

Critical Care MANAGEMENT™

The essential monthly resource for critical care and intensive care managers and administration

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Nursing groups respond to demands for quality accountability in critical care

Measure success with focus on process improvements, patient outcomes

Can success be measured? Nursing organizations are trying to determine a meaningful definition of success for the intensive care unit (ICU). So are other groups. The influential Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, for example, has issued a series of statements in the past year urging hospitals, including critical care units (CCUs), to measure up to quality standards.

Meanwhile, Medicare, Medicaid, and large private employers are contracting heavily with managed care organizations, which are also asking providers for more accountability on quality.

In an unprecedented way, a growing number of outside groups are urging hospitals to determine how they fare on quality standards, says **Joanne R. Duffy**, DNSc, CCRN, a nursing consultant with AdviCare in Burke, VA. The emphasis on quality isn't new, Duffy says, but the message is getting louder.

Can success be measured in critical care? Nurse managers and physicians lean in the direction of saying yes — they *can* measure success in the CCU. Patient acuity outstrips that of almost all other acute care departments except perhaps emergency medicine. And patient mortality rates run higher than elsewhere in the hospital. Nevertheless, nursing administrators say they can measure success in critical care by focusing on patient

EXECUTIVE SUMMARY

A growing chorus of interested groups is asking for accountability from critical care providers. Demands for higher clinical quality have filtered down to ICUs. But can success be measured?

- Process improvements based on standardizing patient procedures lie at the heart of assessing success.
- Over-reliance on data and especially mortality rates can distort perceptions of ICU success.
- What nurses do daily and a team approach to standardizing unit processes are key to making things work.

Phoebe Putney Memorial Hospital Process Improvement Results

Establishing Measures

A change is an improvement if there is a substantial decrease in the following measures for all patients with DRG 475:

- Length of stay (hospital and ICU)
- Median number of days on ventilation
- Median hospital charges per admission
- Percentage of patients with complications (mortality, readmissions, reintubations)

The team measured these indicators during the baseline period. After several protocols were introduced, the team collected data on these measures for all patients with DRG 475.

	Baseline	Study Period
ICU length of stay (Median)	7.5 days	5.0 days*
Days on mechanical ventilation (Median)	5.5 days	3.0 days*
Hospital charges (Median)	\$36,325	\$28,346
Mortality	36%	28%
	(10/28)	(27/98)

*p = <0.02

Number of patients in baseline = 28

Number of patients in study period = 98

Source: Institute for Healthcare Improvement, Boston.

outcomes, but even more on the effectiveness of their clinical processes.

“Outcomes alone tell only part of the story,” says **Judith Fisher**, RN, MSN, a clinical practice specialist in the coronary care unit of 650-bed Inova Fairfax Hospital in Fairfax, VA. “Your outcomes are really a reflection of how effective you are in implementing high-quality clinical processes,” she says.

Her statement takes into account the typical ICU’s record on high patient mortality. “If your nurses are doing everything they’re supposed to do, regardless of whether the patient makes it, your efforts count as a measure of success,” Fisher says.

Process improvements in critical care are receiving a lot of attention these days. They were the emphasis of a groundbreaking project a few years ago initiated by the Institute for Healthcare Improvement (IHI), a Boston non-profit group interested in speeding up improvements in health care through integrated strategies.

In 1998, IHI published findings of an exhaustive study of ICU process improvements in a book, *Reducing Costs and Improving Outcomes in Adult Intensive Care*. This 193-page book is a compilation of internal improvements that focused on positive changes within ICUs.

More than a dozen hospitals participated in testing several “change concepts.” One of the concepts included setting up standardized processes that would help to achieve a variety of goals ranging from reducing inappropriate days in the ICU

to identifying and reducing bottlenecks in the patient management system.

One such effort involved a method to manage patient ventilator support to reduce the time they spent on mechanical vents and avoid complications. By standardizing various activities, the hospitals attempted to achieve four goals over a 12-month period:

- 1. reduce time on mechanical ventilation by 30%;**
- 2. reduce costs for lab tests and X-rays by 30%;**
- 3. reduce length of stay in the ICU by 25% while reducing morbidity, mortality, and complications;**
- 4. reduce complications such as ventilator-associated pneumonia by 40%.¹**

One of the hospitals, 450-bed Phoebe Putney Memorial Hospital in Albany, GA, exceeded the targeted goals. Working with respiratory patients under DRG (diagnosis related group) 475, the medical team reduced the median number of days patients were on mechanical vent to three from a baseline of 5.5 days.

It also was able to reduce average charges for the same cases by about 22% to \$28,346 from \$36,325 per admission during the study period. Mortality rates also fell to 28% (with ratio of 10/28, or 10 of 28 patients surveyed) from 36% (27/98).

Phoebe Putney “proved that process improvements are actually possible for the ICU when the environment encourages change,” says **Connie A. Jastremski**, RN, MS, MBA, an assistant professor at

Breakthrough Series Collaborative Improving Care and Reducing Costs in the ICU

Reduce Time on Mechanical Ventilation (MV) by 30%

	Currently in Place in System	For Consideration and Development
For Short-term ventilatory support		
1. Monitor weekly the average time on MV in hours and display on a run chart.		
2. <i>The process of removal from MV is separated from the extubation process.</i>		
3. Establish a nurse/RT protocol to assess and manage oxygenation:		
a. Assessment on a regular schedule around the clock.		
b. Reduce F102 and PEEP using thresholds from pulse oximeter and blood gases.		
4. Establish and use clear criteria for assessing respiratory mechanics and weaning from mechanical ventilatory support.		
5. Patients are weaned from MV using a nurse/RT-driven protocol.		
6. Sedation protocols are used that promote early weaning from MV.		

Source: Cohen IL, et al. Reduction of duration of mechanical ventilation in an intensive care unit by use of a ventilatory management team. *Crit Care Med* 1991; 19:1,278-1,284. Kollef MH. Ventilator-associated pneumonia: A multivariate analysis. *JAMA* 1993; 273:1,965-1,970. Wood G, MacLeod B, Moffatt S. Weaning from mechanical ventilation: Physician-directed versus a respiratory therapist-directed protocol. *Respir Care* 1995; 40:219-224.

the State University of New York Health Sciences Center in Syracuse and a member of the IHI planning group. **(For a breakdown of the hospital's performance indicators, see chart on p. 50.)**

The IHI Breakthrough Series, the initiative, put much of the theory about benchmarking and quality improvement into direct action, which for Phoebe Putney, led to some striking results, Jastremski says.

How did the hospital achieve its numbers? **Bill Brock**, MD, director of critical care, says the institution's three unattached ICUs (medical, surgical, and coronary) began with a historical orientation of adopting process improvements long before the IHI initiative came along.

The practice of using standardized procedures for the ICU has been a function of practical necessity going back several years, Brock says.

It's been responsible for the medical team's long-term ability to manage patients under stressful conditions that include running three separate ICUs located on three different floors of the hospital with a total of 34 beds. There is also a nursing staff that is largely shared by the three units, Brock adds.

The process of standardizing certain procedures is based on two key elements of patient care. One involves what goes on at each patient's bedside. The belief, according to Brock, is "what

proved to work best with previous patients is likely to work again with the next."

The second is what the clinical team can do to emulate benchmarked parameters using information provided by bedside nurses. These parameters include everything from gradually increasing ventilator weaning to achieving significant reductions in length of stay for patients with respiratory failure, Brock says.

To do this, clinicians have had to keep a close eye on the patient data, which are obtained from daily nursing records, routine monitoring and nursing consults, then analyzed and compared to previous outcomes data of patients with the same DRG (respiratory failure).

As part of the IHI project, the hospital attempted to standardize the process of weaning the ventilator-dependent patients under DRG 475. By standardizing the management of these patients, the team also believed it could streamline and accelerate the weaning process safely.

The team conducted 100 tests on a designated study group of 98 patients over the 12-month period to achieve its outcomes. The tests included ways to prevent unplanned extubations, deciding on the ideal time for tracheotomy, and the value of screening patients for nutritional needs within 24 hours of admission.

The effort was helped substantially by the addition of a full-time respiratory therapist (RT) to the clinical team, says veteran ICU nurse **Debra Williamson**, RN, nursing director for critical care. The RTs — one on each shift — were not borrowed from another department on a part-time basis, but assigned to the coronary unit and specially trained to be part of each patient's care plan, Williamson says.

In a combination of hands-on and classroom training, each RT was integrated into the nursing team. They learned to do conventional ICU nursing tasks as pressure-line set-ups, angioplasty catheter insertions, and intravenous (IV) starts. Some even assisted in performing electrocardiograms.

They also spent most of their time on the floor carefully monitoring each patient's progress while trying by degrees to take the patient down from full vent dependence, IV and pressure line support, and partial vent status, without trying to reach any predetermined goals or minimum days.

The objective included a regulated reduction in the ventilator IMV (intermediate mandatory ventilation) rate in regular time intervals. Patients were monitored every 15 minutes. The RT, however, worked within the shadows of the attending nurses, who stood by at all times for guidance with a set of physician-endorsed weaning guidelines in tow, says Williamson.

The nurses didn't directly supervise each ventilator resetting. For example, the RTs didn't necessarily check with the nurses each time they decreased the CVP (central venous pressure) wedge reading from 18 mm of mercury to 10, or reduced the patient's oxygenation level from 100% to 92% of FiO₂.

But nurses were aware these adjustments were being made, Williamson notes. "There was a certain amount of cross-over between the nurses and the RTs, but they never confused their proper roles," Williamson recalls. **(Chart on p. 51 highlights process steps in time on ventilator reduction.)**

Without the direct involvement of the RTs and an integrated, multidisciplinary team approach to ventilator weaning, the unit could not have achieved the resulting numbers or established a standardized procedure for those particular patients, Williamson concludes.

Fisher of Fairfax Hospital offers a caveat about using internally collected or imported data as a basis for launching into process improvements. Managers who are cautious about an over-reliance

on the quality of data taken from any source would be erring on the safe side, Fisher says.

Evaluate a broad set of factors, she advises. Avoid looking solely at patient outcomes, including mortality figures, whether they are internally generated or taken from outside benchmarks. Don't rely on the face value of a single set or a limited group of parameters such as morbidity or time-to-medication.

Changing conditions can distort reality

Time intervals and circumstances can greatly alter conditions from one scenario to another, which can end up distorting reality and hurting your process improvements, Fisher says. This is especially true when establishing protocols across a multihospital system.

Fisher recalls an effort at Inova Fairfax to decide whether beginning a standard regimen of aspirin on certain patients within 24 hours of ICU admission was a good idea. The clinical literature had shown that an aspirin regimen initiated on patients suffering from myocardial infarction within 24 hours of an ICU admission reduced mortality risk by 20%.

The clinical staff at Fairfax Hospital did not doubt that the literature was correct. But would it work for Fairfax and its three sister facilities well? Could the overworked nurses administer the aspirin to the MI patients within the prescribed time as a standardized procedure?

After collecting initial data, not on patient outcomes but on whether nurses at the four facilities were able to maintain the aspirin regimen over the course of three months, Fisher discovered that the data obtained from the study were faulty.

Each of the hospitals submitted different success rates. After reviewing the causes, nurses at the poorest-performing hospital of the four could have administered the aspirin by suppository but did not. The alternative would have improved their showing.

Yet, the data suggested that the hospital fared poorly. The nurses couldn't administer the aspirin regimen consistently due to factors such as the patients' conditions. The incident reveals the importance of evaluating an entire process rather than focusing solely on outcomes, Fisher explains.

Reference

1. Rainey TG, Kabacene A, Berwick DM, et al. *Reducing Costs and Improving Outcomes in Adult Intensive Care*. Boston: Institute for Healthcare Improvement; 1998. ■

NJ hospital's novel unit saves on patient transfers

A 'flex approach' to patient care eases ICU load

A medical center in New Jersey has found a novel way to tailor the amount of critical care given to certain extremely ill patients while solving a stubborn, costly problem faced by many nurse managers and physicians.

Muhlenberg Regional Medical Center in Plainfield, NJ, is perfecting the use of what its clinicians describe as a "flex unit-approach" to handling certain patients who normally would be regarded as candidates for an ICU admission, but don't quite fit that classification.

In 1994, the 420-bed hospital set up an intermediate critical care floor to serve patients whose diagnoses and conditions qualified for ICU care, but did not require the full, intensive nursing or monitoring traditionally delivered in the ICU.

The flex unit addresses many patient-care issues, but it also solves the burdensome problem of having to physically move a critically ill patient from a medical-surgical floor to an intensive care department, says **Eva Besserman, DO**, Muhlenberg Regional's associate director of critical care.

Unit serves critical patients not right for ICU

"As any nurse knows the time and work involved in transferring a critically ill patient from one department to the ICU usually results in frustrating delays, system slowdown, and higher costs [in labor and time]," Besserman says. "Then there's the discomfort to the patient and families."

By creating a dedicated unit to serve patients who are too sick to remain on most general medical floors, but not ready for full ICU services, clinicians have significantly reduced the number of patient transfers and admissions to the ICU.

The exact number is difficult to determine. The ICU continues to experience daily changes in patient status, discharges, and admissions even with the existence of the flex unit. But clinicians speculate that the flex unit has helped stabilize patient flow in the ICU.

In doing so, the system has enabled the ICU to better control patient management, daily census, and average length of stay by addressing the needs of patients who are likely to receive the full benefit of ICU care, Besserman notes. It also has

reduced pressure on early discharges.

In fact, the flex approach to critical care has worked so well for the hospital that the ICU adopted a similar flex approach for its own patients, says **Sheri Cleaves, RN MSN, CCRN**, a clinical nurse specialist at Muhlenberg Regional.

At most hospitals, units of this type would be regarded as a step-down floor. But it doesn't quite fit that profile, Cleaves observes. For one, step-downs usually take ICU patients who no longer need traditional intensive care.

In contrast, the flex unit is a self-contained floor that manages the amount and type of critical care given to patients by shifting the level of care up or down depending on the patients' individual needs. It doesn't admit patients whose conditions have improved, but quite the opposite, says Cleaves. At most hospitals, a large number of these patients would immediately go to the ICU.

Unit is selective about patient admissions

Criteria for admission to the unit include:

- **cardiac patients with rapidly changing monitoring needs and levels of nursing care who may benefit from a flexible monitoring unit;**
- **patients who require continuous pulse oximetry with or without cardiac telemetry monitoring;**
- **medical-surgical patients who need frequent vital-signs monitoring and intensive nursing care with or without cardiac monitoring, e.g. gastrointestinal bleeding, asthma, sepsis, and hypertensive conditions.**
- **patients with uncomplicated bilevel airway pressure who don't require one-on-one nursing or titration of sedative drips;**
- **cases in need of insulin drips with fingertip glucose every two hours, in addition to uncomplicated illnesses;**
- **newly intubated or tracheotomy ventilator patients who don't require titratable drips or sedatives under long or short-term management;**
- **major post-surgery cases in need of close observation.**

There are additional admissions parameters. But in general, the unit gives priority to patients with acute but reversible diseases over cases with a prognosis that is chronic, irreversible, or terminal, according to the admissions guidelines. It does not admit complicated ventilator patients, who require FiO_2 or a PEEP (positive end expiration pressure) of more than 7.5 cm and who are hemodynamically unstable.

Flex Unit's Patient Assignment System at a Glance

Color-coded assignments determined by acuity

Level I: Red

Extremely ill patients needing some ICU-level care

- Vital signs every four hours
- Cardiac monitoring as needed
- Charting on critical care flow sheet
- Ventilator support with telemetry
- High-risk status requiring frequent assessment

Level II: Green

Non-telemetry cases that require frequent nursing assessment

- Vital signs every four hours
- Charting on critical care flow sheet
- Ventilator patient (non-telemetry) with vital signs
- Charting every four hours
- Telemetry discontinued by requiring close observation
- High-risk patients requiring frequent assessment

Level III: Blue

Non-telemetry cases that require medical-surgical care

- Vital signs every eight hours
- Charting on medical-surgical flow sheet

Source: Muhlenberg Regional Medical Center, Plainfield, NJ.

It also refuses cases with complicated intraoperative tracheotomies, those who require A-line Swan Ganz monitoring, CAVH (continuous arterial venous hemofiltration), CAVHD, (continuous arterial venous hemofiltration dialysis), or balloon pump cases. Patients who are post-code hemodynamically unstable or drip cases whose level of care is undefined are usually transferred directly to the ICU.

To appropriate care to the wide case mix that the unit does admit, nurses divide patients into color-coded nursing categories. The color-coded patient criteria with each patient's name appear on a nursing assignment board kept in the unit. (See chart, above.)

Sorting out patient management criteria for nurses would seem difficult under such circumstances. But Cleaves says the system works well partly because the bedside nurses understand the color-coded assignment system, and the guidelines for patient care are clear. Furthermore, nurses have

undergone considerable training in working specifically for the unit.

When the hospital opened the new floor in 1994, it was a converted obstetrics-gynecology floor that began admitting patients and assigning some nurses who had previously obtained their certification in critical care.

After some initial turnover (several ob/gyn-trained nurses left the unit), a pressing need arose to train the remaining RNs who weren't certified in critical care as increases occurred in the unit's patient population.

New nurses were put through an intensive 15-day training program that included hands-on and classroom work on subjects ranging from taking blood gas measures and interpreting arrhythmia readings, to legal and ethical issues in critical care.

In addition, some nurses were farmed out for training to the ICU to work under preceptors while others received similar preceptorship training on the flex floor, and others were still assigned only the less seriously ill cases. As a whole, the combination of classroom and floor training has given newer nurses the exposure they needed to work with this particular patient population, Cleaves says. ■

Avoid headaches: Plan ahead using pool nurses

Simple help lists and incentives can ease the pain

After more than a decade of debate and misery, nursing administrators are still wrestling with the wisdom of using float or pool nurses to staff critical care units (CCUs). The medical literature appears certain about one thing: Nursing pools and experienced floaters help in a pinch.

"But overall, they yield marginal benefits," says **Gina Bergmooser**, RN, a shift supervisor in nursing services at Grace Hospital in Detroit. This is not news to ICU managers. Sometimes inexperienced floaters even get in the way, Bergmooser notes.

As a result, some veteran managers such as Bergmooser have adopted a none-too-surprising but realistic view toward using nursing pools and floaters. With personnel shortages running high in critical care, it's inevitable that CCUs will have to rely more on outside help. Why not try to make the adjustment less difficult for both the unit and the temporary RNs?

Over the last decade, several practical strategies have been aimed at facilitating this view. But in reality, except for some occasions, CCUs bother little to plan ahead when anticipating shortages that will require pulling in floaters, Bergmooser notes.

Caught in a bind, most supervisors simply pull nurses from other floors. Or at worst, they resort to expensive agency personnel at the eleventh hour.

This “shotgun approach” to seeking remedies is responsible for many of the problems associated with using floaters, says **Amy Strzalka, RN, MSN**, a liver transplant coordinator and former nurse manager at the cardiac care unit at UNC Hospitals in Chapel Hill, NC.

“Let’s face it, if you have to pull a nurse from another floor, in effect you’re using a pool nurse,” she says.

Why not plan ahead, develop a flexible nurse resource pool, and take time to adequately nurture and adapt nurses in the pool to your unit’s demands?

According to Bergmooser and Strzalka, when these steps are combined, they are certain to work better than taking impromptu turns at calling other floors or nurse registries asking for help. But they require initiative, planning, and maintenance.

Here’s how these measures would work:

- **Assess your floater’s potential.**

It’s difficult enough getting full-time salaried nurses to work your unit. But concentrating on incentives in getting nurses from other units and part-timers to form the pool may pay dividends, says Strzalka. It takes effort to find such personnel. Yet, many nurses are willing to work part-time or prefer working on certain shifts. Again, it’s a matter of searching them out, which requires planning and patience.

Then again, money is an incentive, if your department can spring for it and pay floaters more than they might get elsewhere.

“Money is always a great incentive,” Strzalka notes. Of course, it’s difficult with cutbacks and budget constraints, but if you need the staff money will attract any of us, she adds.

- **Determine your existing and future levels of need.**

Except for the occasional periods of mass sick calls or staff turnovers that leave you seriously under-staffed, the unit will likely know its staffing needs by the week or month, Bergmooser says.

The pool should be looked at as a reserve, not a permanent nursing assignment resource. Therefore, managers should be able to predict ahead of time their propensity for spot shortages

and their corresponding dependency on a pool nurse.

Weekends, evenings, or nights might be the time of greatest exposure. By anticipating these events and making mental notes about staffing for those shifts, supervisors won’t be caught short in most cases, Strzalka says.

Management isn’t likely to allow you to staff up permanently in this manner, but for high-risk occasions, the pool will serve as an ace up the sleeve, she adds.

- **Fit the floater to the task.**

Assess the floater and develop a long-term relationship with that individual, Strzalka adds. Charge nurses can plan ahead by discussing a potential floater’s experience and skill levels.

If the individual possesses the minimum qualifications for the CCU, the charge nurse can find an assignment suitable for that individual. Perhaps the floater can help with taking vitals or transferring patients, which require nursing skills but not necessarily critical care expertise, Strzalka notes.

What’s important is to bring the floater into the unit’s culture and cultivate a lasting mutually beneficial relationship with the person. But again, Strzalka notes, this takes an investment of time and effort from management.

- **Be realistic.**

Determine the effect the reliance on a pool nurse will have on your unit’s ongoing, long-term staffing needs. If you need additional permanent personnel, the resource pool will be a disappointment because it was not designed to offer nurses full-time employment, Bergmooser says.

- **Guide the floater’s integration to the unit.**

The process can begin with a brief orientation. Two years ago, Bergmooser devised a help list to facilitate “a smooth unit-to-unit transition” for nurses pulled from other departments. The list, Shared Staffing Help List, was actually an information fact sheet that serves as a transitioning tool to brief outside nurses on the specific duties required in the unit.

The tool also helps prospective floaters and unit supervisors determine whether the pool nurse’s skills and experience fit the responsibilities of the unit, Bergmooser says. One of the virtues of the help list, according to Bergmooser, is that it can be fashioned in any desirable way but also covered the essentials.

The essentials consist of background unit information, shift-report formats, charge responsibilities, and nursing documentation requirements. But the list also contains information of personal

interest such as break times, lunch hours, locations of restrooms, nursing supplies, and medical equipment.

These secondary “issues may not seem important, but they help to familiarize the [pool] nurses with what to them must be an unfamiliar place, and helps break the ice by showing that management has thought of almost everything,” Bergmooser says. ■

Charting in several places can avert legal snafus

ICUs that rely on flow sheets are exposed to risks

A report issued last year by Milliman and Robertson health care consulting firm reveals that nearly 54% of all inpatient hospital days were medically unnecessary.

A great deal of the hospital care, according to the New York City-based consultant, could have been provided in an alternative setting such as a nursing home or a home care program.

In New York, for example, 72%, or nearly three-fourths of inpatient days in 1997 were deemed extraneous to good patient care.

Insurers and third-party payers are seizing such findings to justify closer scrutiny of hospital patient care trends, hospital utilization experts say. And while most of the attention focuses on general medical and surgical suites, critical care units are being put under the same microscope, says **Gayle H. Sullivan**, RN, JD, an attorney and former nurse who reviews hospital patient records for malpractice insurers.

It isn't just cost effectiveness that is prompting the review of hospital care. Government payers such as Medicare and state regulatory agencies are investigating providers for alleged legal improprieties. In the past five years, the federal government has waged an extensive fraud and abuse initiative that has netted millions in alleged Medicare and Medicaid hospital overpayments.

In assessing a hospital's resource utilization, the first place auditors are likely to look is a department's patient documentation, Sullivan says. In most cases, the auditors will be looking for standards of care or omissions as reflected in the record.

In critical care, the growing use of flow sheets and other simplified forms of documenting a

patient's condition opens nurses up to substantial legal and professional questioning, says Sullivan. The questions arise when a lack of more extensive documentation isn't available elsewhere, either in a computer file or the complete paper chart, Sullivan notes.

Collectively, flow sheets may yield a good picture of patient-care management trends over several days or weeks, but at best they reflect only a snapshot, says Sullivan. They can't adequately explain, for example, why a patient's intravenous insertion was left unchanged for three days or the reason a patient's weaning from a ventilator was interrupted, then resumed during the third day.

Some nurse managers advise documenting in more than one place so that the entries supplement and reinforce each other. If nurses rely heavily on using flow sheets, other sections of the medical record should contain entries and supplemental notations that clearly reflect the content of the sheet, says **Kathleen Rafferty**, RN, MS, cardiology ICU patient care manager at St. Elizabeth's Medical Center in Boston.

Nurse managers acknowledge that flow sheets are a handy tool because they simplify some aspects of charting and free nurses to spend more time on patient monitoring. Flow sheets are essentially a set of algorithms or checklist that reflects a patient's care plan or outline a set of smaller nursing protocols such as prescribed nutrition levels, feeding times, or blood pressure assessments within specified time intervals.

However, using flow sheets tends to reduce the likelihood that nurses will spend sufficient additional time in writing thorough, detailed patient entries in the chart's progress notes. The written notes are much more descriptive; and when written correctly, they contain well-supported observations on a patient's condition at a particular point in time, says **Carole Kenner**, RN, DNS, a critical care nurse and professor of nursing at the University of Cincinnati in Ohio.

“A great deal depends on exactly how a hospital adopts these time-saving tools and how well nurses are taught to use them,” Kenner says.

The Joint Commission on Accreditation of Healthcare Organizations in Oak Brook Terrace, IL, the American Hospital Association, and the American Medical Association, both in Chicago, have each promulgated proper documentation standards.

The American Health Information Management Association, also in Chicago, publishes charting and coding standards. **(For information about**

these resources, see the box on right.) Your hospital's medical library or risk management department should be able to furnish additional resources. For the ICU, here are some relevant considerations:

- **Standardize documentation parameters.**

In the ICU, the nurse documentation tracks the patient's medical status in short-term intervals. Therefore, the documentation requires careful, regular maintenance, Rafferty says. In addition to highlighting key patient-assessment factors such as vital signs, pain level, and respiratory data, the flow sheet must be able to supplement and support other corroborative documentation such as medication orders or the full medical record, Rafferty says.

- **Establish clear-cut procedures when relying on flow sheets.**

If the unit adopts a flow sheet, it must be standardized to reflect consistency in daily bedside management, Kenner says. Deviating from the sheet or improvising even slightly between shifts defeats the purpose of a care plan, but it also makes keeping a complete record of care virtually impossible, Rafferty says.

- **Design care maps to be as specific as possible.**

Written care maps represent the third major source of documentation in the ICU, Rafferty observes. If consistently and completely filled out on each shift, the flow sheet can support the care maps and also the corresponding areas of the complete medical record.

- **Assume the need to troubleshoot problems more often than in other departments.**

Sullivan advises doing random chart audits internally (i.e., within the department) more often than the hospital's standard policy. Regular monthly audits are appropriate. Prior to commencing, establish criteria or standards that will be met, says Sullivan. For example, establish goals for determining how often and how thoroughly nurses document patient vital signs during the night or weekend shift.

- **Review the flow sheets weekly.**

Weekly reviews will generate discussions on ways to improve how nurses view and utilize the sheet, Rafferty says. The nurse manager and nurse educator should meet with the bedside nurse during the review, which is conducted according to a checklist that corresponds to areas of the flow sheet. The checklist highlights areas of concern at St. Elizabeth's, but it might vary depending on the patient's DRG or changes in the nursing care plan.

SOURCES

For additional information about proper medical record documentation contact:

- **Joint Commission on Accreditation of Healthcare Organizations**, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 916-5636 Web site: www.jcaho.org.
- **American Hospital Association**, Coding Clinic, One N. Franklin Ave., Chicago, IL 60606. Telephone: (312) 422-3000. Web site: www.aha.org.
- **American Medical Association**, Coding and Classification Section 515 N. State St., Chicago, IL 60610. Telephone: (312) 464-5000. Web site: www.ama-assn.org.
- **American Health Information Management Association**, 919 N. Michigan Ave., Suite 1400, Chicago, IL 60611-1683. Telephone: (312) 787-2672. Web site: www.ahima.org.

Rafferty suggests all nurses bring the flow sheet into the patient room and use them directly at the bedside. "It cuts down on having to remember what to document later or duplicating your note-taking," she says. ■

Hospital ownership could affect mortality rates

Study: For-profits do better on mortality scores

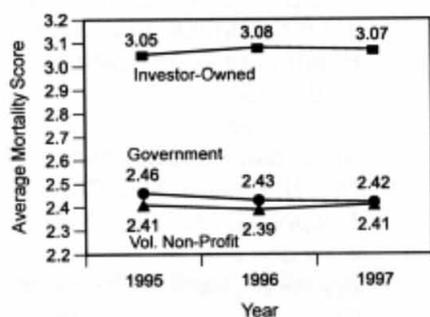
A hospital's ownership status may have an effect on inpatient mortality rates. According to a new study, private, investor-owned hospitals scored significantly better on patient mortality scales than counterparts that are owned by government or not-for-profit entities such as counties or religious organizations.

The three-year study of hospital patient mortality data from 1995 through 1997 was conducted by The Center for Healthcare Industry Performance Studies, (CHIPS) a private Columbus, OH-based research firm.

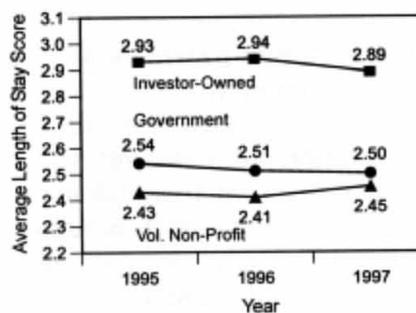
After adjusting for case mix and patient severity, the data found that hospitals that are run by investor-owned organizations for profit fell into the third-highest quartile group when compared to low actual-to-expected patient mortality rates.

In comparison, government-owned and not-for-profit facilities fell one full quartile group

Risk-Adjusted Mortality by Hospital Ownership/Control



Risk-Adjusted Length of Stay by Hospital Ownership/Control



Average Quality Score by Teaching Status

Teaching Status	Mortality Score	Length of Stay Score	Combined Score
Major	2.32	1.89	2.11
Minor	2.42	2.35	2.39
Non-Teaching	2.58	2.67	2.62

Source: Center for Healthcare Improvement Studies, Columbus, OH.

below the investor-owned facilities.

The study looked at mortality rates at some 3,009 domestic acute care hospitals. It also measured inpatient lengths of stays hospitalwide, and did not separate critical care unit data. **(For comparisons, see chart and graphs above.)**

A 3.0 score on the chart indicates a B grade, or a ranking within the third-highest quartile of the survey. A score within 2.0 and 3.0 denotes a location in the second-highest quartile. No hospitals in the study received an A.

"The differences in the data displayed are quite large, and they demonstrate significantly lower mortality and lower lengths of stay for care provided in an investor-owned hospital," states **William O. Cleverly, PhD, CHIPS' president.**

Researchers couldn't point to any conclusive reason for the difference. However, they surmised that the higher quality scores among investor-owned facilities might stem from "an imperfection in the refined grouper used to assign severity levels to

each DRG (diagnosis related group)."

By this, researchers meant they found a disparity in the number of teaching hospitals that fell into each sample group.

The investor-owned hospitals had a smaller percentage of teaching facilities in their sample compared with the other ownership groups, which could mean that the for-profit hospitals saw fewer severely ill patients than the others, researchers speculated.

In general, teaching hospitals tend to achieve lower quality scores than non-teaching facilities, the study reports. The study involves a massive patient database analysis. The data was taken from Medicare hospital reports classified by DRGs.

[Editor's note: For information about the 1999 Performance Review — A Guide to U.S. Hospitals, contact: The Center for Healthcare Industry Performance Studies, 1550 Old Henderson Rd., Suite S-277, Columbus, OH 43220-3626. Telephone: (800) 859-2447. Web site: www.chipsonline.com.] ■

COMING IN FUTURE MONTHS

■ The ideal ICU nurse manager: Does he or she really exist?

■ Managing patient gridlock while keeping your census from dropping

■ How to sell teamwork to your demoralized critical care staff

■ Reducing sentinel events in the ICU: 10 effective steps

■ Deciding whether to train badly needed non-professionals for the ICU

Nurses face yet another order: Cultural competence

Ethnic sensitivity assumes priority among payers

Be careful. The direction in which your patient's bed may be facing could determine whether your ICU wins high or low scores in patient-family satisfaction.

Federal and state health care officials are pushing providers to become more culturally sensitive in dealing with ethnic and cultural diversities among patients. Private health maintenance organizations and some large employers that pay for health insurance are asking for proof of heightened cultural competence from contracting medical providers.

In September, the Health Care Financing Administration proposed new regulations mandating states establish cultural competence guidelines for health plans that contract with the government under Medicaid. In turn, payers are likely to raise the issue in patient satisfaction questionnaires and hospital accreditation assessments.

"The Joint Commission on Accreditation of Healthcare Organizations is also looking into the subject," says **Elaine Waidley**, RN, MSN, a health care consultant and president of EKW & Associates in Laguna Beach, CA. The commission recently began including cultural competence factors in completing their site surveys for accreditation renewals.

Hospitals lag in ensuring cultural competence

The enormous diversity of patient populations in the health care system has given rise to a new mandate, says Waidley. Nurses, physicians, and allied health professionals need to understand how they affect their patients culturally during the patient-provider encounter, she adds.

Waidley is scheduled to present a six-hour workshop on cultural diversity at this month's National Teaching Institute and Critical Care Exposition in New Orleans. The event is part of an annual conference sponsored by the American Association of Critical Care Nurses based in Aliso Viejo, CA.

Despite a growing awareness of cultural diversity, many hospitals have not taken adequate steps to ensure that staff competencies get translated into appropriate actions, Waidley says. "There is still a

ways to go in doing these things."

In the ICU, where family input is usually welcome, nurses have a great opportunity to seek out cultural information about the patient. In the Muslim culture, for example, a patient's family is likely to prefer that the hospital bed be pointed so the patient faces an easterly direction.

Ask about religious preferences ahead of time

The preference may seem silly to Westerners, but it conforms to Muslim religious beliefs, Waidley says. Ask the family ahead of time, she advises. And incorporate the topic in each patient's care plan. Most requests, unless they interfere with medical necessity, will be easy to grant.

Diversity concerns don't only apply to ethnic differences, the consultant says. The same sensitivity on the part of caregivers should apply to any group that is considered outside the mainstream such as the homeless. ■

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Physicians hold talks with HCFA over payment issues

Providers want to clarify standards on CCU claims

Physicians from several critical care organizations are involved in long-range talks with Medicare officials over ways of bringing more consistency to Medicare reimbursements for the care of critically ill patients enrolled in the federal program.

While the discussions focus specifically on physicians' fees, whatever resolutions arise from the talks could have implications on Medicare reimbursements for technical, nursing, and other components of hospital-based care.

A panel of physicians representing several professional societies, including the Society of Critical Care Medicine (SCCM) in Anaheim, CA, has been meeting with officials of Bethesda, MD-based Health Care Financing Administration.

The groups are trying to address some of the problems physicians say they have experienced when billing their Medicare carriers for services delivered in hospital critical care units. The providers assert that the carriers are applying varying standards when interpreting claims, which have resulted in some claims being denied or reduced in level of intensity.

Critical care claims are being denied, reduced

Phil Dellinger, MD, a critical care physician and spokesman for The Critical Care Working Group, a coalition of providers, declined to go into details about physicians' complaints out of concern, he states, for the status of the deliberations. But Dellinger indicated the problem has centered on "inconsistencies in the way the Medicare carriers are viewing critical care claims for payment."

"The group is trying to recommend to HCFA that it clarify its policy on what is or isn't critical care and on what the carriers will and won't allow for payment," Dellinger tells *Critical Care Management*.

However, he declines to comment on the status of the talks, which have been going on since last October, saying only that the discussions are "polite and collegial."

He hinted that the group expects a draft of specific policy clarifications or guidelines to be issued to the Medicare carriers, and that one

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may already be under way.

In addition to SCCM, the coalition consists of members from the American College of Chest Physicians, Northbrook, IL; the American Thoracic Society, New York City; the National Association for the Medical Direction of Respiratory Care, Chevy Chase, MD; the American Association for the Surgery of Trauma, Louisville, KY; and the American Society of Critical Care Anesthesiology, Free Union, VA. ■

CE objectives

After reading each issue of *Critical Care Management*, participants in the continuing education program should be able to:

- identify particular clinical, administrative, or management issues related to the critical care unit;
- describe how those issues affect nurse managers and administrators, hospitals, or the health care industry in general;
- cite practical solutions to problems that critical care/intensive care managers and administrators commonly encounter in their daily activities. ■