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March 2012: Vol. 37, No. 3
Pages 25-36

IN THIS ISSUE

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AHC Media

Do quality indicators lead to over-intervention?

Some suggest they don't take the needs of elderly patients into account

The use of evidence-based quality indicators to ensure consistent treatment is a great idea because it improves patient care and outcomes, right? While most people would agree that the various organizations that create the measures have the best interests of patients at heart, there are others who think the cookie-cutter approach to medicine causes problems for some specific groups of patients.

In a commentary from the *Journal of the American Medical Association* (JAMA) last fall, **Sei J. Lee** and **Louise C. Walter** argue that for older patients in particular, many of the required reporting elements are inappropriate and can lead to excessive care or care that does nothing to improve the quality of life of the patient.[1] In one example, they note that the U.S. Preventive Services Task Force recommends discontinuing colorectal cancer screening for people with a decreased life expectancy. But the Healthcare Effectiveness Data and Information Set (HEDIS) calls for screening for people between 50 and 75 years. Where does that leave a 70-year-old patient with advanced lung disease whose life expectancy would discount the benefits of screening?

"The quality indicators and guidelines are based on research, and that can be driven by the profit motive," says Lee, an assistant professor at UC San Francisco and associate director of the San Francisco VA Quality Scholars Fellowship, Division of Geriatrics. "It is focused on seeing if a treatment or protocol works, rather than if it doesn't work, on doing something rather than not doing something. It is tilted toward intervention. There is not a lot of quality data about over-intervention."

Another issue is that older adults often have so many problems that they are poor candidates to participate in most clinical trials and medical studies. "You have to do a much larger, much more expensive study to develop the same level of information," Lee says. "They have competing risks that younger patients with a single problem don't have. Teasing out what might be because of your intervention and what might be because of some co-morbidity is hard. So we extend findings to older adults and don't force those who create protocols or treatments to take the next step and prove it works for older populations."

The potential problems are not just theoretical but are something that

physicians witness regularly, says **Julianna Lindsey**, MD, MBA, regional medical director of hospital medicine for TeamHealth in Knoxville, TN. "I face this a lot when we have very elderly patients and they have advanced dementia and are bed-bound. You may confirm they have had a myocardial infarction, and core measures say you have to give them a beta-blocker and statins. The same is true with stroke. But that might not be the right thing in this situation. I'm told I have to do this, but it might not improve their quality of life at all. If they could speak for themselves, would they really choose this?"

Other patient populations are affected as well, says **Craig Schranz**, MD, an emergency department physician in Norfolk, VA. In the emergency department, there are concerns about evaluating CT scan rates for a-traumatic headaches. "The thought is that they may be unnecessary," says Schranz. "But our job in the emergency department is to think the worst first. There are a lot of bad things that can cause a headache that are not trauma-related. If you scan them and are wrong, it hurts you," he says, noting that physicians can lose payment based on quality initiatives that frown on such scans. Worse, though, is if you don't do it and the patient needs it. "The indicators don't ask whether the scan was a good idea or for an explanation," Schranz continues. This is very controversial in the ED world because the National Quality Forum advised against this particular indicator, while the Centers for Medicare & Medicaid Services (CMS) continues to move forward with it.

Another indicator that Schranz says was a problem related to how many hours passed before antibiotics were given to pneumonia patients. "It used to be four hours, then six hours, and now it's finally gone. It was creating a perverse disincentive. There is no science behind that six-hour rule. So if someone was near that time but hadn't had a diagnosis yet, you might treat them anyway, before you even confirm a diagnosis with an X-ray. But that patient may not even have pneumonia." That leaves someone open to potential adverse events from a medication allergy or interaction, he says.

Another issue involves aspirin given to heart attack patients, says Schranz. "Every now and then you find a chart where aspirin wasn't given. Maybe the patient is allergic, or the patient was given it en route to the hospital," he says. "But do they screen the data for things like this?" What about in the cardiac cath lab, and the time to thrombolitics in stroke patients? "There could be a rush to take an action that might not be appropriate if you stop and take the time you need."

Some sense, but not enough

Schranz says he understands the rationale behind indicators, "but these measures take on

Hospital Peer Review® (ISSN# 0149-2632) is published monthly and Patient Satisfaction Planner™ is published quarterly by AHC Media, a division of Thompson Media Group 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 105109, Atlanta, GA 30348.

AHC Media 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 and accreditation specialists/coordinators.

Opinions expressed are not necessarily those of this publication.

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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.)

Editor: Lisa Hubbell

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

Associate Managing Editor: Jill Von Wedel, (404) 262-5508 (jill.vonwedel@ahcmedia.com).

Editorial Questions

For questions or comments, call Russ Underwood at (404) 262-5521.

a larger role with things like Hospital Compare, where the facts and figures are laid bare, without context, for consumers. They don't look at why a standard isn't met in a particular case."

The measures are a good start, but there needs to be leeway, says Schranz. "It takes so much energy to make changes. The antibiotic issue had tons of literature saying the measures weren't good. With the headache thing we have experts — NQF is the expert — saying it's not a good idea and CMS going ahead with it. Our perception is that they don't respond to clinician concerns in a timely manner."

"I agree that there are some valid points [in the *JAMA* commentary]," says **Margaret E. O'Kane**, MHS, president of the Washington, DC-based National Committee for Quality Assurance (NCQA). "But HEDIS is a work in progress, and it will get better." She also thinks that some of the concerns raised by providers and in the *JAMA* article are misplaced. "The theme of life expectancy seems way out there. You can't find that in a chart, and I think you could even put an unattractive spin on it like death panels — that someone is too old or too sick to have a particular treatment."

O'Kane says the NCQA is working to enumerate clinical exclusions for many measures and knows that for the elderly, this is a particularly important issue. "We do generalize treatments to the elderly, and I believe we should be doing more trials with them."

But acknowledging the concerns are real is only half the battle, says O'Kane. "We have to figure out a way to address them, and I think part of that is for the medical profession as a whole to get busy on some evidence-based guidelines for when treatments are not appropriate. We don't develop the guidelines, we follow them."

She also encourages physicians who have problems to send those organizations promoting the indicators letters and comments about exclusions that seem appropriate. "This isn't a war between sides. Point out the problems, but also understand what is possible."

Lee says one relatively easy fix would be to extend rules implemented by the National Institutes of Health to include women and minorities in research to also include older adults. "Make researchers explain how they will include geriatric populations or justify the reasons why they don't," he says. "If nothing else, it will force people to think critically about whether the benefits of limiting research outweigh the potential harm."

Lindsey says physicians need to be able to act in the best interest of their patients and work on a case-by-case basis. "We need to be given the leeway to forgo some of the requirements. We are on the ground doing the work and people aren't giving thought to the potential adverse consequences of these rules."

For more information on this topic, contact:

- *Julianna Lindsey, MD MBA, Regional Medical Director, Hospital Medicine, TeamHealth, Knoxville, TN. Email: juliannal1@comcast.net.*
- *Margaret E. O'Kane, MHS, President, National Committee for Quality Assurance, Washington, DC. Telephone: (202) 955-3500.*
- *Craig Schranz, MD, Emergency Department Physician, Norfolk, VA. Email: schranzc@yahoo.com.*
- *Sei J. Lee, MD MAS, Assistant Professor, UC San Francisco and Associate Director, San Francisco VA Quality Scholars Fellowship, Division of Geriatrics, San Francisco, CA. Telephone (415) 221-4810 ext. 4543.*

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Surgical checklists come to ambulatory centers

Time outs required as of January

The first part of new federal rules related to quality and outcomes for ambulatory surgery centers (ASCs) went live in January, with a requirement to implement a surgical safety checklist. While many ASCs started using checklists years ago, others are just getting on the bandwagon. Others are taking the opportunity to revise the checklists they were using to make them more comprehensive. That's what they did at the Center for Ambulatory Surgery in West Seneca, NY, according to **Paula Williams**, RN, the center's director of operations. "We had one when I started a year ago," she says. "But we started over because what we had didn't cover everything we thought it should."

Rather than use an existing template, Williams says they opted to take bits and pieces from

samples offered by the Association of periOperative Registered Nurses, the World Health Organization, and Accreditation Association of Ambulatory Health Care and created something completely new.

It is a document that Williams is particularly proud of — indeed, she will be presenting it at a national meeting later in the year. Along with some of the typical recommended elements, Williams' checklist includes a requirement for all providers in the operating room to sign that there was a time out. It is one element that providers at the center are still struggling with — not out of any ornery resistance to change, but simply because they aren't used to the requirement. Currently, it's up to the nurses to "be the police and remind physicians and anesthesiologists that they have to sign," she says. "We're still doing that kind of chasing."

The goal of any checklist is to reduce or eliminate harm, but Williams wants a little more — to determine the number and kind of near misses, and hopefully to eliminate them. But she doesn't think that a checklist will do it. "I think what makes this have an impact is that the complexity of it — from registration, to preop nurses to procedure nurses — and that there is a checkpoint at each stage. They have to stop. They have to communicate. That's what it's about — the communication, not the tool."

The notion that a piece of paper can solve a problem is false, she continues. "It's not about the piece of paper or what's on it or auditing what's on it. It's about the ritual of the time out and whether you communicate what needs to be communicated and do it properly."

Indeed, one of the things Williams considered while working on the checklist was the increase in emphasis on handoffs evident in the National Patient Safety Goals. "We made sure to incorporate the need to communicate pertinent information at every handoff." They have also created boards to go into each OR that will have the same information as the checklist with sliders that go from red to green if an element is completed. Again, it's not about the board, but about the reminder to communicate "nurse to nurse to anesthesia to physician," she says.

Other elements of CMS's Ambulatory Surgery Center Quality Reporting Program include:

- reporting on five measures — patient burn, patient fall, wrong side/site/patient/procedure/implant, hospital admission/transfer, and prophylactic IV antibiotic timing — October 2012 or face a 2% payment penalty applied to 2014 payments;
- reporting on an additional two measures for 2015 payment determination, including safe surgery checklist use and ASC volume data on selected procedures;
- reporting on an additional measure — flu vaccination coverage among health care workers — for the 2016 payment determinations.

For guidance for creating a checklist, visit the World Health Organization website: http://www.who.int/patientsafety/safesurgery/ss_checklist/en/.

For more information on this topic contact Paula Williams, RN, Director of Operations, Center for Ambulatory Surgery, West Seneca, NY. Telephone: (716) 677-4400 ext. 313. ■

CMS tests hospital infection survey

Expansion nationwide in October

It's 44 pages of questions about infection control procedures — from injections and hand hygiene to sharps safety and personal protective equipment — and it's coming to your hospital soon. The Centers for Medicare & Medicaid Service's "Acute Care Hospital Infection Control Tool for Surveyors" is being piloted in 10 states, Washington, DC, and Puerto Rico before being finalized this summer and released broadly in October. It is one of three new tools that hospitals can expect to be used. The other two relate to quality assurance and performance improvement, and discharge planning, says **Daniel Schwartz**, MD, chief medical officer of the survey and certification group at CMS.

The tool had its start about a year ago as a method to help hospitals assess not just their infection control procedures, but to figure out how adept they are at preventing infection in the first place. "This will help them observe the patients and procedures that have the highest risk of infection," says Schwartz.

He says that he and his team worked with the Centers for Disease Control and Prevention (CDC) to develop the tool. "They told us what they thought the most important infection control observations and questions were and from there we came up with a strategy." The goal was to ensure that surveyors were looking at issues

like catheter and central-line insertions and spinal injections rather than spending a lot of time looking at pieces of paper explaining policies. Indeed, the overriding principle was for surveyors to spend "as little time as possible" looking at documents.

The questions the team developed are pretty high level, Schwartz says, and require the infection control officer to be able to describe his or her control program, and how problems are handled and integrated into hospital quality improvement and patient safety programs. "The other thing we did is that while we can't enforce some of the CDC guidelines, we include questions about them because they are important." So if the answers to some of the questions aren't optimal, that doesn't mean the facility is in trouble, but rather it shows them there is an opportunity to improve. "We don't have the authority to make hospitals comply with issues like oral hygiene or bed elevation, and we can't cite them for it," Schwartz says. "But some of these things are so important that we feel the questions should be in the tool anyway."

Each of the 12 pilot states and territories were required to use the tool in at least one hospital. The test facilities were chosen by doing a risk-adjusted 30-day readmission survey, with the hospitals in the bottom two quintiles targeted. Because the American Hospital Association was kept in the loop from the tool's inception, Schwartz says hospitals were not upset by it in the least. Indeed, everywhere the draft was sent it was copied, shared and pored over, he says.

The second iteration of the tool was completed in February, and training will begin on it in March. The pilot states will use it at least once and then provide further feedback before the final version is completed. The completed tool should be part of the survey process by October, he adds.

Schwartz is excited not just for the potential uses of the tool by surveyors, but because it could easily be used as a self-assessment for hospitals. "We know that infection control is a priority and is getting a lot of attention, and this is something that they can use," he says. "That was in the back of our mind as we developed it. That's why we put some of those questions in for things that we couldn't cite."

Clinical matters, antibiotic stewardship, and quality improvement all demand questions and consideration beyond what is citable, Schwartz says. "It's not just about following good infection control protocols, but about having internal systems that can help identify problems, analyze events, and help you put in place an action plan to improve performance. We think this tool can help achieve that."

For more information on this topic, contact Daniel Schwartz, MD, Chief Medical Officer, Survey and Certification Group, Centers for Medicare and Medicaid Services, Baltimore, MD. Telephone: (410) 786-1104. ■

Spreading the gospel of QI one person at a time

Academic detailing an underused tool

Academic detailing — a way of teaching novel concepts one on one — started as a way for pharmaceutical and medical device companies to quickly disseminate information about new drugs and devices by having individual physicians spread the word among their peers. But it is moving beyond its initial purview to other areas, including to hospital quality improvement directors as a way to lead providers to adopt changes willingly.

"Pharma was so effective in engaging physicians," says **Barry Patel**, Pharm.D., president and co-founder of Total Therapeutic Management, Inc., in Kennesaw, GA, which provides services related to academic detailing to physician practices, health systems and, increasingly, to hospitals. "This is a way to share evidence-based guidelines, identify outliers, and provide them with specific knowledge that will help them improve."

Because academic detailing involves one-on-one learning, it is much easier to get very specific information out and about, Patel says. For instance, if you want to prevent readmissions, you can identify multiple reasons that might apply differently to various providers. What one needs to know may differ from the information that may benefit another. Further, by working individually, you can ensure that physicians don't feel cornered or embarrassed by having their "weaknesses" broadcast. They are even more willing to ask questions that in a public setting would be considered simplistic or even stupid, he says. "They will sometimes admit things they would never admit in another setting."

It may seem inefficient and expensive, but Patel says with proper targeting of data, you can actually make it a more efficient way of changing

behavior and implementing change. "With the right data, you can drill down and see who needs the most help on an issue; you can find the outlying physicians." For those doctors, nurses or other providers, peer-to-peer conversation is probably the most effective way of getting them to listen. "And if you end up saving just one or two readmissions, you can cover the higher 'cost' of this individualized learning." This is especially true as more dollars are put at risk for unplanned readmissions, adverse events, and hospital-acquired infections, Patel adds.

The art of doing this well involves how you talk to the physician, whether you are doing it with an internal person or outsourcing the detailing to an organization like Patel's. They have to be able to assure the physician that their concerns about the validity of the data are heard. "They often tell us that patients are sicker, and that's why they are outliers," he says. "We acknowledge the concerns, let them comment, and tell them we are just providing the information for their knowledge." The unthreatening presentation often works in a way that more direct methods don't — the learners end up listening to information about the evidence-based practices that they had either resisted or applied imperfectly in the past.

Patel says for inpatient settings, it's probably better to use internal thought leaders to do the detailing rather than outsourcing it. However, "you have to find that one person whom everyone loves and respects," he advises. "You need someone who understands that disseminating tough data is hard and has to be done thoughtfully."

Timothy Hannon, MD, MBA, the medical director of blood management at St. Vincent Hospital in Indianapolis, has used academic detailing in his own facility and also brought it to others as a consultant. He says that for quality improvement directors, knowing who the opinion leaders are on every unit and in every department could be very helpful not just to assist in reining in outliers for existing quality improvement programs, but also for getting buy-in for new programs.

"These are the people who are most trusted clinically," he says. "And don't assume it's the department head." In most cases, it probably won't be, Hannon says. The department head, the unit nurse — they are often seen as "them" or a "suit" who doesn't understand the clinical staff who work in the trenches. "They become irrelevant."

Along with the highest clinical regard, the thought leader is usually the most abreast of current literature. They are the ones who are asked about new treatments, controversial topics, and novel processes, Hannon says. "Most physicians don't have time to read all the journals, but there's always someone who does."

The thought leader also should be well-regarded by peers. "If you are looking for someone in cardiology, ask who they would want to come help them if things went to hell in a hand basket in the cath lab," Hannon says. "And ask them who they would want to treat them, or their mother, or their son or their husband." If you find the same name coming up in answer to all those questions, "you are on to something."

Hannon says that in patient safety issues, he wants to use every tool he can to change behavior. "It can take 17 years to integrate innovation," he says. "This is something that works. It gets people to adopt and own change." And if the cost and time involved is more than putting out some written educational material or doing an in-service with the whole staff, Hannon says to consider the cost of inaction and the cost of delay. He speaks of creating a change-accepting environment in terms of war — house-to-house battles as you try to expand something from unit to unit. "I don't think it's a fair fight for patient safety and to change practice, so I want everything I can use to accelerate it."

Hannon's work is in changing behavior around the practice of blood products — something that crosses multiple departments and has multitudes of stakeholders. This method, though, is one that Hannon says has been more successful than others. "You have to make use of the opinion leaders. If you know who they are in your facility, you really only have to detail one person — him or her. Then they become the force multiplier and evangelize the process or system." To a degree, just having that key person on board evokes change that comes passively, without teaching or effort, because that is the person everyone wants to mimic. "Identify them and they will push it out to the rank and file."

For more information on this topic contact:

• *Barry Patel, Pharm.D., President and Co-Founder, Total Therapeutic Management, Inc., Kennesaw, GA. Telephone: (770) 795-0935. Email: bpatel@rxttm.com*

• *Timothy Hannon, MD, MBA, Medical Director of Blood Management, St. Vincent Hospital, Indianapolis, IN. Telephone: (317) 575-9301 ext. 226.* ■

Prenatal initiative yields safety improvements

Birth traumas reduced, gains in documentation

A prenatal care quality initiative at the North Shore-LIJ Health System in Great Neck, NY, has achieved significant improvement in the 11 adverse outcome measures followed via modification of the Adverse Outcome Index (MAOI), according to a study published in the *Journal for Healthcare Quality*.[1] Within the first year, the researchers reported, the MAOI decreased from 2% to 0.8%.[1]

In addition, the authors noted significant improvement in the management and documentation of abnormal fetal heart tracings and the documentation of obstetric hemorrhage. They also cited significant improvements in staff perceptions of safety and in patient perceptions of whether staff worked together.

"The Rationale for the initiative came from several directions," says **Adiel Fleischer**, MD, Chairman of Ob/Gyn at North Shore University Hospital and Long Island Jewish (LIJ) Medical Center, and leader of the initiative. "For one, there was a general realization that we can do things better if we change how we practice, based on statements from IOM and other reports from various specialties, and the impetus from adverse outcomes we had here and reviewed." An analysis of these events, he adds, "Clearly identified areas that could be modified and improved."

The effort, he continues, included obstetrician specialists in maternal fetal medicine, nurses, physician assistants, anesthesiologists, and neonatologists.

"We reviewed a large number of cases in general, and discussed management and clinical care for various types of patients with different complications on a weekly basis," Fleischer says. "Based on that, we identified which practices resulted in the lowest number of complications. We also looked in the literature at what various recommendations were for the management of specific pregnancy complications."

In terms of the complications, he notes, the team looked at where most of the potential problems came from and how to approach them in terms of prevention. "In addition, since we can't always prevent them, we also looked at what could be done to minimize untoward outcomes once the complication was identified," he adds.

Communication is critical

Communication was identified as a key element in potential adverse events, notes Fleischer. "For example, there might be incomplete communication of information provided; it became clear that by having better communication between members of the healthcare team you could greatly improve patient safety and decrease the rate of complications," Fleischer says. "We defined several protocols and methods that are used in order to improve communications — one we use, for example, is the SBAR. We basically had all the people taking care of the patients participate in the Team STEPPS methodology for team training [reported on in 2010 by AHRQ, it emphasizes communication techniques including SBAR] to help ensure the person you were communicating with understood the degree of acuity, and so on."

Another area of concern, also related to communication, was the lack of "escalation" if there was a disagreement in the management of a specific patient or the interpretation of a specific test or finding, such as fetal heart rate tracings. "We noticed that very often if you had a disagreement in general, under the old approach the person with the highest rank — usually the attending — was never questioned," Fleischer says. "We've taken a much more progressive approach; under Team STEPPS, the person who has a concern can voice that concern disregarding that difference in rank. If there was a disagreement, anyone on the floor could escalate the issue to the physician in charge."

Other steps taken

In addition to improvements in communication, concrete changes were made in processes. For example, a standardized approach was introduced for the interpretation of electronic fetal monitoring based on NIH guidelines. "The advantage is that now, when I use a term such as late decelerations, everybody on the team knows what I mean and knows what the implication is," Fleischer says. "In the past, terms might have been used like 'slightly reassuring,'

'OK,' or 'Not so OK.' I'm not sure I would know what you meant if you told me that, but if we all interpret readings and then reach conclusions in the same way you'll know what I mean."

In addition, says Fleischer, certain clinical protocols were adopted. "One of our major concerns is avoidance of iatrogenic prematurity, which is a major public health concern," he notes. This, he explains, involves delivering babies before 39 weeks without a strong medical reason.

"We introduced several protocols, and educated doctors and the entire health care team, and we have specific requirements before a patient can be brought in for induction or a cesarean section," says Fleischer. "We brought the number of elective deliveries before 39 weeks down to zero."

Other evidence-based protocols were introduced, including the following:

- the use of Pitocin augmentation of labor;
- the use of antibiotics and thromboembolics;
- prophylaxis for cesarean;
- the use of magnesium for seizure prophylaxis;
- hemorrhage protocol;
- protocol for induction of labor;
- management of intrapartum fetal heart rate abnormalities;
- obstetrical rapid response team.

Fleischer is very clear on why the initiative was successful. "The main factor was that we changed the way we work and got everyone together in a team approach to improve communication," he says. "We have multidiscipline rounds several times a day, where we discuss the entire number of patients admitted to the clinical floors. If we have a patient admitted with a complication, or if an admitted patient has had a change in status we have a huddle — a meeting of all the individuals and specialties that take care of the patient. Together we decide on the best mode of management; we also underscore the ability to escalate any time a team member sees anything they believe to be unsafe. All of this could be encompassed in the Team STEPPS approach to patient care."

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Med rec initiative achieves 95% compliance

Strategies constant in face of changing guidelines

One of the most challenging of The Joint Commission's National Patient Safety Goals in recent years, at least according to those trying to comply with it, is the goal dealing with medication reconciliation. It has undergone a number of iterations in an attempt to address the complaints that compliance is extremely difficult. Add to that the advent of electronic medical records, or EMRs (perceived as a boon to compliance, but often accompanied by additional challenges), and "meaningful use" standards and the challenge becomes even greater.

And yet the University of California San Diego (UCSD) Medical Center has achieved 95% compliance with its medication reconciliation processes, actually part of an enterprise-wide standard process (for the UCSD Health System).

How was such a high level of compliance achieved in the face of all these challenges? "Mostly through a lot of nagging," says **Brian Clay**, MD, health sciences assistant professor of medicine and a member of the division of hospital medicine, who has overseen the program. "It's something we've sunk our teeth into for six or seven years; our forms underwent four or five revisions, for example."

The first step in assessing and improving compliance, he notes, involved chart auditing. "I won't say it was totally automatic; it was mostly spot-checks and audits conducted retrospectively," says Clay.

The audit data was sent back to all departments, so they were informed as to what their compliance level was. "Way back when we did it on paper," Clay says, "we empowered nurses to contact doctors if they thought the medication review for admitted patients was not complete."

In addition, he continues, "we kept after people." Now, he adds, in the face of meaningful use requirements the system's EMR has a built-in alert that provides a "hard stop" to the doctor if a patient gets up to the floor and medication reconciliation has not been done. "It's kind of like a speed bump," Clay explains.

The alert does not actually prevent additional action on the computer; the user can choose to ignore it. However, adds Clay, "it comes back in an hour if reconciliation is not done, and it dogs them."

UCSD's medication reconciliation process got its start in 2005, shortly after the NPSG was released. "It was conceived and put together by the pharmacy, bedside nurses, and physicians," Clay recalls. "We went through the National Patient Safety Goal language, some of the very minimal literature available at that time, and tried to piece together individual work steps looking for the right things to do."

Over the course of several months a set of paper forms was created for physicians in order to standardize the format of the admission meds list, and a different form was used for discharge.

"At the time of discharge, the provider would complete the form, telling the patient which medications to continue, which were changed, and which should not be taken any more," says Clay. "For any changed medications or new medications needing a prescription, we had a second form, which was a valid prescription for pharmacies." In those days, a carbon copy was made for the chart, with the original going to the patient.

Not surprisingly, the initial forms did not go without a hitch, so they underwent revisions. "The task force continued to meet with end users about what was good and bad," Clay says.

In late 2005, the hospital started going live on electronic orders, with formal rollout in 2006. "But we still did not have clinical electronic documentation, which put us at a disadvantage," says Clay. "We were asking providers to write down information on the forms, but then turn to the computer and order all meds separately."

The "all-paper" method was actually more successful, says Clay, "but we knew go-live was coming, so we worked in this hybrid fashion for quite a long time." Several attempts were made to build a documentation piece, but the EMR being used at that time was "not very welcoming; it was clunky — not very nimble," Clay recalls. So the effort was abandoned until 2008.

"As with any paper form we had legibility problems, so we added some areas to discharge screens in the computer and asked the provider to type in the medication list," says Clay. "We used prompts to spit out separate medication lists of 'new,' 'same,' 'altered,' and 'should be stopped.'"

Finally, says Clay, that system was "sun-setted," and the Epic EMR was launched in February 2011. "At that time we were able to get rid of the forms because you could document in the system and order directly from it," notes Clay. "We were very happy to get rid of the whole paper enterprise and move forward with an EMR that supported medication reconciliation; it was kind of a long process to get to a single format."

While the new system is much cleaner, it's not perfect, says Clay. "In an electronic system you have 'leftovers,' drugs that are on the list that the patient is not on anymore," he says. "That old material could perpetuate throughout the system. There's not a good way to automatically clean that up because it takes a provider decision to determine that a medication is old."

Accordingly, he says, he has launched "a big education effort" to make providers aware of that weakness. "We have put together some fake patients with common problems, like obsolete meds, and we do one-on-one real-time training with physicians to show how it should be dealt with in the system."

This training will take place over the next six months with internal medicine residents and hospital medicine physicians, Clay says. "We will then have about 120 of them certified to be competent to use the Epic system to reconcile medications," he explains.

In addition, he shares, newly developed materials are being provided to the physicians regarding how to perform reconciliation in the system. ■

Three pharmacy safety problems solved

ADCs don't have to get the best of you

One of the most common mistakes found in Joint Commission surveys is expired medications, says **Yosef D. Dlugacz**, PhD, of the Krasnoff Quality Management Institute at the Long Island Jewish Health System in New Hyde Park, NY. It's something that everyone agrees is a bad thing and seems like it would be simple to get a handle on. Yet survey after survey finds that old medications are still on the shelves — or worse, getting through to patients. How can that be?

Dlugacz says it comes down to humans being part of the health care system. They think they'll remember what to do and when to do it, but they skip a step. Or they think that something that expired yesterday is still safe. Or they just plain don't look at the expiration dates.

Still, there are hospitals that have gotten a handle on how to address this and other common safety issues that affect the pharmacy, including problems with automatic dispensing cabinets (ADCs) and shortages of medications that are increasingly common.

At Decatur County Memorial Hospital in Greensburg, IN, expired medications were a problem a few years ago, explains **Denise Fields**, Pharm.D., director of pharmacy services for the facility. "About five years ago, the board of health found that we had some nutritional products that had expired, so we had to look more closely at it."

At the time, the expiration checks were done on paper, with only broad instructions — check the pharmacy, check the units. If someone new was involved in the checking, he or she might not know that in the pharmacy, there were multiple refrigerators to check. A notation to check the med-surg unit might leave someone who is new to the facility unaware of all the places on the unit where drugs are stored. Further, until all the clipboards were returned at the end of the month, Fields says she didn't really have any idea if there was a problem.

Now, she says she makes sure to break the process down into smaller steps — check the med-surg nutritional cabinet, the med-surg refrigerator. "I lead them to all the places on the med-surg unit where drugs or supplements might be."

Another problem was the constant movement of products around the pharmacy. Someone looking for IVs that were out of date might miss some if they had been moved. Now, rather than having a just checklist of places to look, Fields has added to it a checklist of items — IVs, capsules, nutritional supplements.

But perhaps the most important change made was putting a degree of accountability in place. Previously, troubles with the bedside barcode scanning would result in workarounds and staff bypassing the system, which could potentially let expired medications get through to patients. Now the staff are judged during annual review in part on their scanning percentages. That encourages them to report problems and barriers to using the scanning software rather than simply bypassing it.

Joe Sacco, RPH, director of pharmacy at Spaulding Hospital in Cambridge, MA, says his facility uses a sticker system, in which colored, prominent expiration date stickers are put on medications as they are stocked in the automated dispensing cabinets. These are checked on a regular rotation and drugs are pulled as they expire.

Lately the news has been full of stories about how drug shortages may affect patients if things don't change. But Fields says she is already working to ensure that they don't affect patient care.

If a drug is in short supply and she decides to use a compounding pharmacy, she makes sure to note whether the new version will fit in the ADC drawer that the manufactured product used. If not, she has to rework the physical location. Likewise, drug kits may need new forms.

Her worst nightmare is when an existing concentration isn't available — say the normal 25 mg Phenergan dose isn't available, but the 50 mg is. "You have to build in alerts for all staff that this is a two-fold dose," she explains. "I have to update the ADC formulary and all standing physician orders."

Create a checklist for what you will do in the event of a drug shortage, she says. "If you don't, you won't remember all the steps." Don't forget to include how you will revert to old processes when a drug in short supply is available again.

With ADCs, common problems include medications going out of stock despite your best efforts. Other issues may fly under the radar just because no one bothers to assess how their drug dispensing program is functioning.

Automated dispensing is a great way to save money and time and potentially improve patient safety. When Spaulding Hospital went from just narcotic and PRN drugs being dispensed through ADCs to all drugs over the course of a year, the facility saved an estimated 22,000 nursing hours that had been spent locating medications. In addition, patients are getting their medications sooner — especially those who are receiving new orders or getting their first dose, Sacco says. There are no more complaints of running out of meds, of needing something urgently, or of waiting for something the patients requires, he says.

In the last 10 months, the only change that Spaulding had to make to the system was finding new places for some of the drugs to better meet the ergonomic needs of nurses. Short nurses were having trouble doing the daily counts for narcotics, which were kept in the higher drawers. Sacco says to be sure to keep the most-used meds in the most convenient drawers, too.

Know what you use most by doing an audit of the medications prescribed in the last few months, he advises. "If you do your homework, you get it mostly right," says Sacco, who acknowledges that no ADC will be able to stock 100% of what you need.

Both Sacco and Fields have used the Institute for Safe Medication Practices (ISMP) ADC self-

assessment tool to judge whether their programs are working well. Both will be using it again to do further gap analyses.

Fields says she used it when it first came out to figure out where there were problems that needed addressing. Through it, she developed a list of several performance improvement projects and problems to address. For example, one involved getting in touch with the vendor about making changes that would create hard stops preventing dispensing if a patient has an allergy. The initial ADC had active alerts that a certain drug was contraindicated, but a nurse could still dispense it by overriding the system. The newer iteration from that vendor now includes a hard stop for contraindicated medications. Another change that the assessment suggested was needed was to decrease distractions around the cabinet. Near the location of one, there was a phone that was necessary in case a nurse had questions. But it would ring often — and if no one answered, a nurse who was in the midst of dispensing drugs might stop what she was doing and answer it. The distraction was potentially a safety issue. The fix was simple: Turn the ringer all the way down so that nurses wouldn't be tempted to answer it. To further limit distractions, Fields also created a box with red tape in front of the ADC. No one is allowed to talk to any nurse when she is in that taped off area.

Thousands of hospitals have made use of the ADC self-assessment tool, says **Allen J. Vaida**, Pharm.D., FASHP, executive vice president of the ISMP. It was developed using information from the National Medication Errors Reporting Program and onsite work with hospitals. Vaida says they also created a committee of stakeholders from around the country to help develop the tool in 1999, and then revamped it in 2004 and 2011.

In the first two iterations, more than 3,000 hospitals sent in their data from the assessment, and Vaida says there are several peer reviewed articles

COMING IN FUTURE MONTHS

- The benefits of improving patient engagement
- More from the JC survey trenches
- Patient safety and handheld devices

CNE QUESTIONS

1. NIH rules say that researchers have to:
   a. include women, minorities and seniors in all studies.
   b. include women and minorities in their studies or provide a rationale for why they don't.
   c. explain why they don't include older adults in their studies.
   d. none of the above

2. If ASCs don't report on all five initial quality measures in 2012, they face a penalty of
   a. 2%
   b. 0.2%
   c. 20%
   d. 5%

3. Which of the following is NOT a citable issue for infection control:
   a. hand hygiene
   b. oral hygiene
   c. catheter insertion
   d. sharps disposal

4. Academic detailing got its start in
   a. aviation
   b. manufacturing
   c. pharmaceutical and medical device companies
   d. physician practices

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.

that illuminate the positive effect that completing the assessment has had on organizations. "It has spurred many of the National Patient Safety Goals from The Joint Commission," he says, "and it has been used by the National Quality Forum in their medication safety best practices, and by other organizations to improve their medication safety practices."

For more information on this topic, contact:

- *Allen J. Vaida, Pharm.D., FASHP, Executive Vice President, Institute for Safe Medication Practices, Horsham, PA. Telephone: (215) 947-7797. Email: avaida@ismp.org.*
- *Joe Sacco, RPH, Director of Pharmacy, Spaulding Hospital, Cambridge, MA. Telephone: (617) 573-7000.*
- *Denise Fields, PharmD., Director of Pharmacy Services, Decatur County Memorial Hospital, Greensburg, IN. Telephone: (812)663-1378.*
- *Yosef D. Dlugacz, Ph.D., Krasnoff Quality Management Institute, New Hyde Park, NY. Telephone: (516) 472-5000.* ■

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■