is up and working. "We end up with improved communication and therefore reduced errors and higher quality just by having a doctor awake in the hospital at night."

Grace suggests educating nurses to contact on-call physicians and not fear recrimination. It needs to be clear that it is unacceptable for doctors to be rude to a nurse for waking them up, he says.

One thing he's introduced that he says has been helpful is a standardized list that informs nurses, "if this happens, you should call the physician."

"I think what that does is it empowers the nurses a little bit more to say, 'I'm going to call him because this is what the standard order says. I need to call him if the heart rate is over 120 and this patient has a heart rate of 130, and if he yells at me, I'll just tell him it's in that order that they put in the chart." (**See list, below.**)

He says it has gained a lot of traction and empowered nurses, while still emphasizing that "if you have to think twice about whether you should call, you need to call."

As far as weekends, he says, "I think we see not the same phenomenon, but I think during weekends there's just less going on in hospitals. You know most of their departments aren't doing routine work. So I think patients are not watched quite as closely."

He says oftentimes weekends are staffed by agency nurses or per diem or part-time nurses who many not be as familiar with your setting.

He says he's seen many hospitals struggling but improving turnaround times on test results on weekends. Ten years ago, when he began his career as a hospitalist, he says it was difficult to get things such as MRIs or ultrasounds done on the weekend. Now that's changed. The impetus may be financial, to reduce length of stay, but the result does improve patient safety.

"Very often if there's a test we order, a lot of times we'll find something we didn't expect, and it alters the way care is delivered. If you introduce a delay on that or a delay in that diagnosis because it's a weekend and you just can't get the test result, I think that certainly translates into poor quality

**Call physician immediately for the following:**

**Respiratory:**
- rate less than 8 or more than 36 with or without symptoms;
- new onset difficulty breathing;
- new pulse oximeter reading less than 88% for more than 5 minutes (unless patient known to have chronic hypoxemia).

**Cardiovascular:**
- heart rate less than 40 or more than 140 with symptoms or any heart rate more than 160;
- BP less than 90 or more than 200 systolic or more than 120 diastolic;
- chest pain unresponsive to NTG;
- color change of patient or extremity: (pale, dusky, gray or blue);
- deterioration of EKG rhythm.

**Neurological:**
- acute change in level of consciousness;
- new severe headache unresponsive to PRN med use (or no PRN meds already ordered);
- seizure;
- sudden/unexplained loss of movement (or weakness) of face, arm or leg;
- unexplained change in speech or swallowing;
- unusual agitation for more than 10 minutes.

**Systemic/Lab based:**
- allergic reaction beyond simple itching;
- new fever greater than 101F or any elevated
- temp associated with shacking-chills (rigors);
- glucose less than 40 or more than 400 x2 readings;
- potassium greater than 6;
- hemoglobin less than 8;
- any lab critical or panic value;
- new positive blood culture result;
- new sensitivity data on any culture if
- current antibiotic(s) being used show
- resistance.

**Other**
- family requests intervention;
- staff is uncomfortable/worried about patient;
- code status issue;
- new admission or consult requests;
- patient leaving or threatening to leave.

Southwest Medical Center in Lafayette, LA.

for the patients," he says.

One thing he's focused on is handoffs between day and night clinicians and identifying patients' major diagnoses, active problems, and any items on the to do list. "We catch a lot of things by doing a handoff that involves both an electronic or sort of durable written component and a verbal component," he says. Every patient is covered, and the process takes only about 10-15 minutes.

"I think that allows you to respond better. It's very difficult if you get woken up at 2 a.m. and a nurse is asking you somewhat complex questions about a patient you've never seen. You don't know what they're in for, you've never talked to their attending doctor, but now you're responsible for them during the night," he says.

As an example, he says, let's say patient A complains of chest pains about 10 times a day and is in for anxiety and asthma and has complained of chest pain for years, but every EKG has been fine.

"Well, when I get a call that night about this patient having chest pain from a nurse because I got a good checkout, the way I respond to that can be quite different if I never knew anything about the patient. I would probably give all the typical chest pain things. I would give them aspirin, give them a shot of a blood thinner, an EKG, a CT scan of the chest. Any of those can have complications. CT scans can cause renal failure. Anticoagulants can make you bleed. So they're not benign treatments and investigations. But just a little bit of a checkout procedure with my partner clears all that up, and now I don't go down that route, which can obviously provide not just cost savings but certainly some quality savings.

"You're not exposing the patient to as many risky things because you had a good checkout and you knew what was going on. So that makes quite a difference and that's usually when those issues come up — nights and weekends. And I think a checkout can really boost quality for the hospitalized patients," he says.

## Staffing intensivists 24/7

In his hospital "a big transition had taken place in the late '90s into 2000s," says **Emmel Golden**, MD, the medical director of the ICU at Baptist Memorial Hospital-Memphis in Tennessee. The hospital he had worked in had been a large downtown medical center with plenty of house staff. The hospital was closed, and what had been a community hospital was transformed into a tertiary care center with no house staff.

It took about a year to negotiate and form an enterprise, and in January 2003, the hospital began to staff its ICU with an intensivist from 6 p.m. to 7 p.m. 365 days a year. "And so the physician on location in the intensive care unit is available to assist in getting started on new admissions, most of which come out of the emergency department or the recovery room that time of night, or to deal with patients who become unstable in the intensive care unit and also in the hospital," he says.

The physician also backs up the rapid or emergency response team. Through observation and some monitoring, Golden says this has "moved codes from mainly being things that occurred on the floor to mainly being things that occurred in ICU, so it decreased the number of untoward arrests on the floor because we were able to move unstable patients a lot sooner. It definitely improved nursing satisfaction on the night shift because now there's a physician there and the physician can address whatever the issue is."

Other benefits? "The doctors that work at night literally have saved a lot of lives. People would be dead if we weren't here. I know that for a fact," he says.

Another thing "that happened on the legal side was that the suits against the hospital for wrongful death just about disappeared. Because it seemed a lot of those were evolving out of a patient who became unstable at an off-hour time and nobody did anything," Golden says.

Now when a doctor is paged, it usually is a conversation between the intensivist and the physician. "It's a peer-to-peer exchange, which is different from a doctor-to-nurse exchange. They may question us, but it's a different type of exchange that goes on with two doctors talking to one another, especially when one of the doctors is at the bedside with the patient. It moves to a different level very quickly," he says.

Length of stay at the hospital, which has a daily census of about 600-650, also has decreased from about seven days when the hospital began to staff intensivists at night to about four days.

Evening rounds are "very focused," he says. Why is this patient here? Are there any unresolved issues? And does this patient still need to be here?

If patients need to be moved even at night, the nighttime intensivist can consult with the daytime hospitalist, and if the patient is stable, he or she can be moved. "I did this to ensure better patient care and to improve patient outcomes and better patient

safety. A side benefit [is a reduction] in nursing turnover and a lot better nursing satisfaction from the nurses who work at night," he says. ■

# CMS releases final meaningful use rule

*The rule explained and what you can do*

They just happened to go public at about the same time — the Centers for Medicare & Medicaid Services' (CMS') final rule on "meaningful use" as part of the HITECH Act and The Leapfrog Group's study results on computerized physician order entry (CPOE) systems and its subsequent call for action to monitor the safety of such systems and to develop best practices. (**See story page 92.**) CPOE is characterized by many as the largest and most difficult part of electronic health record (EHR) implementation, now a must for hospitals reimbursed by CMS.

First, what is in the final rule on meaningful use? **Allison Viola**, MBA, RHIA, is director, federal relations for the American Health Information Management Association (AHIMA). She says the HIT standards for Stage 1 originally established 23 measures for reporting. In response to comments, CMS did make some revisions in the final version.

"The final regulation published on July 13 provided some relief to hospitals in that CMS divided the HIT functionality measures into two categories, a 'core set' of objectives and 'menu set' of objectives. Under this new approach, eligible hospitals and critical access hospitals [CAHs] would be required to satisfy 1) the core set of measures, and 2) a selection of five objectives from the menu set of objectives. As a result of this modification from the proposed regulation, the required set of measures to report on has been reduced from 23 to 14 from the core set and five from the menu set, totaling 19 measures in all for the HIT functionality measures. The threshold for the measures has also been tweaked a bit to the benefit of an eligible hospital," she says.

"But make no mistake. After Stage 1, CMS plans to turn up the heat on the reporting requirements," she adds.

She suggests the following for hospitals and quality improvement directors to prepare for the incentive program, which will begin with reporting this fall for the fiscal year 2011:

- "If your hospital plans to participate in this incentive program, implementing CPOE is one of the required objectives and measures. Implementing CPOE is complex and often costly to integrate with a hospital's clinical and administrative workflow. This is an area where quality improvement professionals will play a critical role to ensure the workflow integrates successfully with CPOE and that data integrity is maintained throughout the process," she says.
- "Maintaining up-to-date problem lists have long been a source of challenges for hospitals, as there is not one specified method for capturing and maintaining the information. CMS makes it clear along with the Office of the National Coordinator's [ONC] final regulation that was released the same day... that the problem list must be recorded as structured data, and in this context ONC adopted ICD-9-CM or SNOMED-CT for this measure. CMS will not accept the use of free text in capturing problem lists; therefore, if your hospital has traditionally been using free text and you plan to participate in the incentive program, you may select one of the options. This may require the establishment of an internal multidisciplinary coordinating committee to identify and agree upon the standards of data use for problem lists."
- "Reporting hospital clinical quality measures to CMS or the states is another set of measures identified within the HIT functionality measures that requires the use of an attestation methodology for the first year of reporting as a condition of demonstrating meaningful use. This requirement has not changed from the proposed regulation."

She adds that "CMS significantly reduced the clinical quality measures by approximately 43% to only those measures that can be automatically calculated by a certified EHR technology and are further limited to those for which electronic specifications are currently available.... Stage 1 is a reporting requirement only, so hospitals only need to report values as they are calculated and displayed by certified EHR technology. Eligible hospitals and CAHs will report numerators, denominators, and exclusions, even if one or more values as calculated by their certified EHR technology is zero," she says. CMS has not added any measures not already part of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program.

Stage 1 is entirely about data capture in the EHR, says **Jane Metzger**, principal researcher, emerging practices of CSC Corp. She says the rule

for Stage 1 defines what it means to implement an EHR system. "[I]t says you have to be keeping an allergy list, you have to be keeping a problem list, which by the way is a physician-maintained problem list electronically."

At this point, she says, Stage 1 is the only part "we know the details of."

"And in the time frame of 2011, 2012, an awful lot of people are going to be hoping to attain Stage 1 or get as far along as they can. Because the longer it takes to reach Stage 1, the shorter a time you're going to have to work on Stages 2 and 3 because there's an end date when you're no longer eligible for incentives and you are eligible for disincentives."

It's going to be a "big stretch" for a lot of hospitals, and quality improvement professionals are going to be playing lead roles, she says. She characterizes the move to EHRs as not being an IT issue, but rather a change management one — something QI people know all about.

She says the way meaningful use is defined "includes things that directly fall within the purview of quality improvement. It includes the use of clinical decision support. It includes a big focus on quality measurement and on actively using the system to help manage patients. For instance, one of the requirements is to be able to generate reports that allow you to look at patients by condition."

QI directors must be at the table working with IT and the vendor in how and what data will be captured, she says. During implementation, you must verify that every data element needed for the quality measures "is in fact being captured in a coded way so you can use it in reports," she says.

Studies have reported the low number of hospitals that actually have an EHR system. In an article published in the *New England Journal of Medicine* in 2009, of 63.1% of the hospitals that responded to a survey, only 1.5% had a "comprehensive" system and 7.6% had a "basic" system. Only 17% had implemented CPOE.[1]

Referencing the majority of hospitals that do not have an EHR system, Metzger says, "the bulk of the information [needed to meet meaningful use criteria] they do not have electronically." And she cautions that hospitals be prepared for Stages 2 and 3 in which the focus will shift from data capture to measurement and an increase in the numbers of measures.

"To get this successfully implemented in the hospital, they're going to need lots of order sets and all of that is committee process and basically quality improvement. So I think they need to be front and center," she says.

In response to the final rule, the American Hospital Association published a statement in which it expressed concern "that the requirements may be out of reach for many of America's hospitals." The association also expressed concern about CPOE implementation: "We also are concerned that the rule requires hospitals to immediately use CPOE, which can be complicated, costly to implement, and takes time to do right." (**To read the entire statement, visit http://www.aha.org/aha/press-release/2010/100713-st-HIT.html.**)

REFERENCE
1. Jha AK, DesRoches CM, Campbell EG. Use of Electronic Health Records in U.S. Hospitals *N Engl J Med.* 2009 Apr 16;360(16):1628-38. Epub 2009 Mar 25. ■

# Study shows 'troubling results' with CPOE alerts

*Without testing, CPOE can cause harm*

Whether it's over-alerting or under-alerting, it's a problem. A number of studies have taken on computerized physician order entry (CPOE), but the latest findings from a Leapfrog Group study made public June 28 shows CPOE problems can lead to harmful or even fatal errors. With the release of the final rule on meaningful use by the Centers for Medicare & Medicaid Services announced July 13, Leapfrog's findings become even more important.

As part of the study, 214 hospitals were "set up" with orders likely to result in adverse events or even fatal medication errors and thus a CPOE alert. Hospitals tested varied in size and populations served. The study's question was, would the hospital's CPOE system flag the order or issue an alert?

"And that's where we got the troubling results, which was half the time no," says **Leah Binder**, MA, MGA, CEO of The Leapfrog Group.

The most common types of medication errors were tested. They include:

- therapeutic duplication;
- single and cumulative dose limits;
- allergies and cross allergies;
- contraindicated route of administration;
- drug-diagnosis interactions;
- contraindications/dose limits based on age and weight;

• contraindications/dose limits based on lab studies;

• contraindications/dose limits based on radiology studies.

For orders that could result in death, she says, about a third of the time systems did not flag those orders. "Does that mean that these hospitals would have killed all these patients? No, it does mean that. Hospitals always have checks and balances in place to check and double-check and triple-check orders before they're actually administered. I think what our survey says is do not assume that your CPOE system replaces those checks and balances. Those must be in place," she says.

Which is why the group is now asking CMS to include in its meaningful use rule a requirement to continually monitor, access, test, and improve CPOE systems.

She says what the report does is "basically reinforce the importance" of quality improvement directors, who, she says, understand the value of checks and balances.

She says The Leapfrog Group doesn't know why the results were troubling and suggests more research be done and best practices be aggregated. But anecdotally, she says, "we do know that not all vendors create identical systems. Some of the systems work differently. We know they're competitive systems so some seem to be working better than others."

Second, she says, "implementing CPOE is incredibly complex, and there's lots of room for improvement in how hospitals implement CPOE. And there's lots of room for error in how they implement CPOE because it's so complex."

She says some multihospital systems asked if they could test one hospital's system. "We say no. The reason we say no is because invariably hospitals perform differently. Even though they're using the same hardware, systems get customized at the delivery level, and those customizations can often be troublesome. So they need to monitor them and they need to watch them, and our goal is to flag those issues for the hospital so they can improve the systems."

The study addressed over-alerting, as well. Or as Binder refers to it — "frivolous alert-

ing," when "there's a minor interaction but they shouldn't be alerting because it's frivolous. It could create that problem of alert fatigue, which you see in physicians; when there's continual alerts for every single order, they begin to ignore all of the alerts."

The CPOE Evaluation Tool is available on the group's site for free once a hospital completes The Leapfrog Group Survey. It includes testing for under-alerting and over-alerting. She says hospitals can take the test twice a year and suggests asking vendors if they have effectiveness tests you can use for your system.

Moving forward with the meaningful use final rule, she suggests the "quality team be should engaged in a meaningful way." Often, she says, when a system is implemented, the hospital sees it as an IT project.

"And that's about the worst way possible to implement CPOE. Because CPOE is a massive systems change within a hospital... [I]t's a cultural shift of great import and it needs to engage in a very meaningful way all clinicians — nurses, pharmacists, physicians — and it needs to engage management and administration and the board," Binder says.

"So quality professionals are obviously key to any kind of shift like that in the hospital and they're going to be the ones who can bring the expertise and the talent for change management that is so incredibly important for a safe adoption of technology."

**(To see the study or the CPOE Evaluation Tool, visit The Leapfrog Group's website: www.leapfroggroup.org/.)** ■

# Complying with TJC pain management standards

*Handling reassessments, other challenges*

Have you revisited your pain policy? Are you auditing compliance? How will you fare when Joint Commission surveyors come to your facility? *Hospital Peer Review* spoke with three institutions about the challenges they faced, the interventions they made, and the successes they have seen. (**For an update straight from The Joint Commission's annual meeting and where the organization will be focusing on pain management, see story page 95.**)

**Debra B. Gordon**, RN-BC, MS, ACNS-BC, FAAN, senior clinical nurse specialist at the University of Wisconsin Hospital and Clinics (UWHC) in Madison, was involved with the development of The Joint Commission standards on pain management, which went into effect in 2001.

She says a few years after the standards were implemented, surveyors visiting UWHC cited the system with a request for improvement on documenting pain reassessments — an area experts say hospitals continue to struggle with, specifically the time frame of when to document a reassessment. Gordon says she had data showing that assessments and reassessments were being done, but the surveyor said, "You have a lot of numbers, but I can't tell what's happening."

"Unfortunately at the time, there was not a lot of [literature] about the minimum time and elements for reassessment or documentation." And The Joint Commission does not specify when reassessments must be done; it only says that they be recorded in a way that facilitates regular reassessments.

"So we developed a pretty ideal policy like a lot of people have, which is [documentation of reassessment at] 30 and 60 minutes. If you read a textbook, you think that's the peak effect, that's when the patient is most vulnerable for side effects, and that's when I should know whether they've got relief or not."

But about a month ago, several changes were made to the policy. Requiring reassessment at specified intervals seemed to "actually be starting to drive staff away from documenting that they're even doing anything because then they're required to come back in 30 and 60 minutes and it's a burden and it's just too hard to do," Gordon says. Nurses said they were constantly reassessing pain; the problem was the work burden of documenting it. Another problem, Gordon says, is that many people are confused about the difference between screening for pain, assessing it when it's present, and then reassessing it.

In response, the policy was changed to require nurses to screen for pain at least once every 24 hours. If pain is present, nurses assess it. If the patient has received treatment for pain, nurses must reassess and document at a minimum of three times within 24 hours.

The hospital uses a variety of scales, "and I think that is certainly identified in The Joint Commission standards intent. That you need to have a number that is both developmentally and cognitively appropriate." They use scales in dif-

ferent languages, the FACES scale, preverbal scale and scales for cognitively impaired, nonverbal adults. The system created its own preverbal scale for pediatric patients or children or adults who can't self-report.

Gordon says another area that's caused confusion among hospitals is the standard versus what surveyors were actually telling hospitals to do. For instance, surveyors were telling hospitals to tie PRN range orders with the patient's numeric pain rating.

"But if you look at the original standards, the intent of the standards, they were that we assess pain in all people; that we respect rights to appropriate assessment and treatment; that we educate patients, providers, and families; that we do some quality monitoring. That's what it said. It didn't say you have to give morphine if the pain is 10 or you have to give 5 milligrams if the pain rating is a certain thing. That was all a misinterpretation," and a dangerous thing to do, she says.

Along with the American Pain Society, Gordon co-authored a consensus statement about suggestions on ordering explicit as-needed orders. (**See http://www.ampainsoc.org/pub/bulletin/jul04/consensus1.htm.**) "All rules are double-edged swords. That doesn't fit. You cannot cookbook pain treatment. It's dangerous. My mild pain isn't the same as yours. And how I respond to morphine isn't the way you respond," she says.

## Reassessment time lines

Staff at Altru Health System in Grand Forks, ND, also had to reassess their pain reassessment policy. **Janelle Holth**, RN, BSN, regulatory compliance coordinator, says through tracers and work with a consultant, the hospital found "that we had kind of set ourselves up to fail through our pain policy in that we associated times, especially with reassessments. So we took a hard look at that policy and really trimmed it down simply to address how we assess pain, when we do, and how we have that comprehensive assessment initially," removing time frames on documentation of pain reassessments. The hospital does monthly audits on pain documentation "looking to make sure if a pain medication has been administered to see when that reassessment was done and was it effective and was there communication with the physician and did they get new orders if need be," she says.

Staff at University Medical Center at Princeton

# CNE QUESTIONS

5. According to David Shulkin, MD, which of the following can result from "service deficiencies" during nights and weekends at hospitals?
A. increased mortality
B. increased readmission rates
C. increased medical errors
D. all of the above

6. According to Allison Viola, MBA, RHIA, what is the total number of HIT functionality measures in the final rule on meaningful use?
A. 15
B. 19
C. 25
D. 43

7. The American Hospital Association stated that the final meaningful use rule may be "out of reach" for many hospitals.
A. True
B. False

8. The Joint Commission specifies a time line in which a reassessment of pain should occur.
A. True
B. False

Answer Key: 5. D; 6. B; 7. A; 8. B.

# CNE INSTRUCTIONS

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

also were having trouble complying with the policy on reassessment time lines. So they began to look at barriers, says **Karyn Book**, MSN RN CLSSGB, professional practice administrator. One thing they found was oftentimes a patient would be off the floor at the time of reassessment.

Working with IT, nurses now have 60 minutes post-intervention to complete a reassessment, and the computer system is set to trigger the nurse at 30 minutes post-intervention as a reminder. Nurses have the option to document that the patient is not on the floor. The computer system mirrors the policy created and uses drop-down menus rather than free text fields to trigger nurses to include everything. Questions include things such as: Did you ask the patient about pain? What kind of pain assessment did you use — the numeric scale, the FACES scale, the FLACC scale? Did you ask about the location, duration, and pattern of pain? Is it constant?

In the hospital's last survey, The Joint Commission commended the hospital's documentation policy for going beyond by including patients' perception of pain and their functional level. If patients didn't meet the functional level upon reassessment, "then we went further, and said, 'OK, what do we do? We know your pain is supposed to be at 3, but it's still at 5. Did you call the physician? Did you offer any comfort measures?' [TJC] liked that we went above and beyond," Book says.

TJC, she says, likes to see that you address what the patient needs to be at a functional level and what you do to get them there. They also focused on pain in post-op patients and maternity patients, Book says.

Holth says another goal was to have pain tools for any patient population. Now, they use a total of seven scales, including a scale for nonverbal patients. All the hospitals interviewed say using a scale for nonverbal or cognitively impaired patients is essential. ■

# Update on TJC's focus on pain today

**Paul Arnstein**, RN, PhD, clinical nurse specialist for pain relief at Massachusetts General Hospital, is familiar with The Joint Commission's standards on pain. As president of the American Society for Pain Management Nursing and a liaison representing pain management, Arnstein recently attended an annual meeting with TJC.

Among the top 10 standard compliance issues for 2009 was clear and accurate medication orders (MM.04.01.01). Arnstein shared with *Hospital Peer Review* what he took away from the meeting:

## "As-needed" orders

"Too often, there are prescriptions for multiple simultaneous PRN analgesic orders that may represent a physician delegating clinical decision-making to nurses in a way that is beyond the scope of nursing practice. This may vary by state, so organizations should know what, if any related decision-making, is authorized in your locality. Some states specifically address the titration within a range order as part of nursing decision-making authority. Where the state makes no reference to this practice as being in or out of scope, the institutional policies are examined and the organization is held to those policies. In general, three or more simultaneously active orders for

## 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

- ■ Tips on building an informed consent policy
- ■ Joint Commission revises NPSGs
- ■ Quality of care at end of life
- ■ Anesthesia ownership of antibiotic choice

PRN analgesics raise a yellow flag that the medications orders are not clear enough. When asked directly, top leadership of the standards interpretations group said that there is no requirement linking a dose of analgesia to a number or a pain scale; no requirement to delineate mild, moderate, or severe pain; and no required sequence (e.g. try x first then y...) of choosing an analgesic to administer."

## Shifting focus from TJC

"The Joint Commission is shifting its focus from seeing that all patients regardless of their condition are screened for pain, to one that addresses the patient who has been identified as having a problem with pain. For those patients with pain, they want to see that a 'comprehensive pain assessment' has been done to guide treatment. As with most standards, TJC defines what needs to be done, but not how it is done. Thus, depending on the setting and resources, a comprehensive pain assessment may be done by the nurse, doctor or specialist. A comprehensive assessment may be as simple as the nature, location, intensity of pain and response to treatment; or it may be multidimensional, including the patient's emotional state, its impact on functioning and whether or not the patient is at risk for substance abuse. TJC does not define the details of what constitutes this comprehensive assessment; the institution does. The institution then is accountable to see that all staff and involved professionals know their role and are trained to do it."

## Education critical

"Similarly, there is a requirement to educate all staff and licensed independent practitioners who are involved in pain assessment and its treatment. This extends to all physicians, nurse practitioners, physicians assistants, and psychologists who treat patients with pain. Responding to the question, 'How in-depth does this training need to be?' the standards interpretation group said this, too, was up to each organization to determine. But all who are expected to do it are expected to have been trained to fulfill that role.

"The final caveat is that listservs, blogs, mock reviews, and even journal articles often misinterpret the standards. Sometimes surveyors who are passionate about a topic or a way of doing things may say things that seem prescriptive, but are not part of the standards." ■




**To reproduce any part of this newsletter for promotional purposes, please contact:**
*Stephen Vance*
**Phone:** (800) 688-2421, ext. 5511
**Fax:** (800) 284-3291
**Email:** stephen.vance@ahcmedia.com
**To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:**
*Tria Kreutzer*
**Phone:** (800) 688-2421, ext. 5482
**Fax:** (800) 284-3291
**Email:** tria.kreutzer@ahcmedia.com
**Address:** AHC Media LLC
3525 Piedmont Road, Bldg. 6, Ste. 400
Atlanta, GA 30305 USA
**To reproduce any part of AHC newsletters for educational purposes, please contact:**
*The Copyright Clearance Center* for permission
**Email:** info@copyright.com
**Website:** www.copyright.com
**Phone:** (978) 750-8400
**Fax:** (978) 646-8600
**Address:** Copyright Clearance Center
222 Rosewood Drive
Danvers, MA 01923 USA