ED DOCUMENTATION & CODING UPDATE

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How better nurse documentation can boost your bottom line

Improved nursing documentation also can reduce legal concerns

If the nursing documentation in your emergency department (ED) is lacking key information, your facility may not be getting all the reimbursement it deserves. More ominously, inadequate nursing documentation can open the door for costly legal action down the road.

Candace E. Shaeffer, RN, MBA, RHIA, vice president of coding/quality management at Lynx Medical Systems in Bellevue, WA, says that appropriate nursing documentation is especially important when it comes to the Centers for Medicare & Medicaid Services' (CMS) outpatient prospective payment system (OPPS), which includes significant increases in payment for some procedures. "Capture of these charges depends on sufficient documentation," she notes.

"You can look at documentation from two perspectives," Shaeffer says. "They should be blended into one. There's clinical documentation — what's good for medical/legal aspects of delivering care for the patient; what's required for that? And what's required for coding? They're usually just a little bit different, although they shouldn't be."

Currently, there is no national guideline to specify what documentation is needed for correct coding or for reimbursement, she adds. "CMS has told each facility to develop its own system."

In 2000, when ambulatory payment classifications were introduced as part of the OPPS, CMS in its final rule said facilities were expected to develop a system that met certain criteria that would assure the facility was in compliance with OPPS guidelines. Requirements include:

— that the services furnished be documented and medically necessary;

— that the system maps the services to the different levels of effort represented by the codes;

— that the code assigned should reasonably relate the intensity of hospital resources used.

"Beginning at that time," Shaeffer says, "everybody scrambled to try to put a charging mechanism in place so they could capture all the resources that were expended during an ED visit. We were directed to use the CPT, which is applicable to physicians. And the descriptors for the various codes

— 99281 through 99285 — weren't clearly applicable to the facility side. So you've got some very interesting systems out there."

Because every facility currently has its own system, "adequate documentation is going to be predicated on whatever system a site chooses. For instance, if a site has developed a point system, and part of the point system is dependent on the mode of arrival [i.e., a patient who arrives by ambulance is assigned more points than someone who walked in the door] then, for that site, it's going to be critical that they document the mode of arrival."

Also, facilities must ensure that whatever system they've developed meets accreditation requirements from their state and from the Joint Commission on Accreditation of Healthcare Organizations, she says.

Currently, an expert panel is putting together recommendations to CMS about a uniform model for facility coding, which could be in place as soon as 2004. Although it's unclear exactly what that model will look like, it could resemble in some respects the system developed by the American College of Emergency Physicians (ACEP) and backed by the American Hospital Association and the American Health Information Management Association.

"I believe that they're still looking at that model and trying to tweak it," Shaeffer says. "CMS' big concern was that there were separately billable procedures included in the ACEP model, so of course you have the concern of double-billing. If you're charging for a procedure separately — say, an IV infusion, and you're also including it in a category of interventions that would be used to evaluate and calculate the visit level, then you're essentially using it in a double-billing mode. They have to go through and eliminate that double-billing issue."

In any case, ED professionals can't simply wait for CMS to decide on a final model before taking steps to improve their documentation. Whatever system you have in place at the moment — whether it's a point or acuity system or something else — chances are there are things you could be doing with your documentation to more fully optimize reimbursement and minimize legal liability.

"The overarching policy would be to thoroughly document all of the services provided, and make sure the nurses know about those procedures that are separately billable so they can for sure document all of them if they have some type of template or form," Shaeffer says.

Patti Muller-Smith, RN, EDd, a consultant with Administrative Consulting Service Inc. in Shawnee, OK, says that the most common reason for inadequate documentation in the ED is the fast-paced environment. While ED nurses may commonly be documenting what they do, "they're not necessarily supporting the why of what they're doing," Muller-Smith says. "If you go back and look at a document — perform a chart review — basically what it should do is paint an absolute picture or provide a road map for the course of action that the

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Use this checklist when you document

You should include the following items in your documentation, according to **Candace E. Shaeffer**, RN, MBA, vice president of coding/quality management at Lynx Medical Systems in Bellevue, WA:

- ☐ timed and initialed entries;
- ☐ means of arrival;
- ☐ a triage note or presenting problem and pertinent history of the illness or injury;
- ☐ allergies and current medications;
- ☐ important factors that put the patient at high risk per hospital policy (such as suspected child, elder, or spousal abuse);
- ☐ weight, visual acuity, or other factors (if appropriate for age and presenting problem);
- ☐ initial vital signs and a reassessment if abnormal or changed during the emergency department course of treatment;
- ☐ all interventions and patient responses;
- ☐ some type of pain assessment scale;
- ☐ orders noted and initialed per hospital policy;
- ☐ an assessment of the patient's psychosocial needs and ability to understand teaching and instructions;
- ☐ discharge status;
- ☐ disposition and time;
- ☐ referrals and communications with other caregivers or providers regarding the patient;
- ☐ a patient's leaving against medical advice;
- ☐ nurses' signatures.

nurse took at each point in the treatment of the patient. Sometimes it's not clear why they chose to do something, [perhaps] because the changing patient status wasn't documented, the fact that they notified a physician was not documented, and those types of things. Now, they've done them; it just was not documented."

Certainly nursing documentation must be thorough to make sure all appropriate charges are captured. Inadequate documentation also can cause your ED to lose out on the appropriate visit level. Shaeffer explains that if you are using a point system to calculate the facility visit level, resource points are added to arrive at the total number of points, which is compared with the minimum point requirement for each visit level. Additional resource points are added for specific tasks or services, such as a visit from social services.

Therefore, if a service was performed but not documented, a lower level of service would have to be assigned, she says. For example, if additional points are earned when the patient arrives by advanced life support transport, then you must document this means of arrival. "Likewise, if additional points are earned when a patient is placed in restraints, this should be documented," Shaeffer says. **(For more on documenting restraints, see p. 28.)**

To encourage thorough nursing documentation for whatever system your ED is using, it's necessary to establish a set of documentation guidelines that incorporate requirements from the state and the Joint Commission and recommendations from other groups. For example, "AHIMA [American Health Information Management Association] recommends certain documentation be present for quality," Shaeffer says. She adds that facilities "should take a look at all that information and make sure that they have an internal policy that specifies the things that need to be documented. And of course you have to have some guidelines before you can audit. You'd audit based on the standards that you've established." **(See documentation checklist, left.)**

Whatever methods of documentation and coding are implemented, the records should be audited for documentation as well as coding quality, Shaeffer notes. That means developing an audit checklist. "They would take whatever coding system they had and determine what drives the payment," she says. Is it a point system? If it is, what criteria are on it? "Develop a checklist with each of those points on there and have them take a look at their actual documentation audit and give the nurses feedback. Let the nurse manager give them a report about how much money was left on the table."

For example, a focused audit of injections could examine documentation to find out how many injections were documented appropriately so as to allow charging. "If the route [of administration] wasn't there and they couldn't charge for it, then quantify the loss in dollars, and that will really impress the nurses — to let them know, 'Hey, we could have billed X dollars; but instead, we only billed Y dollars for the month of March.' And if you annualize that, it's probably a huge chunk of change," Shaeffer explains.

She also recommends that whoever's doing the coding examine the physician documentation in addition to the nursing documentation. "It's a good idea that the coder look at the physician documentation as well to use it as a kind of cross-reference to make sure that they've completely coded or charged for all of the specific procedures that are separately billable and that were done during the encounter," Shaeffer says.

An example of this is the case of lacerations. "You

can assign lacerations on the facility side, but often times [the nurse] may not clearly say that there was a laceration repair done." All of the laceration codes define specific body area and lengths, Shaeffer notes. "And if the length isn't there, you can't code it. So a coder would either have to go back to the nurse or go back to the physician to find out what the length is. And nurses rarely if ever would document that."

Finally, Muller-Smith notes that, in addition to issues of reimbursement and liability, thorough documentation by nurses helps "demonstrate the skill and competence that you bring to that particular patient that cannot be provided by another provider." ■

Documenting restraints: What you need to know

Documenting means more than checking a box

Restraint and seclusion has been a hot topic in emergency departments (EDs) at least since 1999, when the Centers for Medicare & Medicaid Services (CMS, then known as the Health Care Financing Administration) established a Condition of Participation that set new and stringent rules regarding the practice of restraining patients. The Joint Commission on Accreditation of Healthcare Organizations soon followed by revising its own restraint standards, and restraints remain a key focus of interest on the part of Joint Commission surveyors.

Indeed, because the practice of placing a patient in restraints or somehow isolating that patient is scrutinized so carefully — not just by CMS and the Joint Commission but by internal hospital committees and patients' families as well — it's vitally important for you to be able to document what you did, why you did it, and how often you followed up.

Objective criteria defined

The good news is that, after the initial uproar following CMS' publication of the Condition of Participation on restraints, many EDs have become more consistent regarding their approach to restraint and seclusion. "I think there's a little more clarity now," says **Kathleen Emde**, RN, MN, CCRN, CEN, trauma service coordinator at Overlake Hospital Medical Center in Bellevue, WA. "There's been a lot of discussion of the issue at various levels, probably across the country. I know it has happened here. So I think people are just a little less anxious about it than they were because they've got a plan now."

One benefit of the increased focus on restraints has been the development of objective criteria for when patients should be restrained. "It added a little more complexity to the process, but it also added some accountability and clarity, so that we were all hopefully doing things the same way."

According to Emde, some of the things Joint Commission surveyors look for regarding restraints are whether you tried to use alternative interventions before restraining the patient, and what documentation you included regarding the reason for the restraint. Other questions surveyors might ask include:

- Was there differentiation between medical criteria and behavioral restraint criteria?
- How frequent was the assessment repeated to make sure that restraint still was required?
- Was there documentation that the family was spoken with regarding why the patient was restrained and/or secluded?

Emde says the Joint Commission's recent focus on restraints probably is related to its increased emphasis on patient safety, as well as the fact that historically restraints were misused at some facilities, either because people were restrained inappropriately, restrained for longer than necessary, or they weren't observed closely enough when they were restrained. "I think this was a response to those sorts of situations and those dramatic problems that occurred," she says.

Initial assessment

The first step in the process of documenting a restraint case has to do with the initial assessment, says **Rochelle Caudill**, RN, CEN, BSN, MBA, a staff nurse at St. John Medical Center in Tulsa, OK. The assessment essentially should take note of behavior that might result in harm either to the patient or to others. For example, for a medical/surgical restraint, is the patient at risk of pulling out catheters, tubes, or lines?

"The first thing you're doing is trying to come up with alternatives to the restraints," Caudill says. "Because the last thing you want to do is restrain them. If they have family who can sit with them, that's wonderful."

Emde notes that criteria differ between medical/surgical and behavioral restraints. **(For examples of the different criteria, see the sample restraint/seclusion flowsheets inserted in this issue.)** Overlake has separate order sheets for each. Medical restraint orders usually concern patients with invasive catheters, mechanical ventilation, or other medical issues. If patients are restrained for behavioral reasons, "it's a much higher standard in terms of what needs to be done," Emde says.

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The Documentation-Coding
CONNECTION

Benchmarking ED physician billing

By **Myra Wiles**, CPC
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It's a common practice to benchmark physician-billing patterns against those of peer groups. Most practices benchmark against data furnished by the Medical Group Management Association (MGMA) or against Medicare data available through the Centers for Medicare & Medicaid Services (CMS).

Benchmarking data skewed

Unfortunately, benchmarking against such data is misleading, since it is based upon three incorrect assumptions.

When benchmarking ED physician billing, the first incorrect assumption is that all emergency departments (EDs) are alike. CMS and most other insurance carriers do not differentiate between EDs in urban and rural communities. Nor do they classify Level I trauma centers differently from other EDs. Thus, within a particular state you have only one designation (one classification) for emergency departments and all EDs within the state are lumped into that same category without regard to size or resources.

The second incorrect assumption is that all services were billed at appropriate levels. Insurance carriers pay claims based upon the assumption that the service is billed at a level appropriate for the problem(s) addressed and that documentation supports the code billed. However, as one who has audited various types of practices (including EDs) for more than 10 years, I can assure you that this is simply not true. While most physicians and practices are making a concerted effort to properly bill and document their services, most practices are still far from meeting the criteria set by the American Medical Association and CMS. Many services are billed too aggressively; others, too conservatively.

The third bad assumption is that every provider working in the ED is credentialed with the insurance company in the specialty of "Emergency Medicine." Yet, a large number of hospitals contract with family practice, general practice, internal medicine and various extenders (PAs, NPs, etc.) to staff their EDs. Thus, any emergency department billing by individuals in those practices are excluded from the benchmarking numbers for emergency medicine. This greatly skews any comparisons.

Why benchmark?

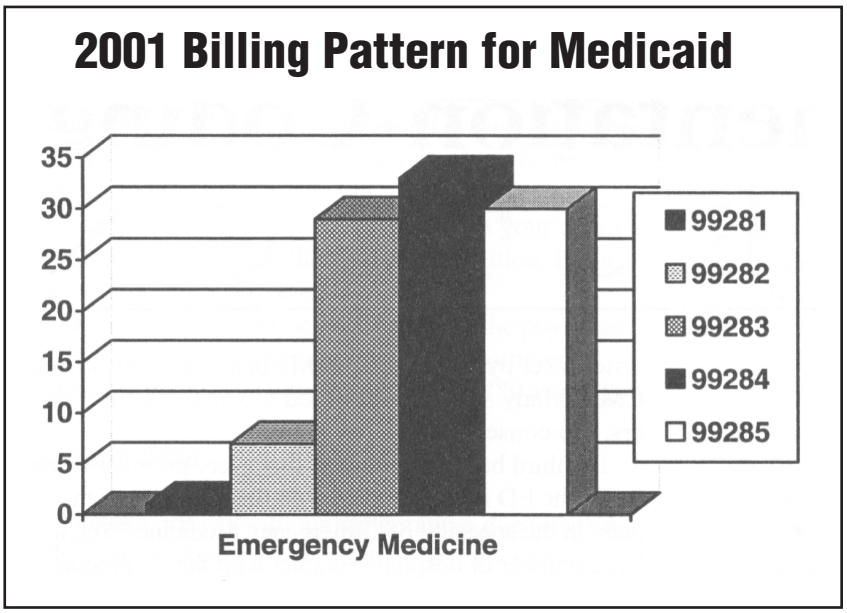
Insurance carriers realize that the data against which you are compared are inaccurate. But it is the only means by which they can focus their auditing efforts toward those practices with billing patterns most likely to be a) in need of additional education and training; or b) defrauding the program. Similarly, it is the most obvious tool available to assess your own billing practice and detect unique billing patterns that increase your risk of carrier audit.

That does *not* mean that you should try to mirror the pattern set by your peer group. Benchmarking is a risk measurement tool and nothing else. I have seen practices with billing patterns that mirror the national averages but have still billed inappropriately for the services provided.

Instead, your goal should be to bill and document at levels appropriate for the patients and problems treated — regardless of the benchmarking data. By doing so, you can be assured that, should an audit occur, your organization can defend the services billed.

Benchmark properly

As much as possible, compare apples to apples and oranges to oranges. Don't try to benchmark all of your ED personnel against the data for Emergency Medicine. Instead, benchmark the ED codes billed by your PA against national data for PAs billing the same codes. Do the same thing for the family practitioner with whom you contract. Benchmark against the data for



Emergency Medicine only if you know that your contracted physician has been credentialed in that field.

The **above chart** reflects the 2001 Medicare billing pattern for emergency medicine. It is expressed in percentages and does not reflect ED billing by physicians (or nonphysicians) in other specialties.

What level is appropriate?

The formula for determining the appropriate code for a service is complex and depends upon the amount of history taken, exam performed, condition(s) treated and recommendations for care. But we suggest the following common sense guide toward quick selection of the appropriate code. Keep in mind that these suggestions have nothing to do with selecting the correct facility code.

• **Level I (99281)** — Appropriate for patients with simple problems that require little or no treatment. This may include patients coming in for scheduled injections or testing, for dressing changes or removal of sutures. Treatment usually is limited to ice packs, bandages, or simple over-the-counter (OTC) meds. The history can be extremely brief, and you need examine no more than one system (using 1994 documentation guidelines).

• **Level II (99282)** — This level describes many of your patients that use the ED as an urgent care clinic and is comparable to the level III office visit for established patients. Patients at this level usually have a simple acute infection (UTI, URI, BOM, etc.), a sprain or strain. Treatment at this level usually is limited to simple blood work, X-rays without contrast or recommendations for meds (OTC or prescription) or physical therapy. When billing this level, your history must include a little more detail (including a review of systems) and the exam should cover at least two systems.

• **Level III (99283)** — The patient at this level is a little more complicated than at Level II but not so bad as to require a more detailed workup. Typically, these are patients with mild exacerbations, simple injuries, or new problems that don't require a detailed workup. The history and exam doesn't require any more detail than at Level II.

• **Level IV (99284)** — Now we're talking true emergency. This level is appropriate for a patient with an acute exacerbation or severe trauma that requires a detailed work-up. Treatment usually includes extensive testing, use of prescription meds, scopes, arteriograms, fracture care, or recommendations for major surgery.

• **Level V (99285)** — This code represents the high-risk patient with a high-risk treatment plan. These patients frequently qualify for critical care codes when properly documented. These are patients with multiple trauma, acute MIs, suicidal patients, strokes, system failure, and similar scenarios. The treatment plan should be complex and require extensive testing and/or treatment with high-risk meds or surgery. Take no shortcuts on documentation of these cases. Get a comprehensive history (including four facts about the present illness, a review of 10 systems, a past, family, and social history) and a comprehensive exam of eight systems (using 1994 documentation guidelines).

Benchmark at least quarterly to detect potential problems and analyze risk. Work with your ED staff on a regular basis to provide ongoing education on billing and documentation issues. At least annually, have an outside firm perform a review of a random sample of ED physician charts to detect any problems that may have gone unnoticed and to correct any internal spread of inaccurate information. ■

Billing and documenting critical care

By **Myra Wiles**, CPC
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When does critical care become just another emergency department (ED) visit? When you fail to document it properly. You may do all the right things and have a patient in crisis, but if the paperwork isn't done properly, you don't get paid for your efforts.

Many physicians think that if the patient is in ICU or CCU, they should bill those services with critical care codes. Others imagine that you can bill critical care in the ED if the patient dies or comes in via ambulance in critical condition. This is not true. Critical care is not a *place* of service; it is a *type* of service. While the care most often occurs in ICU or CCU, it can occur in the ED, a regular hospital floor or a skilled nursing facility. We personally know of one instance in which it occurred in a clinic waiting room. And while the patient's condition must be critical (or imminently so), it is not the only criteria to be met to bill critical care services.

Critical care codes should be used to describe situations in which the physician is personally caring for or directing care of a patient that is critically ill or injured. There should be highly complex decision making to assess, manipulate and manage this patient who likely has impairment of one or more vital organ systems and faces imminent life-threatening deterioration without your involvement.

Documentation

Proper documentation is not difficult, but is seldom found. Three things must be well documented. Omit any of them and you can't bill critical care.

• **Patient condition** — The chart should show that the patient's condition is deteriorating or is likely to do so without intervention. The auditor will look for conditions such as circulatory failure, central nervous system failure, shock, renal, hepatic, metabolic and/or respiratory failure, etc.

• **Time spent in care** — How long were you there? The time doesn't have to be continuous, but it must exceed 30 minutes for the day during which you devoted your full attention to the patient. You can show this as your exact times in and out or approximate how long you were involved in care. (Caution: Don't rely on your nursing staff or anyone else to document this fact for you.)

What activities can be included in the time calculation? Services such as:

— Time spent at bedside caring for the patient.

— Time spent in the unit or at the nurse's station engaged in work directly related to care of the patient. This includes reviewing test results, documenting charts or discussing care with other medical staff. (Note: Time spent in activities that occur outside of the unit or off the floor may <u>not</u> be included in the critical care calculation since you were not immediately available to the patient.)

If the patient is unable or clinically incompetent to participate in discussions, time spent with family members or other decision makers to obtain a history, reviewing prognosis or discussing treatment limitations or options, *provided that the conversation bears directly on the management of the patient.* However, time spent in activities that do <u>not</u> directly contribute to care of the patient (team conferences, courtesy or compassionate care for the family) may not be included — even if they happen in the unit.

— Time spent performing procedures that will be separately reported (such as CPR, endotracheal intubation, insertion of Swan-Ganz catheter, etc.) should be excluded from your time calculation.

• **Activities involved** — It's not enough to just show the patient's condition was critical. Critical care can be billed only if both the patient's condition and the treatment provided meet the above criteria. Thus, your note should specifically state which of the above services were provided during your encounter.

• **Who can record it and where** — Some facilities keep very detailed logs of activities occurring during critical care times — much like the *Code Blue* logs that are kept. Those critical care notes document who was present and what was being done. While this certainly helps, it should not be relied on to document your physician services since many of those services occur away from the patient bedside and without involvement of other team members. Thus, the physician should record in the progress note those facts necessary to support his/her services.

Bill it right

Codes **99291** and **99292** should be used to bill for critical care activities. The CPT has an excellent chart that shows what codes should be billed based upon how long you were with the patient. Use it, but keep these rules in mind when billing those codes.

Only one physician can bill for a specific episode of critical care. This is true even if two physicians of different specialty are involved at the same encounter. If two physicians bill for different episodes of critical care on a given day, they should be prepared to submit notes documenting that care was provided at separate times. (Don't forget that different of the same specialty in the same clinic are considered one physician.)

Code 99291 represents the first hour of critical care and should be billed only once per day by the physician.

Do NOT bill extra for services such as reading chest X-rays or EKGs, ventilator management, pulse oximetry, blood gases, analyzing data stored in computers, gastric intubation, temporary transcutaneous pacing, and insertion of simple vascular access devices such as IVs.

DO bill extra for services such as CPR (that you do), endotracheal intubation, insertion of complex vascular access devices and similar services. Be sure to add modifier –25 to the critical care codes if you bill any of these procedures to avoid denial of the critical

care as a bundled service.

Don't bill separately for a hospital visit on this date *unless that other visit occurred at a separate encounter during the day that was not included in this critical care calculation.* Such a visit must be fully documented to support the E&M code you bill for the visit.

Be sure the diagnosis code you use on your claim reflects the severity of the patient's condition. It may have a bearing on coverage.

Don't bill the 99291 or 99292 for time the physician spends during the transport of critically ill or injured patients to another facility. Instead, use 99289 and 99290.

Sample note

"Patient critical with multiple trauma due to MVA. I directed CPR and inserted T-tube. X-rays and labs reviewed. Orders written & IVs placed. Discussion with family about pt's condition and decision made to proceed with care. Calls were made requesting consults from orthopedics, neurosurgery, and pulmonology. Dr Smith called to admit. Total time in care: 80 minutes, excluding time spent in above procedures."

What can you bill? You bill for:

- CPR (92950);
- Placement of T-tube (31500);
- Critical care (99291-25 and 99292-25). ■

CPT-4 coding inconsistent; templates could help

Agreement in coding of emergency charts between coding agencies used by one hospital system was only poor to fair, and the distribution of assigned CPT-4 codes was significantly different among the agencies, according to a study from William Beaumont Hospital System in Royal Oak, MI, published in the *Annals of Emergency Medicine* (Bentley PN, Wilson AG, Derwin ME, et al. Reliability of assigning correct current procedural terminology-4 E/M codes. *Ann Emerg Med* 2002; 40:269-274).

The researchers did three prospective trials, with two interagency audits and one intra-agency audit. In addition to poor agreement in coding, they found that the distribution of CPT-4 codes was significantly different in each group.

"We find this latter observation startling and disturbing, and if generalizable, this will have important economic and legal ramifications," they wrote, pointing to the possibility of prosecution for billing fraud. They suggested the following solutions:

- using templates to reduce variation of documentation;
- requiring more rigorous formatting of dictations for more consistent documentation;
- performing a more thorough review of documentation guidelines provided by the Centers for Medicaid & Medicare Services (CMS) for use in assigning CPT codes.

(Editor's note: The guidelines can be downloaded at no charge at the CMS web site: http://cms.hhs.gov. Click on "Medicare" and "Documentation Guidelines for Evaluation and Management Services.") ■

CMS issues HIPAA checklist for providers

The Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) has issued a checklist to help health care providers who do business electronically and their business partners to comply with the administrative simplification requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Use standard format

HIPAA does not require a health care provider to conduct all transactions such as claims or equivalent encounter information, payment and remittance advice, claim status inquiry and response, eligibility inquiry and response, and referral authorization inquiry and response electronically. But any of these things that are done electronically must be done in the standard format outlined under HIPAA. Checklist items include:

- Determine, as a health care provider, if you are covered by HIPAA because you conduct any of the typical transactions electronically.
- Assign a HIPAA point person to handle the remaining checklist items, having that person educate others on the office staff.
- Familiarize yourself with key HIPAA deadlines.
- Determine that software is ready, find out what needs to be done to comply for all electronic transactions, ask vendors how and when they will be making HIPAA changes and document the response.

Talk to payers you bill to see what they are doing to prepare for HIPAA and ask for trading partner agreements that specify transmission methods, volumes, timelines, and coding and transaction requirements that are not specifically determined by HIPAA. ■

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"There are more frequent reassessments."

"Usually, when we do behavioral management, it's because a patient is of harm to themselves or to others," Caudill says. "They have suicidal ideation and they want to leave. Then we are bound by law to keep them there, and sometimes that means we have to restrain them. Or we might have a violent-type patient."

Whatever the reason for the restraint was, it's important to note that you must go beyond simply checking a box on a flowsheet, Emde stresses. "You have to carefully document what your indication was. In other words, what criteria did the patient meet? That needs to be not just checked off on the list; it also needs to be documented within the nursing documentation."

Ongoing monitoring

It's also vital to document the ongoing monitoring and reassessment of the restrained or secluded patient. At St. John, the monitoring includes making sure the restraint is intact, that the patient has adequate circulation, and checks of color, temperature, and skin integrity. Range of motion also is checked regularly.

In reality, of course, "you're checking the patient all the time," Caudill says. "Certainly, patient safety and their comfort and those sorts of things are utmost in your mind."

Emde agrees: "Really, in the emergency department, if we have a patient who is restrained, they're under continuous observation."

Other ongoing issues with restrained patients include offering them food, fluids, and toileting; assessing their level of consciousness; assessing whether they are experiencing pain; and reassessing whether the reason the patient was restrained in the first place is continuing or has been resolved. "All of those issues come into play," Emde says. "That's where the documentation gets a little cumbersome. On the flowsheet, you can see all of the data points there that are addressed. It's a lot of documentation."

Of course, even the best-designed flowsheet that reflects the state of the art in care is worthless if nurses either aren't aware of it or don't know how to use it properly. That's where training comes in.

At Overlake, the initial instruction was conducted two years ago as part of the facility's workplace violence training. "We did a massive training of all of the staff — not just in the emergency department but also in the hospital," Emde says. Not everyone received the same level of training, of course. Staff were assigned risk categories according to who most likely would be exposed to violent patients and/or family members. "For instance, if they work in the boiler room, they're low risk. If they work in the emergency department . . . then those people got higher-level training."

The training didn't just focus on the process of restraining patients. "We approached it as an entire program. What are the signs that a patient's behavior is escalating? What techniques can you use to de-escalate their behavior? What if it doesn't work and you have to defend yourself — how do you do that? What if you have to restrain the patient — how do you do that?" ■

Use better documentation to head off ED errors

USP offers tips to help prevent medication errors

It's no secret that the fast-paced and often crowded environment at many emergency departments (EDs) can pose problems not faced in other, more sedate levels of care. And it's perhaps no surprise that many of the factors that cause inadequate documentation in the ED also can lead to medication errors.

"I think what we see is that, in other areas of the hospital — and I have to admit it's not the best there, either — there seems to be some kind of a process," says **Diane Cousins**, RPh, vice president of Rockville, MD-based U.S. Pharmacopeia's (USP) Center for the Advancement of Patient Safety. "Typically, things happen in sequence, so that before a medication is administered, a verbal order has to have been documented." The order then usually is reviewed by the pharmacy or someone else on the floor before the dose is prepared for the patient.

Lack of sequential processes

"So usually there's some sequential processes," Cousins says, that provide for double-checking and give clinicians a pause in which they can gather themselves and make sure they're providing the right dose for the right patient at the right time. "I think that's what we see so differently here [in the ED] — that, because it is a fast-paced environment, you don't have sequential processes where one task must occur before a second task is able to be completed."

Recently, USP identified leading medication errors in hospital EDs and offered tips for preventing medication errors in this critical setting. The recommendations were created after USP analyzed medication error data from its national databases containing more than 360,000 medication error reports since its inception in

USP lists most frequent medication errors in ED

Improper dosing tops list

Because the ED typically is organized to deliver prompt, life-sustaining care, its role, purpose, and function differ from other patient care areas, according to Rockville, MD-based U.S. Pharmacopeia (USP). The combination of interruptions, intense pressure, and a fast-paced environment can lead to medication errors and fewer error interceptions. In the ED, USP found that 23% of errors were intercepted before reaching patients, as opposed to 39% intercepted in other areas of the hospital.

Although omission errors were most frequently reported among hospital systems overall, improper dosing was found to be most common in the ED. Seventy-seven percent of medication errors cited in EDs occurred during the prescribing and administering phases.

"We're seeing similarities among hospitals across the country," says **Diane Cousins**, RPh, vice president of USP's Center for the Advancement of Patient Safety. "By implementing standardized policies and procedures and maintaining an awareness of the most prevalent errors, emergency department staff can deliver prompt, safe care in an environment that can change at any given moment."

Upon analysis of drug errors submitted to MEDMARX, its anonymous national medication error reporting database, and USP's Medication Errors Reporting Program, USP identified the following medication errors as those most frequently occurring in the ED:

- prescribing errors — when a physician or other authorized subscriber fails to prescribe the correct medication through verbal or written communication;
- omission errors — the failure to administer a prescribed medication;
- improper dosage errors — when a patient receives the incorrect dose of a medication.

USP offers health care practitioners the following recommendations to help ensure that medication errors do not occur in the ED:

- Educate personnel about the types of errors that occur in the use of high-alert medications (which are known to cause severe injury to patients when administered incorrectly).
- Expand the use of decentralized pharmacists to cover the ED.
- When possible, minimize verbal orders for medications and require that medication orders be entered electronically.
- Design workflow within the ED in a manner that improves communication, minimizes interruptions and distractions, and provides for double checks and verbal confirmations before medications are given to the patient.
- Purchase premixed intravenous solutions and unit-dose medications. ■

1998. In 2001, hospitals reported more than 2,000 ED-related medication errors. **(For more on USP's findings, see story above.)**

Not surprisingly, many of these errors have a documentation component. Cousins cites one example in which a nurse received a verbal order from the physician. Two nurses were in the patient's room. One went to get and prepare the medication. The second went to transcribe the verbal order. After transcribing the order, she also got and administered the medication to the patient — so the patient was dosed twice. "So the first nurse didn't get the chance to document it before she gave the med, and the second nurse gave the med presuming that if she transcribed [the order] that she also would also administer it," she says.

Errors of omission can occur in a similar way, she notes. "You could imagine that both left the patient's bedside and one went and documented the order and presumed the other was giving it. The other didn't give it, presuming the one who documented it would give it," Cousins says.

Clearly delineate responsibilities

Such problems can arise when multiple people are with the patient at a point in time, as often is the case in the ED. On a patient care unit, by contrast, you're more likely to have a sequence such as: "The physician goes to the bedside, visits the patient, comes back to the nursing station, prepares the order; nurse goes to the bedside, checks the patient, leaves, prepares the does, returns to the bedside," Cousins says.

In the ED, where care is less predictable, it's still helpful to clearly delineate responsibilities so that for a given patient everyone knows, for example, who is documenting, who is administering, and who is

repeating back the verbal order to the physician, Cousins notes.

Another helpful step would be to institute a system of computerized physician order entry (CPOE), something that only about 5% of hospitals have done so far, according to the Leapfrog Group of Washington, DC. The Leapfrog Group has advocated strongly in favor of wider use of CPOE. Cousins notes that as much as 20% of hospitals may be moving toward the use of CPOE, but many more have not yet committed to do so.

CPOE issues

In a CPOE system, physician orders such as medications, lab tests, diagnostic tests, and other clinical care orders, are entered electronically and automatically transferred to the next area, such as the pharmacy or to nurses, effectively reducing the number of "handoffs" of information. One facility that has made extensive use of CPOE, Montefiore Medical Center in Bronx, NY, has achieved a 60% reduction in the time elapsed from writing a prescription to a patient receiving the medication, and a 50% reduction in the number of potential prescribing errors.

Given the potential upside, why aren't more facilities using CPOE? The answer is twofold, according to Cousins. First, there are no national standards concerning what a CPOE system should include. In the

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers given to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the June 2003 issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE/CME *questions*

Please refer to the CE/CME instructions, below left. For more information on the CE/CME program, contact customer service at (800) 688-2421. E-mail: customer service@ahcpub.com.

9. Which of the following items should be included in your nursing documentation, according to Candace E. Shaeffer, RN, MBA, vice president of coding/quality management at Lynx Medical Systems in Bellevue, WA?
A. all interventions and patient responses
B. discharge status
C. disposition and time
D. all of the above

10. At Overlake Hospital Medical Center in Bellevue, WA, hospital staff were trained in restraint and seclusion as part of what training initiative?
A. employee health training
B. workplace violence training
C. new hire orientation
D. case management training

11. According to data from Rockville, MD-based U.S. Pharmacopeia, what percentage of medication errors in emergency departments is intercepted before reaching patients?
A. 23%
B. 39%
C. 45%
D. 67%

12. According to Myra Wiles, CPC, physician reimbursement specialist with Administrative Consultant Service Inc., in Shawnee, OK, this level is appropriate for patients with simple problems that require little or no treatment.
A. Level I (99281)
B. Level II (99282)
C. Level III (99283)
D. Level IV (99284)

Answer Key: 9. D; 10. B; 11. A; 12. A.

COMING IN FUTURE MONTHS

- Tips from the pros on influencing physicians to document better
- What you need to know about documenting for EMTALA
- Computerized documentation in the ED
- More sample forms and templates to help improve documentation in your ED

absence of such standards, "there have been efforts within the hospital to try to make those decisions, and oftentimes as you can imagine, there's a lot of disagreement among physicians as to what those rules should be," she says.

The second issue is cost. Most facilities recognize that the best way to build a CPOE system is to integrate it with other information systems within the hospital, and such an undertaking can be costly. It can come down to a matter of priorities, Cousins says. "There are systems, for example, that use barcode bedside technology. How does that technology fit into the CPOE system?"

Even beyond CPOE, there's little question that documenting with computerized systems can have a positive effect on error reduction — not just on the front end, but on the back end as well, by detecting variances. "For example, you might review the drugs administered to patients during a single-day period and find how many narcotic antagonists have been administered," Cousins says. "That would be a clue, for example, that a narcotic overdose may have been administered."

Cousins does caution, however, that computerized systems are not a panacea for error reduction. Indeed, computer entry is one of the most common causes of medication errors. "We're finding that there are new errors that may arise because of the application of technology," she says. ■

Leapfrog Group to help hospitals with investments

A member of the steering committee of The Leapfrog Group, a Washington, DC-based patient safety organization, said the committee is developing plans to help hospitals recoup some of the money they invest in changes to meet Leapfrog recommendations.

Francois de Brantes, program leader for health care initiatives at GE Corporate Health Care, said the employer group recognizes that the cost of implementing Leapfrog recommendations can exceed what hospitals get from payers as a result of making those changes.

"Shame on us purchasers, and shame on this country, to have created a system where better quality costs hospitals money," said de Brantes, speaking in San Diego to the Healthcare Information and Management Systems Society.

Leapfrog has designed incentives to urge hospitals to implement computerized physician order entry systems and employ intensivists and evidence-based hospital referrals.

De Brantes said Leapfrog is developing a procedure to examine the cost of fulfilling these recommendations, forecast their fiscal impact, and help cover the difference, usually through direct payments by Leapfrog members or by telling insurers to redirect premium payments to the hospitals. ■

CE/CME objectives

After reading this month's issue of *ED Documentation and Coding Update*, the CE/CME participant should be able to do the following:

1. List documentation techniques that can be used for reducing claims denials and ensuring proper reimbursement.
2. Describe the latest legal and regulatory developments affecting your documentation and/or coding responsibilities.
3. Cite sample forms and templates that can be used to improve or facilitate emergency department documentation.
4. Describe clinical and financial outcomes in the ED. ■

24-Hour Restraint/Seclusion Flowsheet

INITIAL ASSESSMENT AND FAMILY EDUCATION TO BE COMPLETED BY RN

Attempt(s) at Alternative intervention(s) *(check all that apply)*

Medication review	Bowel/bladder assessment/toileting	Ambulate/reposition	Food/ Fluids
Pain assessment	Frequent reorientation/ reminders	Family/S.O. at bedside	Help pt express feelings
Diversional activities	Near nursing station/? environment	Bed/ Leg alarm	Other:

Alternative Interventions unsuccessful or inappropriate ***Focus note required on back of form***

Medical Criteria for restraint	**Behavioral Criteria**
Patients with Invasive Catheters, Lines, Tubes	Significant risk of self-injury
Requires immobilization to aid therapy/healing	Significant risk of injury to others
Mechanical Ventilation	Significant risk of injury to environment
Fall Precaution (significant risk of severe injury if fall occurred)	

Restraint use Education: explained to patient/family/S.O. family/S.O. unavailable restraint education sheet given

Pt. / Family (circle one) **Response to Education:** verbalizes understanding refuses information needs reinforcement

For Leather Restraints and Seclusion only: ♦ *if leather restraints or seclusion are used, documentation on flow sheet is required q 15 min.*

Searched by: Dangerous objects removed by: Valuables removed by:

RN:_____ **Date:**_____

DATE :

Time♦ q 2 hrs	Type	Level	Food Fluids	Elimination	Position Change	Initials	* LOC	* Response	* CMS	Pain/ Comfort *	Restraint* Criteria Met	Reason for continued* restraint use if applicable	RN's Initials

Shaded Areas RN assessment only** ** **New form to be initiated at 0000 hrs q calendar day.

Type of Restraint	***Level***	***LOC***	***Response***	***Food & Fluids***	***Positioning***
CW=cloth wrist L= Leathers CV=cloth vest S= Seclusion CA=cloth ankle SR= Siderails HM=hand mitt C= Chemical R = recliner O= other_____ OFF=restraint off	2=2 point 4=4 point 3=3 point 5=5 point ***Restraint Criteria Met Assessed by RN*** v=patient continues to meet criteria	O=oriented C=confused E =easy to arouse D=difficult to arouse	A =agitated C =calm I =irritable CO=combative R =restless S =sleeping	OR=offered, refused T =taken ***Elimination*** OR=offered, refused V =voided BM=bowel movement INC=incontinent	R = repositioned ROM=ROM to affected extremity ***Pain/Comfort*** Level 0-10 ***CMS*** v = intact

Init	Signature/Title	Init	Signature/Title

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24 Hr. RESTRAINT/SECLUSION FLOWSHEET

[3159]6226-7230-52 (6/01)

When the Restraint and Seclusion flowsheet is implemented an initial Focus note is **required.**
Information in this note should include:

1. **What alternative interventions were tried?**
2. **Why they were unsuccessful or inappropriate?**
3. **A description of the behavior or medical necessity that led to the use (or continued use) of the restraint or seclusion.**

**Additional focus notes, with the above information, is required q 8 hrs.*

Date	Time	Focus Notes	Initials

DEBRIEFING (for behavioral use only)

Date of behavioral episode: _____ Date of Debriefing: _____
Time of behavioral episode: _____ Time of Debriefing: _____

Who attended the debriefing:

1. Identify what led to the incident:

2. Identify what could have been handled differently:

3. Were the patient's physical well-being, psychological comfort, and right to privacy addressed? Yes No
Comments:

4. Was counsel provided to the patient involved for any trauma that may have occurred from the incident? Yes No
Comments:

5. Was the patient's treatment plan modified? Yes No
Comments:

Signature:

[3159]b

Source: Overlake Hospital Medical Center, Bellevue, WA.

Behavioral Restraints/Seclusion Orders

1. Apply:
   - o **Cloth Restraints for _____ hours** *(not to exceed 4 hrs for adults, 2 hrs for ages 9-17, or 1 hr for age <9 yrs.).*
     - o Vest and Wrist(s)
     - o Vest and opposing limbs
     - o Vest
   - o **Leather Restraints for _____ hours** *(not to exceed 4 hrs for adults, 2 hrs for ages 9-17, or 1 hr for age < 9 yrs)*
     - o Opposing wrist + ankle + waist (3 point)
     - o Two ankles + wrist + waist (4 point)
     - o Two wrists + ankle + waist (4 point)
     - o All extremities + waist (5 point)
   - o **Seclusion for _____ hours** *(not to exceed 4 hrs for adults, 2 hrs for ages 9-17, or 1 hr for age < 9 yrs.).*
   - o **Chemical Restraints** _____

     _____
2. Indication(s) for restraint or seclusion: ☑ Attempt(s) at alternative interventions unsuccessful on flowsheet.
   - o Significant risk of injury to self
   - o Significant risk of injury to others
   - o Significant risk of injury to environment
   - o At risk for elopement
   - o Requests to be restrained
   - o Other: _____
3. ☑ Pharmacy consult
4. Remove restraints/discontinue seclusion when indication(s) for restraint/seclusion no longer present.
5. RN must reassess patient for continued need for restraint/seclusion every 4 hrs for adults, every 2 hrs for ages 9-17, and every 1 hr for < age 9, and continue restraint/seclusion if indicated, for up to a maximum of 24 hrs.
6. Check circulation/condition periodically, at least q 1-2 hours for cloth restraints or q 15 minutes for leather restraints (Document on Restraint Flowsheet)
7. May trial out of restraints and reapply if needed without obtaining a new order, if restraint is needed for same indication and original order has not expired.

VERBAL ORDER from _____ ***taken by*** _____
Physician *R.N.*

at _____ ***on*** _____
Time *Date*

***(Physician must sign the order within 1 hr of application of restraints or seclusion)**

Date: _____ **Time *(Required)*:** _____

_____
Physician Signature

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BEHAVIORAL RESTRAINT / SECLUSION ORDERS
A0305 (10/00)

1. Apply:
   - ❑ **Side rails**

   - ❑ **Cloth Restraints**
     - ❑ Vest Restraint
     - ❑ Soft Limb restraints
     - ❑ Hand Mitt
     - ❑ Other: _____

   - ❑ **Other**: _____

2. Indication (s) for restraint: ☑ Attempt(s) of alternative interventions unsuccessful per restraint flowsheet

   - ❑ Invasive Catheters, Lines or Tubes
   - ❑ Requires immobilization to aid therapy/healing
   - ❑ Mechanical Ventilation (Endotrachial tubes)
   - ❑ Fall Prevention (pt at risk for severe injury if fall occurred)
   - ❑ other: _____

3. ❑ Pharmacy Consult

4. Check circulation /condition q 2 hrs or more frequently if condition warrents.

5. Initiate and document on Restraint Flowsheet

6. Discontinue restraints when the patient no longer meets the medical criteria for restraints.

VERBAL ORDER from _____ ***taken by*** _____
Physician *R.N.*

at _____ ***on*** _____.
Time *Date*

Date: _____ **Time (*Required*) :**_____

Physician Signature: _____

MEDICAL RESTRAINT ORDERS

OVERLAKE Hospital Medical Center
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A0339 (3/01)

Source: Overlake Hospital Medical Center, Bellevue, WA.