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Medicare's shifting of call panels could be good news for ED managers

Proposed change would allow community call arrangements

In a move that emergency medicine experts hope will provide at least partial relief to the call coverage challenge, the Centers for Medicare & Medicaid Services (CMS) has proposed a new regulation that would allow hospitals to establish community call arrangements at a regional level to satisfy their Emergency Medical Treatment and Labor Act (EMTALA) on-call physician requirements. If formally approved, the regulation would become effective on Oct. 1, 2008.

What will these community call arrangements look like? Although CMS' Technical Advisory Group studying the issue had recommended the establishment of a preapproval process or preauthorization, "CMS is actually defining it fairly loosely, although everybody is subject to CMS' post-hoc determination," observes **Stephen A. Frew**, JD, vice president of risk consulting for Johnson Insurance Services of Madison, WI. "They have always shied away from proscriptive or even reasonably [detailed] information."

It appears from the language of the proposal, Frew says, that the goal of allowing community call is to provide a mechanism whereby hospitals that might not be able to man a full-time call list would work with other hospitals to create a combined call list. "I would infer that as long as there was not a capability at a single hospital, they would not need [to provide individual call]," Frew offers. "Of

Proposed 2009 OPPS: Quality push continues

ED managers have the opportunity to increase reimbursements under the proposed 2009 rule for the Outpatient Prospective Payment System (OPPS), but they also will come under greater scrutiny by the Centers for Medicare & Medicaid Services (CMS) for the quality of their care. For example, CMS proposed to implement a data validation approach starting with January 2009 encounters in which it would randomly select 800 reporting hospitals and validate the accuracy of reported data by selecting 50 records per selected hospital on an annual basis.

(See **2009 OPPS,** p. 88)

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course, if you had 15 'orthopods,' you could probably not get away with only taking orthopedic coverage one day a month and spinning the rest to other docs in the community."

The proposal would allow, under very detailed parameters, for on-call specialties to be regionalized while participating facilities still could meet their coverage requirements under EMTALA, according to **Michael J. Williams**, MPH, HAS, president of The Abaris Group, a Walnut Creek, CA-based health care consulting firm specializing in emergency services. "Each community is different, in terms of which types of call panels would apply, but ENT, plastics, and orthopedics are some examples," he says.

How will proposal benefit ED managers?

ED experts aren't in complete agreement on the impact.

Frew says, "The proposed changes offer possibilities, particularly for smaller communities and smaller hospitals in suburban areas, to meet their call obligations in a manner that will provide some relief to their beleaguered specialists and, in turn, means that EDs will have a better chance of getting the specialty backup they need."

For Williams, it's more of a mixed bag. "It has a lot of good potential, but maybe some serious harm," he notes. "All in all, it's a little bit of bright light in the corner of the sky." **(For more details on Williams' concerns, see the story, p. 87.)**

Whether the ultimate result will be positive or negative, it's imperative that ED managers clearly understand the new proposed regulations, especially if they become law in October, he says. "For example, there may be antitrust ramifications, Williams says. "As consultants, we think you may need a third-party representative [to set up the community panel]," he says. Otherwise, he notes, if a group of hospitals agree on a price structure among themselves, it could be considered price fixing. "You might go to your local EMS"

Executive Summary

While the news that the Centers for Medicare & Medicaid Services likely will allow hospitals to establish community call arrangements sounds good for ED managers, you would be well advised to study the proposed new regulation carefully. There are many critical details an ED manager must be clear on to stay in compliance and avoid potential pitfalls. For example:

- Assessments of ambulance patients must begin while they are on a stretcher.
- You may need to engage an attorney or consultant to help you establish a pricing structure.
- In what some say is one of the biggest changes to EMTALA in 10 years, if you have a specialist on call who could handle a given case, you are now required to accept the patient under EMTALA.

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as an objective third party, he suggests. In any event, he says, it would be advisable for the ED manager to approach the hospital CEO or administrator and discuss such issues. "You might need an attorney or consultant to advise you as to the best approach," he says. *(Editor's note: The CMS proposal was published in the April 30, 2008, edition of* The Federal Register, *which can be accessed at www.access.gpo.gov/su_docs/fedreg/frcont08.html.)* ■

CMS proposal could have unintended consequences

At first glance, it sounds like only good news for ED managers who are frustrated at their inability to have specialty services adequately covered. The Centers for Medicare & Medicaid Services (CMS) has proposed allowing hospitals to establish community call arrangements at a regional level to satisfy their on-call physician requirements under the Emergency Medical Treatment and Labor Act (EMTALA). However, warns one expert, there could be some potential pitfalls in this new reality.

For example, the proposal includes "one of the biggest changes in EMTALA in 10 years," says **Michael J. Williams**, MPH, HAS, president of The Abaris Group, a Walnut Creek, CA-based health care consulting firm specializing in emergency services. Now, he explains, if you have a specialist on call who could handle a given case, "you are absolutely required to accept the patient."

Another area where unintended consequences might result is ambulance patient "parking." Since ED managers try their best not to go on diversion, it might take ambulance patients as long as 45 minutes to get into a bed, notes Williams. "In the new proposed rules, CMS says your EMTALA obligations begin when you arrive at the ED," he says. "So EMTALA now says you are responsible for beginning the screening exam in the hallways on a stretcher."

Not doing this assessment also could be a violation of the hospital's condition of participation as it pertains to providing speedy emergency care, says Williams. "At the very least, you have to start the assessment while the patient is still on the stretcher," he advises.

ED managers "will have to write new policies that ensure if there is any parking, you need to go over and assess the patient," Williams says. "You are not obliged to complete the MSE [medical screening exam], but you at least have to perform a simple assessment."

The riskiest implication of all, says Williams, is that hospitals that have specialized capabilities must accept patient transfer and not put any conditions on it if they have the capacity and capability. "This is new," he says. "In the past, you would not accept patients when you should have had on-call coverage; you might, for example, have called a trauma center." ■

Final passage for new regs is likely

The recent proposal by the Centers for Medicare & Medicaid Services (CMS) to allow hospitals to establish community call arrangements to satisfy their federal on-call physician requirements at a regional level is likely to be formally adopted, says **Stephen A. Frew**, JD, vice president of risk consulting for Johnson Insurance Services of Madison, WI.

"I would say that barring unforeseen political implications, I would expect it to go into play in October fairly closely approximating the language that's there now," he says. "The area where we might see some change may be the wording in the section dealing with transfers."

That section, Frew notes, says even if you have established a community call panel, it doesn't relieve you of your transfer obligations under the Emergency Medical Treatment and Labor Act (EMTALA). "You still have to call and get [transfer] acceptance, document it, and send the patient by an appropriate medical vehicle," he says. "They may play with some of the language, but the final form will be very close to the language we have now." ■

2009 OPPS

Continued from cover

"They will be auditing your records to validate whether the quality data you have reported is actually supported in the data," explains **Dennis Beck**, MD, FACEP, CEO of Beacon Medical Services, an emergency medicine practice management company in Denver, and chair of the quality and performance committee of the American College of Emergency Physicians (ACEP). "It will require coordination [of the ED manager] with the coders, or whoever is doing the entry of quality reporting, to make sure they can only report what is documented in the ED."

In the past, the increase in Medicare's payment for outpatient services has not been specifically tied to the quality of health care. Now, however, the law requires that the annual outpatient prospective payment system (OPPS) inflation update be reduced by two percentage points for hospitals that do not meet quality reporting requirements. To receive the full OPPS payment update for services furnished in calendar year 2009, hospitals must report quality data from calendar year 2008.

CMS also has added an ED quality measure endorsed by the National Quality Forum (NQF) — median time from ED arrival to ED departure for discharged ED patients — to a list of 18 new quality measures that have been released for public comment. However, those 18 measures are proposed for implementation in fiscal year 2011, which means they would likely apply to encounters beginning January 2010.

"We think this is an important measure, but it's only *one,"* notes **John Moorhead**, MD, professor of emergency medicine at Oregon Health & Science University, Portland, past president of ACEP, and co-chair of the NQF steering committee that made the recommendation. "We want people to start reporting their throughput times, which would then give us a basis on which to report to the public."

As for what that median time should be, Moorhead says, "we don't know what that median [throughput] time is; it is a reporting measure, not a benchmark."

This is just one of 10 measures Moorhead's committee has recommended to NQF. **(See chart, below, for the complete list)**. The rest of the measures have not yet been endorsed by NQF, notes **Dell M. Conyers**, senior program director for NQF. "They are out for comment, and then our members will vote, so there are a few more layers until final endorsement."

Any final endorsement would come in November 2008, he says. "We could endorse all of them, none of them, or somewhere in between," he notes. ■

Executive Summary

The documentation of services and the collection of quality data will become even more important under proposed Medicare changes for 2009. Documentation gains added importance with a significant increase proposed for ED reimbursement in the next fiscal year that is dependent on whether you submit quality data.

- With random checks of facilities for data validation, work closely with those responsible for data entry of quality reporting.
- Report only those services that you have documented.
- Place an even greater emphasis on throughput, as it may become part of new quality measures.

ED fares well on APC increases

ED managers should be pleased with the proposed increases in ambulatory payment classifications (APCs) for fiscal year 2009, says **Dennis Beck**, MD, FACEP, CEO of Beacon Medical Services in Denver and chair of the quality and performance committee of the

ED Quality Measures Recommended by Steering Committee

1. Median time from ED arrival to ED departure for admitted ED patients
2. Median time from ED arrival to ED departure for discharged ED patients
3. Admit decision time to ED departure time for admitted patients
4. Door to provider
5. Left without being seen
6. Severe sepsis and septic shock: management bundle
7. Confirmation of endotracheal tube (ETT) placement
8. Pregnancy test for female abdominal pain patients
9. Anticoagulation for acute pulmonary embolus patients
10. Pediatric weight documented in kilograms

Source: National Quality Forum, Washington, DC.

Sources

For more information on the proposed rule contact:
- **Dennis Beck**, MD, FACEP, CEO, Beacon Medical Services, Denver. Phone: (303) 306-7783. E-mail: info@beacon-medical.com. Web: www.beacon-medical.com.
- **Dell M. Conyers**, Senior Program Director, National Quality Forum, Washington, DC. Phone: (202) 783-1300. Fax: (202) 783-3434.
- **John Moorhead**, MD, Professor of Emergency Medicine, Oregon Health & Science University, Portland. Phone: (503) 494-7551.

American College of Emergency Physicians (ACEP).

"They are pretty decent for EDs," he says.

For example, while the overall Medicare inflation adjustment was 3%, the APC payment rate for Levels 2, 3, and 4 emergency visits are 3.2% higher than the 2008 rate, according to Beck. The rate for Level 1 visits is 5.6% higher than in the previous year. In addition, there was a 4.8% boost in the critical care APC rate, "which is a good thing," he notes.

The one area where reimbursement will drop involves "Type B" EDs, which refers to facilities that provide emergency level services but are not open 24 hours a day, seven days a week. Currently, Medicare pays for emergency visits to those facilities as nonemergency visits to the outpatient department, but it now has data that show most emergency visits in such facilities are more costly than clinic visits but less costly than emergency visits in "Type A" EDs.

"They will get paid less," says Beck. "For example, the 2008 rate for a Level 4 visit was $212.59, while the proposed rate for 2009 is $156.56."

If these proposed changes go through, he predicts, "That may cause some facilities to consider changes, such as whether it is viable to maintain 'Type B' beds." ■

ED swings into action following helicopter crash

Cooperation with fire department was essential

When an Aero Med helicopter crashed and burst into flames on the roof of an 11-story tower at Spectrum Health Butterworth Hospital in downtown Grand Rapids, MI, on May 29, 2008, during a training run, the ED team swung immediately into action to get to the two victims and prepare the department to receive them. They also needed to prepare to receive inpatients from areas of the hospital evacuating due to the fire.

The ED learned of the disaster in real time, notes **Jim Schweigert**, MD, the medical director. "One of our techs happened to be at the triage desk and saw it crash on their screen," he explains. Schweigert notes that the cameras are there to monitor Aero Med landings when patients are being brought in.

"I coordinated with the charge nurse and set up response in the trauma bay area, making sure there were other places to see patients," he recalls. "We immediately discharged any patients that were stable to make extra room."

At the same time, knowing that Schweigert, the nurse supervisor, and the charge nurse were all in the department, **Jeanne Roode**, RN, MSN, CNA, CNRN, director of emergency, trauma, and neuroscience services, says she "went as close as I could to the site and get a sense" of the situation. She found herself meeting the fire department on the stairwell and directing them up the stairs at the same time. The elevators were not operational because the fire alarm had kicked in.

"Essentially what I was doing was preparing for what we might be encountering as far as survivors of the crash," says Roode, who dispatched a team of nurses, physicians and techs to the site to assist the first responders.

Roode also helped the fire department work more efficiently. While the first crew climbed all 12 flights of stairs with their heavy hose, she took a second crew up the next-door tower elevator to the seventh floor, where they were able to use a bridge across to the other tower and met the first crew coming up.

The ED team contributed directly to patient care, after waiting until the fire department extricated the patients from the hot zone. Then they carried the two victims down to the seventh floor on back boards.

Executive Summary

The crash landing of an Aero Med helicopter on the roof of a Grand Rapids, MI, hospital required the ED team to spring into action. Here are some lessons you can draw from their experience:
- You or your staff might need to assist fire or EMS personnel in transporting victims to the ED or evacuating the hospital.
- Even if your ED is not overwhelmed with patients, it might be necessary to go on lockdown to keep onlookers and other unwanted visitors out.
- Be prepared to discharge stable patients to make room for others with more urgent needs.

Sources

For more information on dealing with an accident at your facility, contact:

- **Jeanne Roode**, RN, MSN, CNA, CNRN, Director, Emergency, Trauma, and Neuroscience Services, or **Jim Schweigert**, MD, ED Medical Director, Spectrum Health Butterworth Hospital, Grand Rapids, MI. Phone: (616) 391-1683.

The upper floors of the hospital had begun to fill with smoke and had to be evacuated, and again the ED staff was incorporated. "I was stationed there so I could also coordinate with the pediatric ED evacuation going on at the same time, and had stretchers waiting for them at the seventh-floor stairwell," says Roode.

ED 'reconfigures' to meet disaster needs

The ED leadership took steps to ensure there was a seamless response to the disaster.

"We decided to go on diversion status. We found ourselves with a significant amount of media outside our doors," Roode says. "There were a number of people curious about what was going on."

The decision also was made to house patients evacuated from the affected floors. This required one section of the ED to be dedicated to pediatric patients. "We cleared that section to accommodate some of the sicker 'peds' patients from the [upper] floors," Roode explains. "We took in 14 inpatients along with physicians and nurses."

Many of the kids in the ED were discharged and relocated to another part of the department, says Roode. "When their families realized a helicopter had crashed on top of the building, there was no resistance," she notes.

The ED managers took steps so that other facilities impacted by a lockdown received additional help. Because Butterworth also is the only Level I center for adult trauma in the city, the ED leadership team decided to send a couple of pediatric trauma nurses to the closest hospital, and they obtained privileges for one its trauma surgeons to operate there in case any trauma cases came up.

"We also deployed four nurses and one or two docs to our other ED" in Spectrum Health's Bladgett facility, adds Roode. "We sent four nursing staff and one physician and midlevel tech to help manage the surge over there, with us being closed." The Bladgett ED is only about one-third the size of the Butterworth ED. ■

Mobile units let ED reopen after flood

Vendor staff train providers on use of new equipment

When a flash flood hit Columbus, IN, in June, Columbus Regional Hospital had to be evacuated. But just two weeks later, the ED was able to reopen, thanks to a mobile unit called the Carolinas MED (Mobile Emergency Department)-1, which was first deployed in New Orleans in the wake of Hurricane Katrina.

The "unit" is actually two 53-foot tractor trailers. One is a support unit, which contains all the necessary supplies, including 72 hours worth of medications, general medical equipment, and its own fuel supply. **(For more information, see resource box, p. 91.)** The medical unit itself includes:

- 1,000 square feet of workspace;
- eight ED beds;
- two OR beds;
- four critical care beds;
- an attached drop tent that can create space for another 250 beds in the event of mass casualties;
- cardiac monitors;
- point-of-care testing for labs;
- portable, digital X-ray capabilities;
- a portable ultrasound machine.

Thomas A. Sonderman, MD, an ED physician, vice president and chief medical officer at Columbus Regional Hospital, says, "I learned about this unit from an employee who stood up in the very first employee

Executive Summary

When Columbus (IN) Regional Hospital flooded, staff continued to offer emergency services through a mobile unit named the Carolinas Mobile Emergency Department (MED)-1. To take advantage of this and other similar options as quickly and smoothly as possible:

- Have contact information handy for the various governmental agencies whose approval will be required.
- Discuss with the provider of the mobile service the type of equipment you have in your ED, so that staff orientation will be conducted properly.
- Recommend to administration that in such situations, the entire staff should be kept on salary, to ensure full staffing of the mobile unit.

update session on June 13. I took out my smartphone, searched the Internet, and within minutes I was talking to the administrator who manages the deployment."

The unit was deployed on June 23 and remained on site until early July. The hospital held a press conference to let the community know about the unit. During the period the unit was open, the ED saw between 60 and 70 patients a day, or about two-thirds of its normal patient load. He describes the unit as "pretty slick" and said the clinical sophistication of the equipment was a significant advantage. "I'd give it a 10 out of 10," says Sonderman.

The deployment was made relatively simple because of the staff Sonderman had available, says **Tom Blackwell**, MD, medical director for the Center for Pre-Hospital Medicine, Department of Emergency Medicine at Carolinas Medical Center, Charlotte, NC, and one of the two physicians who spearheaded the development of the mobile unit.

"The hospital CEO kept all his employees on the payroll, so the ED docs, nurses, X-ray techs, and pharmacists all worked in MED-1," he says. "We just provided oversight staff: two doctors, two nurses, and one paramedic." ■

Sources/Resources

For more information on using a mobile ED, contact:

- **Tom Blackwell,** MD, Medical Director, Center for Pre-Hospital Medicine, Department of Emergency Medicine, Carolinas Medical Center, Charlotte, NC. Phone: (704) 355-8660. E-mail: Tom.blackwell@carolinashealthcare.org.
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For more information about mobile and temporary emergency units, contact:

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- **MACH-1** (Mobile Emergency Trauma Department), Hackensack (NJ) University Medical Center. Phone: (201) 996-2000. Web: www.humed.com.

ED staff trained on new equipment

In the wake of a flash flood in June that forced the closing of Columbus (IN) Regional Hospital, the ED reopened about two weeks later in a mobile unit called the Carolinas Mobile Emergency Department-1 (MED-1). To be able to operate efficiently in that new space, the ED staff had to receive a day's training and orientation from an oversight staff of two doctors, two nurses, and one paramedic who arrived with the unit.

"The ED staff knew a lot about our cardiovascular monitor because they used the same equipment, but we had to teach them how to use the X-ray equipment and the lab equipment because they used different machines, and they also had to learn about point-of-care testing," explains **Tom Blackwell**, MD, medical director for the Center for Pre-Hospital Medicine, Department of Emergency Medicine, at Carolinas Medical Center, Charlotte, NC, and one of the two physicians who spearheaded the development of the mobile unit.

In reality, the training was ongoing as new crews rotated in, adds **Thomas A. Sonderman**, MD, an ED physician, vice president and chief medical officer at Columbus Regional.

Once the staff were trained, they saw turnaround times they had never seen before, Blackwell recalls.

The efficacy of the unit was demonstrated immediately after it opened; the first patient was an elderly man who went into cardiac arrest. "He had to have his airway managed and receive ventilator support and resuscitation, after which he was 'air-vacked' to a critical care unit," says Sonderman. "Right away, we saw we could resuscitate somebody in this place." ■

Mobile unit can be available quickly

When an ED is forced to close due to a disaster and requests delivery of a mobile unit called the Carolinas Mobile Emergency Department-1 (MED-1), "we like to think we can be mobile in 72 hours," says **Tom Blackwell**, MD, medical director for the Center for Pre-Hospital Medicine, Department of Emergency Medicine, at Carolinas Medical Center, Charlotte, NC, and one of the two physicians who spearheaded the development of the mobile unit.

Paperwork is the only limiting factor, he says. For example, when administrators at Columbus (IN)

Regional Hospital called to make the request, they were directed to their state Emergency Management Agency (EMA) to request a contract. "They filled out a request form, the governor's office took the request, they send it to the Department of Health and Human Services in Washington, DC, who then forwarded it to the North Carolina EMA, who then called us," recalls Blackwell. "Within five days it was done, which is actually lighting speed." All the while, he adds, his team was "ramping up" the mobile unit — for example, loading it with enough pharmaceuticals for 72 hours.

The good news is this convoluted process means the ED will not have to bear the cost of the unit, Blackwell says. "When a site has been declared a disaster area by the president, this opens doors for resources," he explains. "The state of Indiana will pay us, and they will then get reimbursed by FEMA." ■

Is 'the ED was just too crowded' ever a defense?

Strategy is likely to backfire

Crowding is increasingly becoming a factor in litigation involving ED care and is putting nurses and physicians at increased risk for being named in a lawsuit.

"I expect that there will be more lawsuits involving adverse outcomes in a crowded situation," says **Robert Shesser**, MD, professor and chair of the Department of Emergency Medicine at George Washington University Medical Center in Washington, DC. "Because the hospital system is so broken, your exposure to medical legal risk goes up."

There is no question that patient outcomes are adversely affected by delays in assessment and treatment caused by ED overcrowding, according to **Jeffrey Freeman**, MD, clinical assistant professor in the Department of Emergency Medicine at University of Michigan Health System in Ann Arbor. "Overcrowding directly causes errors due to understaffing relative to workload," Freeman says. "It also causes patient dissatisfaction, which leads to increased perception of negligence if damages occur."

Also, long wait times increase the number of patients who leave prior to completing their emergency evaluation. This is a group of patients at high risk for bad outcomes, says Freeman.

When inpatients are boarded in the ED, significant and sometimes fatal delays can occur, warns **Sandra Schneider**, MD, professor of emergency medicine at University of Rochester (NY). Patients often are on complicated inpatient medical protocols that are unfamiliar to the ED nurses, which may lead to errors. "It is actually remarkable how rare those errors are. It is a testament to the nurses who staff the ED," says Schneider.

Freeman points to an ominous sign: Attorneys are beginning to advertise for clients to call them if ED wait times are long and are publishing articles about long ED wait times on their web sites. "It is inevitable that overcrowding will lead directly to bad outcomes and increasing medical malpractice claims," he says.

Juries probably won't sympathize

Jurors are unlikely to look closely at the underlying issues involving ED crowding, and instead, usually are focused on the individual who is suing.

"After Hurricane Katrina, we learned a lot about how the public views care in a disaster," says Schneider. "While the medical profession understood the decisions made, such as euthanasia during the disaster, the public clearly did not. If they don't understand that standard of care is compromised in a disaster, how would they understand it in a crowded ED, even if we are in a disaster mode each and every day?"

There is nothing stopping a defense attorney from pointing out that a waiting room was flooded with critically ill patients, to explain why a patient's care was delayed. But would this get the ED physician off the hook, or make things worse? "In my opinion, most juries would not consider overcrowding sympathetically," says Freeman. "They would likely blame the inefficiencies back on the doctor and the system for not correcting the problem before the event occurred, despite the inability of either to make a significant impact in most cases."

Even if a particular nurse or physician was seen as sympathetic and not liable for a patient's adverse outcome because the ED was simply too crowded, this would likely be offset by the same jury placing an equal blame on the facility for not coping with the problem before the event, says Freeman. "I wouldn't recommend that a defense attorney try this appeal. It reminds me of asking a judge to forgive a traffic violation because of icy road conditions," says Freeman. "Their response is inevitably that a driver is responsible for adjusting his operations to meet the conditions, even if they are outside of his control."

It may be true that the number of patients in your ED was a factor in the plaintiff's outcome, but it's not necessarily information you should share with a jury. **Frank Peacock**, MD, vice chief of emergency medicine at The Cleveland Clinic Foundation, says, "I'm not sure it is a good legal strategy to say, 'We saw 50 people that day, and I can only see three at a

time.' I think that hurts your case rather than helps it. I don't know anybody who has successfully used that as a defense."

What the jury will hear is that the ED doctor was too busy to do his job and that the patient paid for it. "You can say to the jury, 'I had three people dying at the same time and I had to make some decisions, and this guy got a little bit ignored.' But I don't think you really want to admit that on the stand, even if it was a fact," says Peacock. ■

Consider these arguments to defend docs, department

When you are faced with more patients than resources, and a lawsuit results, one possible defense argument that would encompass the hospital and the emergency physician is that everyone did everything that could be reasonably expected under bad circumstances.

"In other words, there was more demand than supply," says **Robert Shesser**, MD, professor and chair of the Department of Emergency Medicine at George Washington University Medical Center in Washington, DC. "But in the event that this defense doesn't prevail, the ED physician and their liability carrier might have to participate in settlements and judgments, for things that are really not their fault."

In fact, plaintiff's attorneys may themselves use the strategy of blaming errors on overcrowding, arguing that the state of the ED is evidence of lack of adequate care resources. When **Frank Peacock**, MD, vice chief of emergency medicine at The Cleveland Clinic Foundation Peacock, was sued by an ED patient, the plaintiff's attorney brought up the issue of crowding. "The best part was they didn't know what they were talking about. We pulled up the numbers and said, 'It wasn't too busy. Your patient was seen in six minutes,'" says Peacock. Still, the incident reflects the fact that crowding is coming up more often in ED lawsuits, something that managers will ignore at their own peril.

"Hospitals become targets when they don't do their job. The idea that the ED can be ignored is going to get hospitals in trouble," says Peacock. "The ED has become the barometer for the health of the hospital. The longer ED patients wait, the higher the death rate for some kinds of patients, and that means liability for a hospital."

Because it's impossible to recall if the ED was particularly crowded on a given day, use electronic tracking systems, although this won't fully reflect staffing and space considerations, or stamp ED charts with a code signifying that the waiting room was crowded at that particular time, suggests **Sandra Schneider**, MD, professor of emergency medicine at University of Rochester (NY). "However, in some institutions, all charts every day would be stamped," she says. ■

ED boarding adds to risk

When intensive care unit (ICU) patients are held in ED hallways, this situation poses a serious liability risk.

The ED physician has some liability to care for these tremendously ill patients, "and you are doing so in a unit that is not really designed for ICU patients," says **Robert Shesser**, MD, professor and chair of the Department of Emergency Medicine at George Washington University Medical Center in Washington, DC.

Even though the ED physician has admitted the patient to another physician, that physician isn't physically present to see the patient. Because the patient doesn't leave the ED, the ED physician has some legal responsibility to keep monitoring the patient and to intervene as appropriate. "To my mind, that is really the hospital's liability. The hospital should be indemnifying the ED physician group when they can't get patients to the ICU within a certain period of time," he says. However, that indemnification isn't happening, Shesser acknowledges.

More importantly, patients are put at risk because less than appropriate care is given in an ED hallway. "Even if the ICU physician comes down and rounds on the patient, the ED is not a substitute for an ICU," says Shesser. "And the ED nursing staff is having to worry about these critically ill patients, while still receiving patients by ambulance and so forth."

There are two immediate consequences of overcrowding related to the Emergency Medical Treatment and Labor Act (EMTALA), says **Jeffrey Freeman**, MD, clinical assistant professor in the Department of Emergency Medicine at University of Michigan Health System in Ann Arbor. If a patient is triaged, but suffers delays in care due to overcrowding, then it is possible that the delays could constitute an EMTALA violation for not providing care sufficient to stabilize the patient. In addition, EMTALA states the hospital must provide care "within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition."

"I don't believe that being overcrowded would fall

under not having the staff and facilities available," says Freeman. "But there is increasing likelihood that the threat of EMTALA investigations will coerce hospitals into settling malpractice claims." ■

Could electronic records get your ED sued?

Risk of tools may not yet be known

Increasing numbers of EDs are implementing electronic medical records (EMRs), including computerized physician order entry (CPOE), with the goal of improving patient safety. However, not much is known about the liability risks of these new tools.

"We are still on the steep portion of the learning curve with regard to the medical-legal risks of CPOE," says **Tom Scaletta**, MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL. "It is a relatively new technology, and suits take years to come to fruition."

While electronic systems potentially can prevent errors, automation also can create a false sense of security. "There are no perfect CPOE or electronic charting systems," he warns.

The ideal documentation system is one that adapts to the user, says Scaletta. Your ED's system should offer a template style for past medical history, review of systems, normal exam findings, and diagnoses. It also should offer a free-form style for a description of the present problem, abnormal exam findings, medical decision making, and the treatment plan.

Whether electronic or paper template charting is employed, users should not be pressured to check every box just so the charges can be enhanced. To put a stop to that practice, Scaletta suggests doing an internal coding audit to identify and counsel outliers that might be embellishing charts. "The end result should pass the 'sniff' test," he says. "It is not realistic that a detailed family history has been obtained in every ankle sprain case."

Transition time is high risk

The benefits of CPOE are readily apparent: Handwritten and verbal patient care orders are no longer transcribed, so errors due to illegibility or nonstandard abbreviations are prevented. Additionally, alerts flagging medication interactions, allergy warnings, dosing limits, and order duplication can prevent other common errors.

However, during the initial phases of implementation, systems might not be fully functional, and safety mechanisms might not be put into place until later. For this reason, transition to an electronic system is a high-risk period for your ED. "While robust systems decrease errors on the whole, it can take months or years for systems to be adapted to meet the unique needs of the health care environment," says Scaletta.

In addition, until the system is fine-tuned, there may be a high rate of false-positive alerts. "Ignoring or overriding such alerts where a poor outcome results could be viewed as a more serious error by a jury," he warns. "If drug sensitivities are coded the same as life-threatening allergies, those false alerts get doctors accustomed to dismissing alerts."

. . . During the initial phases of implementation, systems might not be fully functional, and safety mechanisms might not be put into place until later. For this reason, transition to an electronic system is a high-risk period for your ED.

Using a point-and-click method to rapidly choose an order can be fraught with inadvertent selection errors that might go undetected by the person carrying out the order. "Ideally, you should have a smart system that pairs the order with a complaint or finding," says Scaletta. "A low-tech solution is to alternate color coding of lines, like some spreadsheets do."

Initially, all systems will severely slow an ED's operations. To offset this, users should be well trained and EDs overstaffed until the system becomes familiar, he recommends.

Another risk with computerized systems is that physician-nurse communication becomes less active and more passive. "With CPOE, we can get out of the habit of a quick powwow," says Scaletta. "CPOE should not replace person-to-person communication in truly emergent situations. Time-sensitive or unusual treatments ought to invoke a direct physician-nurse conversation."

Scaletta recommends setting up electronic systems to create individualized care plans for some patients. Then, when the patient re-enters the system, the case can be flagged so the clinician is immediately directed to review the care plan. "We do this for any case that the care would be better should the team have a 'heads up,'" he says. This includes patients who failed to obtain follow-up care and reappear in the ED, patients with narcotic dependency, and patients with a history of unpredictable violence.

Processes for late charting and signing should be designed such that there can be no inappropriate alteration of medical records. "There should be the ability to record time-stamped addenda when information comes in later, such as a culture result, and requires modification of the patient treatment plan," says Scaletta. ■

Emergency management given separate chapter

In The Joint Commission's revised standards, rationales and elements of performance for 2009, which will take effect on Jan. 1, 2009, the emergency management standards have, for the first time, been placed in their own chapter. As a Joint Commission spokesperson explained to *ED Management,* there are no new standards for 2009; rather, the new chapters resulted from the reorganization of existing standards.

Despite the fact that it does not include new standards, observers see significance in the creation of a new chapter for emergency management. "The Joint Commission has mandated — and rightly so — that this is a high, high priority," says **Freda Lyon**, RN, BSN, MHA, director of the ED at Tallahassee (FL) Memorial Healthcare.

Lyon believes that this move may encourage facilities to create a new position to oversee all of the hospital's emergency management activities (which her hospital already has), and she thinks this is a good idea. "I will tell you that we are light years ahead because we have someone who can be thinking only about disaster preparedness, mitigation, and recovery," she says.

The person who holds this position at her facility has background as a paramedic and a respiratory therapist, which raises the question of whether an ED manager could (or should) aspire to such a position. "I would say in a facility that has a fairly large volume ED, say 40,000 patients or more a year, it is not a good idea to have the ED manager do [both jobs]," says Lyon.

Other considerations come into play, says **John L. Hick**, MD, medical director of emergency preparedness at Hennepin County Medical Center, Minneapolis, "I agree this will prompt hospitals to create one position, because this takes a lot of time and dedication. But this would only be appropriate for ED managers who have the interest and the background; I do *not* see this as necessarily being a natural move for an ED manager," he says.

The changes are part of The Joint Commission's Standards Improvement Initiative, launched in 2006, which focuses on clarifying standards language. The 2009 standards are available online at www.jointcommission.org/Standards/SII/sii_hap.htm. ■

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity with the **September** 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. ■

CNE/CME objectives

1. **Apply** new information about various approaches to ED management.
2. **Discuss** how developments in the regulatory arena apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■

CNE/CME *questions*

25. According to Michael J. Williams, MPH, HAS, the proposed new regulation by CMS concerning community call panels have several potential pitfalls, including:
A. possible antitrust violations.
B. the requirement to begin your assessment of "parked" ambulance patients while they are on the stretcher.
C. the requirement for hospitals that have specialized capabilities to accept patient transfers.
D. All of the above

26. According to Jeanne Roode, RN, MSN, CNA, CNRN, the ED went into lockdown following a helicopter crash on the roof because:
A. not enough staff had showed up to treat patients.
B. debris that fell of the roof was endangering patients and visitors.
C. the media and curious onlookers were trying to gain access to the ED.
D. It was impossible to handle the number of patients in the ED.

COMING IN FUTURE MONTHS

- ED to nonemergent patients: Pay up front or go to clinic
- How to make sure patients understand their discharge instructions
- How rude language, inappropriate staff behavior affect quality, safety
- How to avoid long waits for psych patients

27. According to Tom Blackwell, MD, the deployment of the Carolinas MED-1 at Columbus Regional Medical Center was made relatively simple because:
A. there was not a large number of patients needing care.
B. all the ED staff was available to work in the mobile unit.
C. the ED staff knew how to use all the equipment in the mobile unit.
D. the ED manager had used the mobile ED before.

28. According to John Moorhead, MD, which of the measures has actually been endorsed by CMS?
A. Confirmation of endotracheal tube (ETT) placement.
B. Pediatric weight documented in kilograms.
C. Median time from ED arrival to ED departure for discharged ED patients.
D. Left without being seen.

29. According to Peter Angood, MD, which of the new patient safety goals is most difficult for EDs to comply with?
A. Preventing hospital-acquired infections due to MDROs.
B. Preventing central line-associated bloodstream infections.
C. Preventing surgical-site infections.
D. Educating patients about infection control.

30. According to Diana Contino, RN, MBA, FAEN, which of the following strategies can help and ED prepare for a random Joint Commission survey?
A. Team change of shift reports at the bedside.
B. Having charge nurses do unit rounds assessing patients and their risk for falls or pressure ulcers.
C. Assessing the accuracy of patient identification through unit rounds and regular accuracy performance metrics.
D. All of the above

CNE/CME answers:

25. D; 26. C; 27. B; 28. C; 29. A; 30. D.

ED ACCREDITATION UPDATE

Covering Compliance with Joint Commission Standards

Hospital-acquired infections are a major focus of National Patient Safety Goals for 2009

When The Joint Commission announced its National Patient Safety Goals for 2009, it became clear that the recent interest in hospital-acquired infections (HAIs) has only intensified. Among the major changes for 2009 are three new hospital and critical access hospital requirements related to preventing HAIs due to multiple drug-resistant organisms (MDROs), central line-associated bloodstream infections, and surgical site infections.

While noting the difficulty of complying with some of those goals in a busy ED, ED managers nevertheless agree these are important concerns.

"We all play a part in helping to reduce these infections, and ours is an important part," says **Christopher Beach**, MD, vice chair, Department of Emergency Medicine at the Northwestern University Feinberg School of Medicine and Northwestern Memorial Hospital in Evanston, IL.

In truth, he says, the original case of infection is often *not* acquired in the hospital, but the ED sees many of these patients first and must minimize the risk of it spreading to other hospital patients. "When people come in, it's common that they've already been afflicted," Beach says. "Our job is not as much to prevent, but to correctly identify the infection and provide appropriate treatment and management."

A difficult challenge

While recognizing the need to prevent HAIs, **David John**, MD, FACEP, director of the ED at Caritas Carney Hospital in Boston, says it often is difficult in a fast-paced ED to practice optimal infection control measures. For example, when it comes to surgical sites, "It's 'crash'; it's heroic action," he notes. "You may not have five minutes to think about everything when time is of the essence."

Peter Angood, MD, vice president and chief patient safety officer for The Joint Commission, says his organization is well aware of the challenges faced by the ED. "We recognize that of the three areas, [practices to prevent] multiple drug-resistant organisms would be a little difficult to implement within the ED, and we actually debated whether or not to exclude them," he admits. "The ED is a complicated area within the hospital, but these goals are targeted to the hospital in its entirety, so while it will be hard, we felt it was important that it be applicable to the ED." ■

Hand washing is key to stop infection spread

With The Joint Commission's 2009 National Patient Safety Goals focusing on hospital-acquired infections (HAIs), ED managers say the key to compliance remains one of the most basic — but difficult to implement — strategies of all: hand washing.

"Good hand washing and overall good hygiene around the patient must become more a part of everyday practice, but these sorts of simple things are not easy to do in a complex and fast-moving environment," says **Christopher Beach**, MD, vice chair, Department of Emergency Medicine, at the Northwestern University Feinberg School of Medicine and Northwestern Memorial Hospital in Evanston, IL.

Proper ergonomics can help improve compliance, he says. "You should have sinks, soap, and towels

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available and close by in all patient care areas," Beach says. "Also, your people must be made aware of how important it is to have good hand washing practices." His hospital has been holding regular inservices for at least two years, he says.

In addition to good hand washing, says Beach, the ED staff should be taught some common-sense hygiene techniques. "For example, try not to wear the same set of scrubs every day for a week," he says. "When a patient has left a room, wash it down and put in clean linens." These simple techniques, he says, "can have a big impact."

David John, MD, FACEP, director of the ED at Caritas Carney Hospital in Boston, says a more proactive approach is needed. "We put [alcohol gel] dispensers outside each room and outside the ED, and it jogs my memory every once in a while, but until somebody actually watches you to see if you are washing your hands, nobody will change behavior," he insists.

He notes that at a Veterans Affairs facility, one individual designated as the hand washing monitor went to each department and observed staff hand washing behaviors. "They drove the drug-resistant organism infection rate down to zero," says John. ■

Patient involvement, education can help

Involving the patient in their own care, an important component of the National Patient Safety Goals for several years, including 2009, also can be a big help for EDs looking to control hospital-acquired infections (HAIs), says **Christopher Beach**, MD, vice chair, Department of Emergency Medicine, at the Northwestern University Feinberg School of Medicine and Northwestern Memorial Hospital in Evanston, IL. So can education, he adds.

"The ED is a difficult place to address preventive care, because our focus is on emergent conditions," Beach notes. "As medicine involves patient more and more, the public health education in the news media can help them be more engaged in their health care."

However, "the institution needs to make efforts to educate patients on various types of infection control processes," adds **Peter Angood**, vice president and chief patient safety officer for The Joint Commission.

Beach agrees. "We actually have a patient advocacy group through the ED where we meet with real patients twice a year, listen to them, hear what they have to say, and try to address their issues and improve our interactions with them," he says. Fliers posted in the department inform patients of the availability of these patient advocates. "The advocates go and speak with patients in the waiting room and the ED, and they address the patients' concerns and questions," says Beach. ■

Meds reconciliation: Breathe a sigh of relief

After years of lobbying by emergency medicine groups and a summit last fall to take a closer look at the issue, a significant change has been made in the National Patient Safety Goal concerning medication reconciliation for 2009. ED managers welcome the change.

"Now, as long as things do not change dramatically in the ED, you do not have to do an entire medication reconciliation," notes **David John**, MD, FACEP, director of the ED at Caritas Carney Hospital in Boston. In the new goal, the ED is included among the locations where, it is noted, new medications are used "minimally" or "of short duration." While compiling a list of meds still is important, ED providers no longer have to document the dose, route, or frequency of use for the prior meds.

"Anything that involves a tremendous amount of work in the ED, without adequate funding or staff, is counterproductive," John says. He cites the example of an elderly patient. "The meds that person is on should be known and an effort should be made to get that information, but sometimes it's impractical," he notes. "It may be 3 a.m., and the pharmacy is closed and family is not available."

Christopher Beach, MD, vice chair, Department of Emergency Medicine, at the Northwestern University Feinberg School of Medicine and Northwestern Memorial Hospital in Evanston, IL, also is pleased with the new medication reconciliation goal. "I think it's reasonable," he says. ■

Preparation can lead to good survey results

Just because surveys by The Joint Commission are no longer announced, it doesn't mean you can't prepare for them, say ED experts.

"It is optimal to integrate aspects of The Joint Commission regulations into departmental daily and shift rounds," advises **Diana Contino**, RN, MBA,

FAEN, senior manager with Costa Mesa, CA-based BearingPoint, which provides management and technology consulting services. "Teach the charge nurses, clinical managers, and some of the key staff to survey your ED and other areas on a regular basis," she advises.

At St. Jude's Medical Center in Fullerton, CA, "for each of the different areas of standards for environment of care, one person in leadership in our department is responsible for a binder that has all our background information to support all of the different standards," says **Vicki Sweet**, RN, director of emergency services. "Prior to our code JUDE [Joint Commission Unannounced Disruption Event] drills, [we use these forms] to make sure [the ED leaders] are updated." **(See more on JUDE, at right.)**

Contino adds these other tips:

• **SBAR** (Situation-Background-Assessment-Recommendation), "board rounds," and team change-of-shift reports at the bedside are all ways that improve the effectiveness of communication and involve patients in their care. **(For more information on SBAR, see "SBAR Techniques help EDs comply with handoff regs," *ED Accreditation Update*, November 2007, p. 1.)**

Board rounds, Contino explains, usually involve the ED physician, nurses, techs, and registrars, who review what the patients need, what is pending, and what the staff can do to expedite care. They enhance team coordination and communication, she notes.

Change-of-shift reports, Contino says, are conducted at the bedside and involve the nurse, the physician and the patient. "Some off-going physicians introduce the patient to the oncoming physician and review what has been done, what is pending, or what needs to be done, and at that time they give the patient and family the opportunity to ask questions," she says. "This is a big patient satisfier and helps to improve safety and quality."

Having charge nurses, ED staff and staff from other departments trained in observation and the Joint Commission requirements is beneficial for ongoing preparedness.

• Improvement in the accuracy of patient identification can be assessed through unit rounds and accuracy performance metrics — the routine measurement and reporting of errors, delays, omissions, or near misses, putting particular emphasis on improving processes to reduce errors. Use registration accuracy programs, which are setting up a mechanism to check the accuracy of the key elements of the registration process. For example, is the address correct? Was a Medicare conditions of participation form signed? Registration accuracy programs combined with assessments and observation of how staff members are identifying patients help departmental improvement teams identify performance gaps.

• Charge nurses can do unit rounds assessing patients and their risk for falls or pressure ulcers. As they conduct these rounds, they increase discussions and staff awareness, and they actively identify solutions to increase patient safety on a shift-by-shift basis. ■

Preparation pays off for emergency department

In anticipation of unannounced survey visits by The Joint Commission, the ED at St. Jude's Medical Center in Fullerton, CA, created a "Code JUDE," or Joint Commission Unannounced Disruption Event, drill to help it prepare.

"This code would be paged to all managers, directors, and administrators, and everyone knew exactly what to do," explains **Vicki Sweet**, RN, director of emergency services.

A checklist was created for the drills, which was discussed during every shift. This checklist, which has evolved over time, includes items such as medications, crash carts, emergency drug boxes, patient rooms, confidentiality of information, documentation, open chart review, and infection control. **(See a sample of the checklist, p. 4.)**

"We want staff members to do it the drills to increases their level of awareness," Sweet explains.

As it turns out, the ED was planning a drill on the day of their actual survey. The plan includes "stall tactics," during which the visitors are stopped by security and asked for identification. "Security then calls the administrative resources nurse. She then notifies our quality management department and a global page goes out to all managers," says Sweet. "As soon I got the page, I called our coordinator and said, 'The Joint Commission is coming; get out your lists and get busy."

For the most part, the visit went well because staff had been prepared, Sweet says. She admits that making sure your staff are prepared for those unannounced surveys is not easy.

"You have to treat each day as if The Joint Commission can walk in, and that's easier said than done; it requires a real difficult culture change," she says. "But the more transparent you make the process to your staff, the better off you will be." ■

EMERGENCY DEPARTMENT JOINT COMMISSION/DHS MAINTENANCE SURVEY 2008

Environment of Care
- ❑ Evacuation route signage posted on unit
- ❑ Emergency exit signs lit and operable
- ❑ No equipment or supplies stored in stairwells or near fire doors
- ❑ Fire extinguishers secured, location identified, checked monthly
- ❑ Alarm pull stations visible and accessible
- ❑ Fire doors/linen chutes self close and positively latch
- ❑ **Nothing stored within 18" of sprinkler heads/ceiling**
- ❑ No supplies stored directly on floor
- ❑ No obvious penetrations in walls/ceiling — report to Engineering
- ❑ Equipment stored on one side of hallway only
- ❑ Medical gas shut off valves with distribution labels
- ❑ Oxygen cylinders in holders — not laying / standing on floor
- ❑ Medical equipment with current PM
- ❑ Equipment is clean and in proper working order
- ❑ Chemicals appropriately stored, labeled, and contained
- ❑ Current MSDS available for chemicals in work area
- ❑ Electrical panels locked
- ❑ Non-approved electrical equipment removed from area
- ❑ Housekeeping carts have chemicals locked when unattended
- ❑ **No outdated supplies (blood tubes, dressing kits, tubing, etc.)**

Patient Rooms
- ❑ Bed in lowest position
- ❑ Call bell within patient's reach and in working order
- ❑ Trash bins not overflowing
- ❑ No linen on floors
- ❑ Privacy curtain intact and clean
- ❑ Room clean and orderly
- ❑ Bathroom clean and orderly
- ❑ Call bell in bathroom in working order
- ❑ Medical equipment plugged into electrical outlets
- ❑ Emergency outlets used for critical equipment
- ❑ Patient clean with hygiene needs met
- ❑ No tubes or drains touching the floor
- ❑ Sharps container < ¾ full. Secured in room
- ❑ Waterless hand cleaning gel available
- ❑ Nothing posted on patient doors or rooms that provide protected patient information (i.e., I&O sheets, charge sheets, etc.)
- ❑ **No sharps/meds in ANY drawer in patient area**
- ❑
- ❑
- ❑
- ❑

Medications
- ❑ No medications left on top of counter in med room
- ❑ All medications / syringes labeled
- ❑ Med room is clean and kept in orderly condition
- ❑ No outdated medications in stock, or in refrigerator
- ❑ Only NPH and Regular Insulins stocked on unit
- ❑ Open multi-dose vials clearly labeled with expiration date
- ❑ Pyxis discrepancies resolved
- ❑ Medication refrigerator temp checked per policy and within limits
- ❑ Meds requiring refrigeration stored in refrigerator
- ❑ Internal/external medications stored separately
- ❑ Look-alike/sound-alike drugs stored separately from each other. Warning labels of other identification used

Confidentiality of Information
- ❑ Assignment boards (in public view) do not link name to diagnosis
- ❑ **No patient identifiable information in normal trash**
- ❑ Computers (public view) do not display patient identifiable info.
- ❑ Audio/visual privacy provided in registration areas
- ❑ Registration logs hidden from view or peel-off label system utilized.
- ❑ Charts not left in public view. Names hidden from view
- ❑ Charting areas do not have patient identifiable information in public view
- ❑ **Suspend computers when not in use — don't just minimize**

Documentation — Open Chart Review
- ❑ Pain is documented whenever vital signs are taken (or "no pain" is noted)
- ❑ Reassessments are documented following interventions or medications
- ❑ Hand-off report is documented when primary caregiver changes

Crash Carts / Emergency Drug Boxes
- ❑ Cart clean and kept in orderly condition
- ❑ Earliest expiration date of medications listed on cart (or binder)
- ❑ Supply drawers locked
- ❑ Defibrillator (including paddle wells) clean and in working order
- ❑ Ambu Bag supplies (age appropriate) intact and ready to use
- ❑ Oxygen canister secured — not empty.
- ❑ Portable suction in working order with appropriate supplies
- ❑ Respiratory supplies fully stocked
- ❑ Plugged into red outlet when not in use.
- ❑ No outdated defib or pacer pads on top of cart
- ❑ Checks performed per policy

Infection Control
- ❑ Infection Control Manual on unit
- ❑ No soiled linen bags or trash bags on floor
- ❑ Soiled linen containers covered — not overflowing
- ❑ Nothing stored under sinks
- ❑ Hand washing promotional signage above sinks
- ❑ Negative pressure rooms (if any) with air flow testing validated
- ❑ Clean and soiled storage areas maintained separately
- ❑ Patient food refrigerators clean, temperature maintained, food labeled with date
- ❑ Environment and equipment clean
- ❑ **No torn mattresses or gurney covers**

Name: _____ Date: _____ Shift: _____

- Be sure any deficiencies requiring intervention from Engineering, BioMed, or EVS are reported to Manager for follow-up.
- Any other deficiencies should be corrected when found.

Thank you for helping us sustain our standards throughout the year!

Source: St. Jude Medical Center, Fullerton, CA.