



## Patient flow getting increased scrutiny during surveys: You'll need these data

*Joint Commission will ask how bottlenecks were alleviated*

Seasonal increases in respiratory illnesses. Overflowing emergency departments (EDs) when other hospitals go on ambulance diversion. Scheduling issues with the operating room. Physicians failing to make timely decisions on transferring patients. Your facility failing to grow in response to the needs of the community.

These are some of the many factors — some controllable, others not — that can wreak havoc with patient flow at your organization.

With the addition of a new patient flow tracer for 2008, surveyors from The Joint Commission will use tracer methodology to look for “patient backflow” that creates congestion in the EDs, critical care units (CCUs), and surgical areas. “This often results in treatment delays, medical errors, and unsafe practices,” says **Michelle H. Pelling**, MBA, RN, president of The Propell Group in Newberg, OR, a consulting group specializing in healthcare performance improvement and Joint Commission accreditation.

According to **Pat Adamski**, RN, MS, MBA, director of The Joint Commission’s Standards Interpretation Group, surveyors will require organizations “to really take a serious look at this. We expect them to do a thorough assessment of flow, and determine any issues that may impact their ability to provide quality and timely care.”

### **What surveyors will ask**

Since the tracer will determine how well the organization is complying with the patient flow standard LD.3.15, surveyors won’t merely ask questions during the Leadership Interview — they’ll want to review actual processes in the hospital. Staff should be able to answer the questions: “How have you improved patient flow?” or “What has the hospital done to remove barriers to patient flow?” says Pelling.

Surveyors will identify patients who experienced backflow during their hospital stay, even if it didn’t affect the care they received, by reviewing medical records, interviewing staff members involved in patient care, and visiting different units and departments throughout the hospital.

Patient flow tracers won’t necessarily be done during every survey — it will depend on what surveyors see onsite. A surveyor may decide to

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do a patient flow tracer because they identify a delay in treatment during another tracer, or because they see patients backed up in the ED hallways.

“Those kinds of things could set off a red flag in the surveyor’s mind to do a patient flow tracer to see what they can learn,” says Adamski.

During the Leadership Interview, surveyors may ask about the process for identifying barriers to patient flow, results from data collection, how the medical staff have been involved, and actions taken to lessen the impact of patient backflow.

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### Editorial Questions

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“We don’t say, ‘You have to be at this level.’ We say you have to identify what your problems are and be actively working on them,” says Adamski.

Surveyors won’t automatically assume there is a problem with flow if your ED is backed up with patients; however, they’re more interested in the process in place to address inevitable backlogs. For example, if a surveyor happens to be onsite on a day that three other hospitals are on diversion, that is a valid explanation for why your ED is crowded with patients.

“Share with the surveyor how you manage the situation,” says Adamski. “We may see a backup of 30 patients in the ED in the morning, but if you have an effective plan in place, we can go back down in a few hours and it could be empty.”

### Use data to evaluate flow

Patient flow is a “network of queues” throughout the hospital that need to be studied, and then improved wherever possible, says **Kirk Jensen**, MD, chief medical officer for Best Practices, a Fairfax, VA-based consulting group specializing in physician leadership and management. Jensen also is a faculty member of the Institute for Healthcare Improvement, and served on the expert panel for urgent matters, a Robert Wood Johnson Foundation initiative aimed at helping hospitals eliminate ED crowding and congestion.

Performance improvement teams should monitor the relevant metrics to create a “road map” of the patient’s journey, identify where waits are occurring, and then work to improve or eliminate those waits, says Jensen.

Joint Commission surveyors will want to see your data on four specific areas: available supply of patient bed space, the efficiency of patient care treatment in service areas, the safety of patient care treatment in service areas, and support services that impact flow.

“Organizations can develop their own indicators, as long as those four areas are addressed,” says Adamski.

However, data are not enough on their own — surveyors will want to see what’s been done. If the data have revealed problems, expect to field questions from surveyors about the process improvement plan in place to mitigate those.

A common pitfall: Organizations have all of the required data in hand, but aren’t analyzing them properly. “The person in charge may have left unexpectedly and no one picked up the ball. Or, you may fix a problem and think you’ve got it

resolved — and then the dam breaks loose in another area,” says Adamski. “You need an ongoing PI process to constantly re-evaluate the situation, put fixes in place, and follow through to make sure they hold up.”

Since the patient flow tracer is new this year, it should be practiced internally, says Pelling. She recommends tracking a sample of patients from the time they enter the hospital until they reach their initial destination, such as an inpatient bed, and following them until discharge.

“This can be done both concurrently and retrospectively,” says Pelling. “Track the time from when each order was written to the time it was executed. Establish a reasonable time goal for each stage.”

Benchmark with other organizations to compare your performance, which will give you a “high-level view” of the process, says Pelling. “If there are delays at any point, follow up by drilling down to determine the cause. Evaluate whether they are isolated incidents or problems that occur frequently,” she says. “If it’s the latter, evaluate the potential causes and establish plans to improve.”

Pelling recommends collecting these data to evaluate how efficiently care, treatment, and services are being provided:

- time of the physician’s order to the time of transfer or discharge;
- time of a request for housekeeping to the time the room is clean;
- time of notification to bed control that beds are available;
- time of the patient’s arrival to the unit.

For the ED, specifically, she advises tracking arrival to discharge, arrival to admission, arrival to transfer, and average length of stay.

Collect data on hospital length of stay, ED boarding hours, hours on diversion, and bed turns, recommends Jensen. “Just like in a restaurant, you need to be able to turn those tables,” he says.

**Diane Jacobsen**, MPH, CPHQ, director of the Institute for Healthcare Improvement’s initiative on Improving Flow through Acute Care Settings, recommends measuring the time the patient presents to the ED to the time he or she is placed in an inpatient bed, the number of hours that a hospital is on diversion, the percentage of patients leaving EDs without being seen, and overall length of stay.

“There are guidelines as to what the normal length of stay should be for some diagnoses, and if it is very long for a certain patient population,

it provides an opportunity to understand why some of the delays might be occurring,” says Jacobsen. For example, you might find that there is a delay in transferring patients to a nursing home because of lack of available beds at that facility.

“Data are helpful and important, but collecting large amounts of data should not become the only thing that we do,” adds Jacobsen. “You need a big picture understanding of the measures, and also the chronic bottlenecks that affect those measures.”

To eliminate barriers, work on reducing delays between units, such as the time it takes to get patients from the ED or the intensive care unit to inpatient floors. “The first measure that you will see an impact on is between units, not the overall hospital measure,” adds Jacobsen.

### ***Collaboration is needed***

Improving patient flow requires a number of “puzzle pieces” to come together, with the involvement of physicians and hospital staff. “Quality professionals are not the only ones in their hospitals concerned about efficient patient flow. They are part of a team working to improve it, and often ‘in the middle of all this,’” says Pelling.

This is one reason why sustaining gains for patient flow is particularly challenging for quality professionals. “It requires a systemwide focus that hospitals often don’t have,” says Jensen. “It’s easier to focus on individual silos.”

Physicians are key players in the process, since the assessment of whether a patient is ready for discharge is often delayed due to surgery schedules and unexpected patient crises, says Pelling.

Once the discharge order is present, hospital operations come into play. This includes cleaning and turning over the room, timely communication with bed control or others who assign beds, and ensuring appropriate staffing levels for patient volume and complexity, says Pelling.

Working with individual departments or units isn’t enough — you need to work across the system to get results. “We can improve a process within the ED, but the ability to move a patient from the ED requires a connection to the next place that the patient is going to,” says Jacobsen. “So matching those up is very important. That requires working together with all of the different areas.”

Staff on inpatient floors are a resource you

shouldn't ignore — they know which patients will be going home, and the number of patients coming into their units. "There needs to be a partnership between quality and the hands-on experts on the units, with communication about where the demand is coming from," says Jacobsen.

Frontline staff are the group that "can make or break you," says Adamski. "If they know you are working to move through patients quicker, they may see it as creating more work for them," she says. "But in reality, if you correct a lot of these flow issues, it should help the staff as well."

### **Staff must answer questions**

To demonstrate to Joint Commission surveyors that impediments to patient flow were mitigated, staff at Virginia Mason Medical Center in Seattle will point to the following, says **Dana Nelson-Peterson**, RN, MN, administrative director of hospital operations: hourly divert/bypass logs, graphs showing the number of hours on diversion, and 90 day re-measures from rapid process improvement workshops on ED throughput.

"We will also encourage them to observe our standard work processes, including twice daily bed flow huddles, surgery schedule review huddles, and how our bed board is used for communication of bed availability," she says.

The organization has implemented the following to prepare for the new patient flow tracer:

- A 24-hour bed control/flow area, staffed with nurses in supervisory roles.
- Twice-daily "bed flow huddles," with representation from all floors and peri-operative services.
- A visual bed board to manage the flow of admissions, discharges, and bed turnover.
- A "bed ahead" standard for floors — a process where the assistant nurse manager on each floor indicates electronically where the next patient admission will be placed on the unit.
- A 9 a.m. standard for physician discharge orders. "This has allowed us to move up the average time of discharge significantly throughout the hospital, creating capacity to absorb the post-operative patients and unplanned admits through the ED," says Nelson-Peterson.
- A daily huddle with peri-operative services to review the upcoming three days of OR schedules to ascertain CCU/monitored bed needs and capacity.

Patient flow is assessed continuously through Virginia Mason's "bed board," which tracks discharge orders. "This allows us to measure cycle

time from order placement to discharge, and identify barriers from which we create our improvement plan," says **Valerie Ferris**, RN, administrative director of the Hospital Kaizen Promotion Office. "We assess the impact of improvements on flow by routinely measuring cycle times, lead times, and designated quality metrics."

For example, cycle times were reduced on transfers to skilled nursing facilities, freeing up bed capacity earlier in the day to accommodate unplanned admissions through the ED.

At Lucile Packard Children's Hospital in Palo Alto, CA, questions about patient flow are incorporated into monthly tracers, to increase the ability of staff to articulate what the organization has done. "When we go to the surgical floor, we ask staff about how they plan for admissions, and what resources are available to them for this," says **Vicki Link**, RN, BSN, MBA, director of quality management. "We also expect managers and nursing education to do tracers and give feedback to staff."

The hospital is having a mock survey done by an independent company and has asked them to do specific tracers for patient flow. "Since patient progression is such a huge component of our daily procedures, we feel staff will be comfortable with these new tracers," says Link.

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# Surveyors finding problems with medication standards

Nearly half (43%) of hospitals surveyed in the first half of 2007 were not compliant with The Joint Commission's standard requiring medications be properly and safely stored, and 20% were non-compliant with the requirement for medication orders to be written clearly and transcribed accurately. Here are some of the non-compliant areas surveyors are finding for The Joint Commission's medication management standards:

- **Processes to ensure medications are stored under suitable conditions for product stability.**

"This is a requirement that we see organizations struggle with a fair amount," says **Pat Adamski**, RN, MS, MBA, director of The Joint Commission's Standards Interpretation Group. "That is probably the top issue that we see."

For example, if a medication needs to be refrigerated, the temperature must be monitored to ensure it's maintained within a certain range, by using a thermometer that alarms when it's out of range, or by doing a manual check every day. And if the temperature is out of range, there needs to be a consistent process followed for correction.

"If the temperature in the refrigerator goes out of whack, which does happen from time to time, do the staff involve the pharmacy to come up and evaluate whether the medication needs to be disposed of?" asks Adamski. "And what is done while you are waiting to get the refrigerator repaired, to make sure that the medication stays at its appropriate temperature and potency?"

Staff may forget to check temperature readings on a given day, but another more serious concern is failure to act if the temperature is documented as out of range.

"That is where people sometimes drop the ball," says Adamski. "The staff may be diligent about writing down a temperature, but if they don't pick up the phone and call somebody when it's out of range, they are defeating the whole purpose."

- **Policies for what practitioners do after they obtain medications.**

The organization needs to specify how a medication is stored between the time the health care practitioner retrieves a medication and when he or she administers it. "Sometimes physicians, nurses, and respiratory therapists like to put medication into their lab coat or uniform pockets or storage pouches. If the organization allows

that, we want to know how they assess the process to make sure the security and stability of the medication is maintained, and that any infection control issues are addressed" says Adamski.

- **Making sure that expired, damaged or contaminated medications are segregated.**

"Those medications need to be kept away from all the other medications the staff are going to use, until they can be removed from the hospital," says Adamski.

- **Removal of concentrated electrolytes from patient care units.**

"Only in very specific situations are they allowed to be there, because of the potential for safety issues if an electrolyte is administered in its concentrated state and not diluted," says Adamski. "We took care of that a couple years ago with a National Patient Safety Goal, but now that it's back in the standards, every now and then we'll see it scored."

- **Policies and procedures for medication orders.**

"Whether or not the organization allows certain things must be clearly identified, so staff know exactly what the expectations are," says Adamski. For example, policies must state whether an indication for use must be within the medication order itself, or if it can be documented anywhere within the medical record. Special precautions for look-alike, sound-alike drugs must be identified, and processes must be defined for staff to follow if they can't read an order because it's illegible.

"Then, we want the organization to weigh in on whether they will allow certain types of medication orders, and if they do, we want to know how they manage those processes," says Adamski.

For instance, a policy for range orders may not give staff enough guidance for when to give specific dosages. "Or sometimes there is an issue with the titration of the medication — what allowance do the staff have to titrate a dose up or down, and is that within their competency skill set? Also, blanket reinstatement orders can never be allowed, and that must be clearly defined," says Adamski.

Most of the time, however, policies are specific enough — the problem is that they aren't being followed all the time. "Occasionally we will come across organizations that have not defined one or more of the requirements, but generally speaking, they have a pretty robust set of medication management policies," says Adamski. "But there is a lot of opportunity for staff, being human beings, to miss an aspect of a policy and procedure. That's what we see most often scored in this standard."

Adamski recommends using standard MM 8.10, which requires evaluation of the entire medication management system, to identify points where your organization may be vulnerable and drive your data collection efforts.

Review occurrence reports with risk managers, and ask frontline staff what procedures they find problematic. "It could be that the policy itself needs to be revised," says Adamski. "If people don't follow a policy, there is usually a reason. It could be totally impractical in terms of their work flow. Or when the policy was developed things were different, and it's never been updated."

Assessing compliance with policies is an area where many quality improvement initiatives fall short. "The organization may develop a wonderful set of policies, and have everybody sign a piece of paper saying that they have read the policy and will follow it — and then they stop," says Adamski. "They don't go back to see what is really happening — if staff are really following the policy. This is one of the biggest problems I see."

You can do this by interviewing staff, performing observations or doing random checks, in order to "close that PI loop" to evaluate whether a policy is being implemented as intended, says Adamski.

The Joint Commission has revised its medication management standards through a Standards Improvement Initiative in order to make them easier to understand, but the requirements will essentially remain the same, reports Adamski. "The intent is to get rid of a lot of the jargon and make them much clearer for the organizations," she says. ■

## ACCREDITATION *Field Report*

### What surveyors found in patient, system tracers

During a February 2008 Joint Commission survey at Temple East/Northeastern Hospital, a 187-bed community hospital in Philadelphia, surveyors asked several staff members if they knew how to contact The Joint Commission about quality or safety concerns.

"We have developed a poster telling staff, patients, families, and physicians that if they have concerns about quality and patient safety issues that they can contact the Department of Health or The Joint Commission," says **Sherry Mazer**, FACHE, CPHQ, regulatory officer at Temple University Health System in Philadelphia. "They are hanging in elevators and bulletin boards on the patient care units and other departments."

The question underscored the "staff-driven" nature of the survey, says **Sally Hinkle**, RN, BSN, MPA, Temple East/Northeastern's director of quality management. "Managers were present, but it was clear that the surveyors wanted to speak with the staff about their processes and how they were delivering quality, safe patient care," she says.

Here are some areas surveyors looked at during system tracers:

- **Data use tracer:**

"The surveyors started with the core measures, which were most problematic from the data that they received," says Mazer. "We weren't improving one of the measures in one of our core measure sets very quickly. We did a detailed analysis of that measure showing results over time, and action plans for quicker compliance. They were very satisfied with our analysis."

- **Medication management tracer:**

Surveyors asked these questions:

- What is the pharmacy's role in medication reconciliation?
- How are medications obtained when the pharmacy is closed?
- Are patients or physicians allowed to bring in their own medications?

Surveyors then traced a patient on heparin, and wanted to see how the order for a high-risk medication was handled by pharmacy and nursing, and checked for a double signature before the drug was given.

- **Infection control tracer:**

Surveyors did a detailed review of dialysis machine testing, and reviewed flash sterilization logs and policies. "The surveyor also observed the dialysis nurse providing a treatment, checking to see that she properly reviewed the patient's identification using two identifiers, used good hand hygiene, and wore the proper personal protective equipment," says Mazer.

- **Environment of care tracer:**

"A very thorough building tour was done by the Life Safety Specialist," says Mazer. "The surveyor found equipment in front of electrical panels, which was not allowed even though the

equipment was on wheels.”

All testing logs were reviewed, including fire suppression systems and generator testing, and fire doors were checked, with the surveyor finding one with a gap that was too large.

The administrative surveyor closely reviewed the hospital’s emergency preparedness program. “He read the emergency operations plan, and looked at our drill after-action reports and hazard vulnerability analysis,” says Mazer. “He asked a lot of questions about the emergency supply inventory, and toured our new incident command center, ED, emergency supply shed, and decontamination area. He was impressed with the amount of supplies that we maintain.”

The surveyor asked to see medical staff credentialing files for the most recent appointment to staff, the senior dentist, the after-hours radiologist, the most recently appointed podiatrist, the latest physician to be granted a new privilege, and any physician with involuntary reduction in privileges. “He congratulated the medical staff coordinator on the consistent detail she used in all of the required checks,” says Mazer.

The surveyor reviewed the files with the chief medical officer and medical staff office personnel first, then interviewed the medical staff members. Regarding the requirement for an ongoing review of practitioners, the surveyor said that one year was too long of a timeframe, and that six to nine months was acceptable. “We have decided to change to providing the ongoing practitioner profile every six months,” says Mazer.

For all of the patient tracers, surveyors looked for completeness of the history & physical, legibility, and that notes and verbal orders were authenticated with time, date, and signature. “The timing of chart entries was a big focus, especially since CMS updated their conditions of participation in late 2006 to include this,” says Mazer.

Surveyors liked the form used for verbal orders, which has a flag sticking out of the chart for the physician to see, and can be torn off once it’s signed. “All the rules for taking and signing a verbal order are on the form — verbal order read back, sign within 24 hours, date and time,” says Hinkle.

Here is what surveyors looked for in specific units:

- **In the post-anesthesia care unit:** The surveyor checked for evidence of the time out, post-operative note, signed consents, medication reconciliation, and competencies for staff that he interviewed.

- **In the ED:** An ED nurse was asked about the

competencies and certifications needed to care for a patient receiving moderate sedation. The nurse was also asked about medication reconciliation, peak flows, reassessments, turnaround time for lab values and critical values, patient identifiers, and the process for accessing interpreters.

- **In the intensive care unit:** The surveyor asked about processes for medication reconciliation, assessment of deep venous thrombosis, high-alert medications, vaccination assessment, isolation, addressing medical staff abusive behavior, and nursing orientation.

A staff nurse was interviewed about the communication process used for shift report, and the process for contacting the previous nurse with questions or concerns after the shift has started.

Last year, the organization did an intensive, mandatory education program on hand-off communications using the “situation background assessment recommendation” (SBAR) format. “It paid off, because all disciplines were able to speak to the process and show the forms and reports that are used,” says Mazer.

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## Get pressure ulcers near zero with these best practices

A recent development has put greater emphasis on pressure ulcer prevention in hospitals: The Centers for Medicare and Medicaid Services (CMS) will stop reimbursement for certain hospital-acquired conditions, including pressure ulcers, as part of an update to the hospital inpatient prospective payment system.

Unless pressure ulcers are documented as present on admission, CMS will no longer provide reimbursement — an extra incentive for organizations to get the number of pressure ulcers acquired in the hospital as close to zero as possible.

“In looking at our pressure ulcer rates, we didn’t

like the numbers we were seeing,” says **Beth Kaiser Schafer**, RN, MS, director of professional practice at Hennepin County Medical Center in Minneapolis. “We did a gap analysis comparing our practice to national standards, and we didn’t like where we were.”

A group of staff was sent to a pressure ulcer summit in 2005, held by the Minnesota Hospital Association, to find the most current evidence-based practices. “From there, it was time to get out and apply what was best practice,” says Schafer. “We educated a large number of our nurses, and put skin care best practices into our annual training for nurses.”

The first and biggest challenge was to get direct clinical staff to buy in to the urgency of the initiative. “After we identified an organizational need, we had to drive down that need and make staff feel the same importance as we did,” says Schafer. “We know that in their educational program, our nursing staff learn how to do skin assessment and prevent pressure ulcers, as well as how to care for skin. They know the right thing, but something must have been getting in the way of doing it.”

The next step was to look at whether nurses had the supplies and equipment needed to put prevention strategies in place, and treat pressure ulcers if they occurred.

“We discovered that staff didn’t have easy access to skin products when they needed them. People can’t do what you want them to do, if they don’t have those things,” says Schafer.

After skin products were standardized, skin carts were created for the units with all the necessary products fully stocked. A skin care guide was developed and placed on the carts, as an easy reference for staff.

A designated person was hired to oversee the organization’s wound and skin program, which includes coordinating the monthly meetings, skin rounds, and serving as an expert consultant for challenging wounds. Additional education was given on skin safety, with updated information about best practices for assessment, prevention, and intervention.

An organization-wide skin team of 20 members visits nine inpatient units each quarter, to conduct head-to-toe assessments on every patient. These data are analyzed, including the patient’s age, gender, risk assessment scoring, timeliness of prevention strategies, and assessment of skin breakdown.

The team found a link between pressure ulcers and certain treatment protocols, and in other

cases, the equipment being used. “We looked at what kind of mattresses we used and developed a mattress algorithm,” says Schafer.

Monthly “skin meetings” are held with a team of champions from various units. “We discuss issues that members may have, and we work to improve them at either a unit or an organizational level,” says Schafer. For example, an organization-wide approach to documentation in the electronic health record was recently implemented.

Quarterly data are collected on an organization-wide basis, and submitted to the National Database of Nursing Quality Indicators (NDNQI) database. Initially, the number of pressure ulcers identified in 2006 increased, but the number has since dropped 75% in the hospital’s surgical intensive care units and 57% in other units for certain stages of pressure ulcers.

In addition, individual units do their own skin rounds and data collection. “Some of our units are doing weekly or monthly rounds so that they are sure they aren’t missing anything,” says Schafer. “This drives it down to the actual people in the areas where the patient care is occurring. It takes on a very personal level, and gets the staff very passionate about skin care.”

Unit champions carry the message much more strongly than any one person can, says Schafer.

“We have had skin team members who were transferred to another unit, who asked to stay on the skin team of the previous unit because they want to continue to share their knowledge,” she says. “There is nothing like peer-to-peer-knowledge transfer to get things done. One person can’t do it all.”

In 1996, the University of Virginia’s Health System’s pressure ulcer prevalence rate was 8%. Although national prevalence statistics for pressure ulcers range from 10% to 17%, the organization set out to decrease its rates by implementing a pressure ulcer prevention program, including ongoing monitoring of pressure ulcer prevalence to measure outcomes.<sup>1</sup>

“We would like for our rate to be zero. There is no acceptable rate for someone developing a pressure ulcer,” says **Catherine R. Ratliff**, PhD, APRN-BC, CWOCN, clinician and manager of the wound ostomy continence department.

For more than a decade, the hospital’s wound ostomy continence nurses have done pressure ulcer rounds, something that most organizations have only begun implementing recently, says Ratliff.

The nurses analyze the data obtained during

the rounds and distribute them to the appropriate administrators and clinicians, who use the data to benchmark the health system against itself, and against national benchmarks including the NDNQI.

Each year, prevalence rates are compared to previous years to identify trends. "For example, in the late 1990s the prevalence rate increased slightly. We attributed this to needing better support surfaces," says Ratliff. "We got new pressure redistributing mattresses for the hospital, and then the prevalence rate decreased again."

As a result of the below interventions, in 2006, the pressure ulcer prevalence rate was down to 5%, and has remained at this level throughout 2007. "We continue to implement interventions to hopefully decrease the rate," says Ratliff.

Here are key changes that were made:

- A standardized wound assessment form is used, for consistency in documenting wound care.
- Pressure redistributing mattresses are used on all inpatient units. These reduce pressure and also provide a more comfortable support surface for patients.
- Comfort products such as egg crate mattresses and doughnuts were eliminated from the hospital storeroom, as these do not provide redistribution of pressure.
- Modules on pressure ulcer prevention and specialty bed usage were written, and are available to the hospital staff electronically.
- The Braden Risk Assessment Scale is used to identify patients at risk for developing pressure ulcers. A section on the hospital admission form was added to fill in the patient's score, with check off boxes listing interventions to reduce risks.
- Algorithms on pressure ulcer prevention and treatment were developed and distributed throughout the health system to all disciplines.

Hospital staff regularly consult the wound team nurses to assist with the management of patients with pressure issues. "Our biggest challenge now is to continue to be vigilant about pressure ulcer detection and not to become complacent, thinking that we have done all we can do," says Ratliff. "That is never the case."

## Reference

1. Cuddgian, J, Ayello, EA, Sussman, C. Pressure ulcers in America: Prevalence, incidence, and implications for the future. National Pressure Ulcer Advisory Panel 2001: Reston, VA.

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## How to score an 'A' in knowledge management

*Communicating lessons learned is integral*

By Patrice Spath, RHIT  
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Forest Grove, OR

A variety of improvement projects are going on throughout your organization. Some are aimed at improving the efficiency of services and some are undertaken in an effort to reduce adverse events. There are also customer satisfaction and documentation improvement projects. And the list goes on...

While many of these projects achieve the intended goals, what's often missing is a formal process for sharing lessons. Lessons typically are shared by word of mouth during hallway conversations.

Disseminating the lessons learned during each project is a principal component of your organization's commitment to knowledge management and continuous improvement. That's why it is important to share the knowledge gained during each improvement experience — both negative and positive experiences.

The sharing of lessons learned is a component of the organization's system of knowledge management. Effective knowledge sharing and organizational learning leads to ever better performance. Often people equate knowledge

management with information technology tools; however, these tools are merely facilitators, not the essence of knowledge management. The goal of knowledge management is to deliver the intellectual capacity of the organization to the people who make day-to-day decisions.

The Institute for Health Care Improvement uses the term “spread” to describe the learning that takes place in other parts of the organization when improvement information is actively shared and acted upon. This includes not only those parts of the organization that are the same as the original improvement site but also other parts of the organization that have similar processes or face similar issues. For instance, ideas for improved patient flow developed in an outpatient department are spread to other units where patient flow is a problem.

To achieve spread, dissemination of lessons learned must be active — lessons must be “pushed” to potential users using various communication channels. If an organization relies solely on passive dissemination through word of mouth, the likelihood of spread is low. A formal method, coordinated through the quality department, is needed to capture and disseminate the knowledge or understanding gained in improvement initiatives.

To create a formal system for identifying, sharing, and using lessons learned, the first step is to define the infrastructure and communication mechanisms. Consider these questions:

- How will you identify applicable lessons, document the information, and distribute to appropriate areas?
- What actions are expected to be taken as a result of the lessons learned and how will com-

## CNE objectives

To earn continuing education (CNE) credit for subscribing to *Hospital Peer Review*, CNE participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from The Joint Commission or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

## CNE questions

17. Which is true regarding patient flow tracers conducted by surveyors from The Joint Commission?
  - A. Surveyors will not ask staff direct questions about patient flow unless a problem is clearly identified.
  - B. Surveyors will want to know what barriers were identified, but organizations are not required to show what actions were taken as a result.
  - C. If surveyors see patients waiting in ED hallways, this will be considered as noncompliance with the patient flow standards.
  - D. Surveyors will want to know how any identified problems with patient flow have been mitigated.
18. Which is a requirement in The Joint Commission’s medication management standards?
  - A. Manual check processes for refrigerator temperatures are not allowed.
  - B. Blanket reinstatement orders are allowed as per the organization’s policy.
  - C. A consistent process must be followed when temperatures are documented as out of range.
  - D. Range orders for medications may not be used.
19. Which of the following must an organization’s medication management policy specify?
  - A. Whether or not an indication for use must be within the medication order itself, or if this can be documented anywhere within the medical record.
  - B. What special precautions must be taken for look-alike, sound-alike drugs.
  - C. What processes staff must follow if they can’t read an order because it’s illegible.
  - D. All of the above.
20. Which intervention was successful in getting pressure rates to decrease at the University of Virginia Health System?
  - A. New pressure redistributing mattresses were placed on all inpatient units.
  - B. The organization’s wound assessment form was changed to be unit-specific instead of standardized.
  - C. Comfort products such as egg crate mattresses and doughnuts were purchased.
  - D. Use of the Braden Risk Assessment Scale was discontinued.

Answer Key: 17. D; 18. C; 19. D, 20. A.

## CNE instructions

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

pletion of the actions be monitored?

- What resources, procedures, and personnel will be needed to support the system?

The overall scope of the lessons learned system should be broad, including lessons from the many projects within the organization — operations, clinical care, business, management, and more. Don't just focus on what is learned during investigations of adverse events or failures as you'll miss opportunities to improve all processes. Sharing a "good practice" or innovative approach to promote repeat application is just as valuable as sharing adverse experiences to avoid recurrence. Participation in sharing lessons learned needs to be continuously reinforced at all levels. At every

performance improvement meeting the question should be asked, "What is the lesson learned?"

Create hard copy and electronic input mechanisms that people can use to submit lessons learned. An example is shown in Figure 1. Reporting should be as simple as possible, but sufficiently detailed to be useful to other people in the organization. Every documented lesson learned should contain at least these general elements:

- project information and contact information for additional detail;
- a clear statement of the lesson;
- a background summary of how the lesson was learned;
- benefits of using the lessons and suggestion

## Figure 1. Lessons Learned End-of-Project Report

Project Objective: \_\_\_\_\_  
 Departments Involved: \_\_\_\_\_  
 Prepared by: \_\_\_\_\_  
 Date: \_\_\_\_\_

### List this project's three biggest successes:

Description	Factors that Promoted the Success

### List other successes or insights that the team would like shared:

Description	Factors that Promoted the Success or Influenced the Insight

### List areas where the project could have been more successful along with strategies for improving future projects:

Description	Suggestions for Improving Future Projects

Comments:

Source: Brown-Spath & Associates, Forest Grove, OR.

## COMING IN FUTURE MONTHS

■ Give physicians valid, timely data they can't dispute

■ How to tell if root cause analyses are ineffective

■ Evaluate whether patients are getting poor care during off-hours

■ Update on revised medication management standards

■ Assess compliance with new MRI recommendations

how the lesson may be used in the future.

Encourage collection of lessons learned throughout the project cycle so that reporting isn't viewed as just another "add on" at the project end. This makes the reporting process less labor intensive. At any time during a project, the leader or team members may identify lessons that should be shared. By starting the report at the beginning of the project these lessons won't be forgotten. Lessons learned should be compiled throughout the project and then finalized during a debriefing when the project is complete.

The organization's culture can affect reporting of lessons learned. If the organization's culture does not encourage sharing of information — people want to get and hold and not give — lessons learned reporting may be difficult to implement. In some situations people may not want to show their weaknesses if an improvement project didn't go as planned. Leaders need to encourage and reward reporting of negative lessons as well as best practices and successes.

Lessons learned reports are forwarded to the quality department for organization-wide sharing. This involves more than copying the reports and distributing to appropriate departments. While reports often contain good information, people must be able to quickly find lessons with-

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out going through each document. The lessons must be summarized into concise statements. In addition, the quality department can see across multiple improvement projects and should identify and link related lessons for reporting purposes. A simple truism to remember when preparing reports — if people can quickly find what they want, they are more likely to use it.

Summaries of improvement project lessons learned should be regularly distributed throughout the organization. Some of the common tools for distribution are:

- electronic mail and bulletin boards;
- virtual communities in an Intranet environment;
- face-to-face discussions at management and staff meetings.

The quality department can help the organization achieve ever-better performance by facilitating the collection and distribution of improvement project lessons learned. Remember, two (or more) heads are always better than one and great benefits can be gained from sharing someone else's prior experience.

*(Editor's note: We regret that Patrice Spath will no longer be writing The Quality-Cost Connection column. Spath, who will continue to serve as consulting editor, has written the column since 1985 and we thank her for all of her insight and support.)* ■