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Health system sets 'zero errors' as its goal for patient safety, quality

Instead of compliance percentages, errors are used as benchmarks

Winners of quality and safety awards often have much in common, but there is something about Eastern Maine Healthcare System in Brewer, recent recipient of The VHA Foundation and National Business Group on Health's Patient Safety Leadership Award, that sets it apart: the way it measures success.

"We've done a few things that have changed our approach, specifically relating to the culture of safety, and also a different way of thinking about our goals for specific projects," says Erik Steele, DO, chief medical officer for the system. "We said that as an organization, our goal was to achieve zero errors in key safety and quality initiatives, rather than having a goal of being better than other organizations or hitting a certain percentage. We have now set getting to zero errors as our default for quality and safety initiatives." If in certain instances it is decided that it is not reasonable to aim for zero errors, he adds, the goal can be changed.

Steele is responsible for the management of systemwide quality and safety initiatives. "We have seven hospitals, each of which has individual programs, but I am responsible for the ones we do in concert," he explains. The name of the systemwide quality and safety project is the Zero Defect Project. "So up front we are stating our goal," says Steele. "We have stopped reporting by percentage, such as the percentage of patients who have been given aspirin or

Key Points

- Small percentage "gaps" can mask large numbers of errors.
- Hard wiring processes can speed up, enhance improvement.
- Use family members as standard for "acceptable" risks.

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a beta blocker for acute myocardial infarction, and instead just report the number of patients who have not. So everyone registers, first, that our goal is zero and, second, the number of patients for whom we did not achieve this goal.”

Creating a plan

The system created a strategic plan in November 2007, with a goal of becoming “the best rural health system in America.” “We asked ourselves what such a system would look like in terms of quality and safety, and I said I think you’d have zero errors,” Steele recalls.

The system leaders identified about 40 initia-

tives based on standards of the Centers for Medicare & Medicaid Services (CMS), the National Quality Forum (NQF), The Leapfrog Group, The Joint Commission, and the Institute for Healthcare Improvement. “These were expert-vetted, bang-for-your buck kinds of things; we evaluated them with a systemwide committee of doctors and nurses and determined the most important ones,” says Steele. “So, to be specific, NQF says every patient admitted should be screened for risk of blood clot, and high-risk patients should get prophylaxis. Our goal is everyone, so we count how many we fail to do.”

When reports are made to the board, a composite number of errors is shown. “Instead of a blizzard of data, the board can follow one big-picture number over time,” Steele explains. “We were pleasantly surprised at the impact it had on our reporting and how it changed how everyone thinks. Setting zero as a goal changes how you think and has a profound impact on what you’re willing to do.

“So, for example, if zero is the goal, as you talk about how to get to the goal, you have a very specific target, instead of something nebulous like ‘We’re trying to be better than,’” Steele continues. “Second, you are much less likely to have discussions where you decide you want to keep educating people forever; you’re much more willing to get into discussions about hard wiring the right thing.”

Hard wiring success

Eastern Maine is installing systemwide computerized physician order entry. “We want 100% of our patients to get a screening for blood clot risk when admitted, so we are hard wiring into admission status that you must assign a risk category,” Steele explains. “If you don’t do that, you can’t complete the admission process.”

To help reinforce the “zero defect” attitude among the staff, says Steele, the “Your Mamma” rule is used. “Anything you’d be willing to do to protect your mother from harm, you have to be willing to do for all patients,” he explains. “When we have discussions about quality and safety, we challenge ourselves; would any of us accept the possibility of this error for a parent, daughter, or spouse? If the answer is no, then it’s not acceptable for any of our patients. That’s really hard, but it’s a very effective check on our tolerance or systems of care that allow errors, and works hand in hand with zero defects.”

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Editorial Questions

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System uses ‘pyramid’ to perfection’

Eastern Maine Healthcare System in Brewer, recent recipient of The VHA Foundation and National Business Group on Health’s Patient Safety Leadership Award, pursues its “zero defect” goal by employing various steps in a quality pyramid. (**See pyramid, page 40.**)

“We have said that education is dead as a principal tool for improving performance; it won’t get you much past 60%,” explains **Erik Steele**, DO, chief medical officer for the system. “The next phase is data feedback; you get maybe another 20% bump. Then come reminders and queuing.”

At Eastern Maine, for example, the staff wear buttons that say, “Remind me to wash my hands.” “There are also little pop-up box reminders on the computer, saying ‘Did you remember?’” adds Steele. “There are signs on the doors, asking, for example, if the staff member remembered to put on gloves. Order sets fall into this category as well. That gets you another 5%-10%.”

Phase IV is initial hard wiring. “We make pre-printed order sets mandatory — so, for example, if you want to admit a person with congestive heart failure, you have to use the order set,” says Steele.

“We hardwire reminders into the EMR system with pop-ups you can’t shut off. We have double-checks for high-risk procedures; for example, two nurses must validate right patient and right blood type. The universal checklist for surgery is hard wired for right patient, extremity, and so on. That gets you another 4%-5% bump.”

Phase V, he continues, is the final go/no-go. “For example, the surgeon cannot have a scalpel to start surgery until the checklist is done. For high-risk medications, we now just take them off the formulary,” says Steele.

“That’s how you get up to 98%-99% performance,” he explains. “The rest is where the culture of safety becomes so important. We think it’s now possible to say, ‘We want this level of performance in this period of time using this methodology.’ We achieve the desired perfection in the desired period of time by rapidly going up this pyramid.” ■

What’s more, he continues, percentages can be deceiving. “As soon as you move out of percentages to errors, you find you’re making a lot more than you thought because you had such a small percentage,” he notes. “If you admit 20,000 patients and screen 95% for risk, you are at the top of the curve, missing on only 5%. But 5% is 1,000 patients not screened for the most common cause of an unanticipated death in U.S. hospitals — a blot clot that travels to the lungs. Any time you do something a lot, you can have a very good percentage of doing the right thing — but would it be OK if your mother was one of those 1,000?”

Hard wiring, Steele adds, also can be used to engender rapid change. “So, for example, CMS has said recently that if you’re going to prescribe vancomycin to a hospital patient, you must provide documentation as to why you use it, since it is one of the few remaining antibiotics that is effective against MRSA [methicillin-resistant *Staphylococcus aureus*]; if resistance were to develop, that would be devastating. So, we said it was very important to achieve change quickly.”

In a more traditional model, he notes, you would educate staff and then feed data back. “It

takes about 10-15 years to really achieve a high level of performance that way,” he observes. “We simply said that as of a certain day you can’t order this medication without providing a reason. It’s easier to do this in an EMR [electronic medical record] environment, but you can do it in a paper environment as well.”

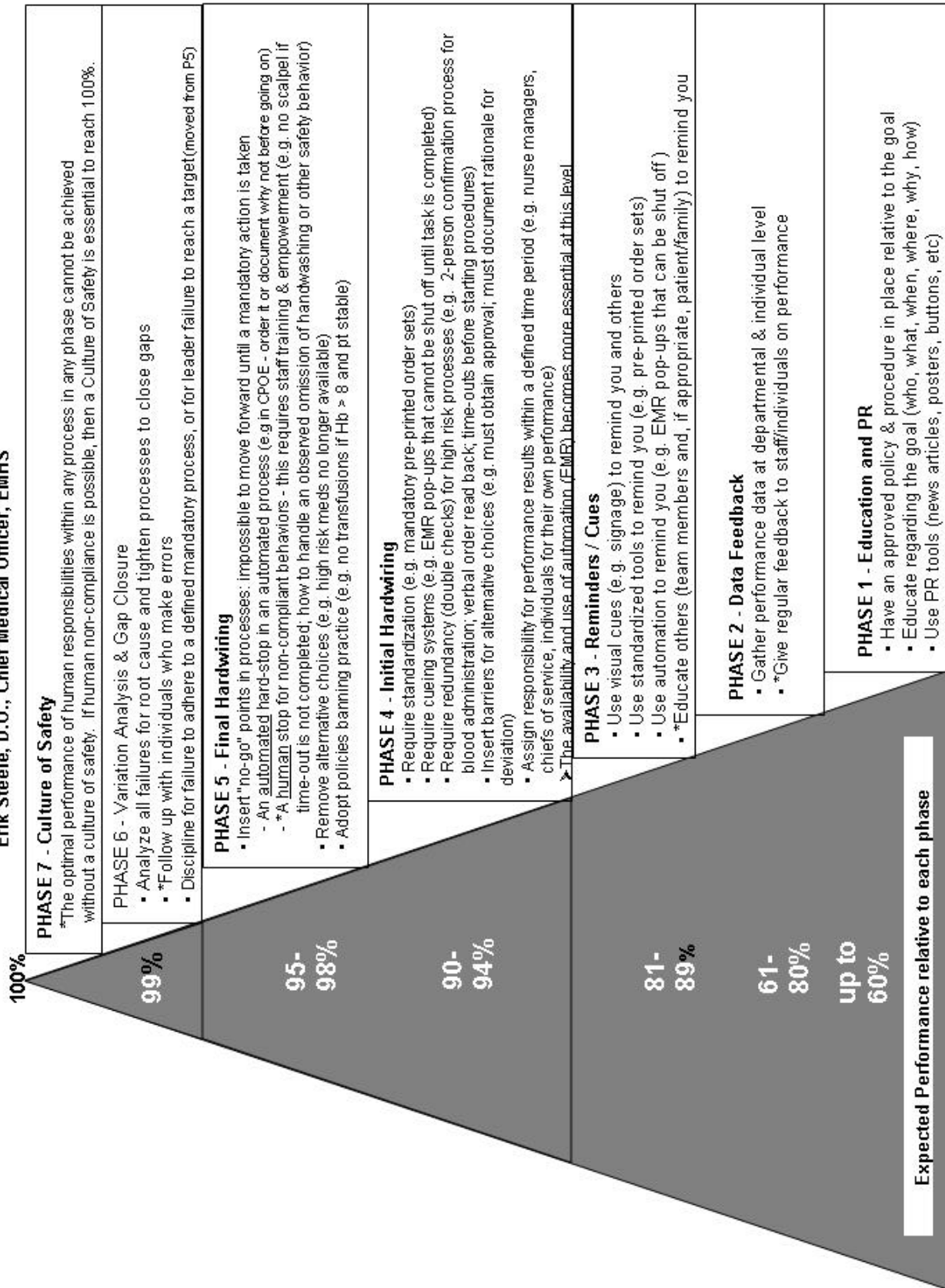
Change on the hospital level

Vicki Loughery, RN, BSN, MS, chief nursing officer at Seabrook Valley Hospital, part of the Eastern Maine system, explains how these initiatives translate into change on the hospital level. “Erik will bring forth at a CCC [the systemwide clinical coordinating committee] meeting a new best practice or initiative and ask everyone if this is something we want to be involved in; we all vote as a group,” she shares. “He generally provides some of the beginning information, we discuss it as a group, come up with a plan of where we want to go, and set the benchmark. Then, each hospital has a quality team within its own organization. We bring it back there and come up with a

(Continued on page 41)

Conceptual Framework for Progressive Performance Improvement Strategies

Erik Steele, D.O., Chief Medical Officer, EMHS



Source: Eastern Maine Healthcare System.

(Continued from page 39)

plan on how to roll it out and get education to everybody.”

Every hospital, she continues, has a quality web page, and each is in the same format. “This way, we all look at and do the same things, and we try to measure the same way,” Loughery explains. “Being an affiliate, we are a small community hospital, but patients will go back and forth between us and the tertiary hospital, and they need to see we provide the same quality care, speak the same language, and that the same things are important to all of us.”

She describes her hospital’s participation in the venous thromboembolism initiative. “The very first thing we asked was how we could hard wire this,” says Loughery. “The problem is that at present we have all different levels of connectivity to the EMR in the system; we don’t have it yet. So, for example, at Eastern Maine they can set things up so a physician can’t go to the next question unless he takes a certain action, but we can’t do that.” So her facility developed an order set to achieve the same goal.

“We have our own zero defect team here, which includes the director of quality, vice president of medical affairs, nursing directors for various departments, and a clinical nurse consultant, and we meet every Tuesday morning to look at every initiative,” Loughery continues. “We look at any gaps that exist and discuss how we can fill them. A lot of our doctors were ordering prophylactic Coumadin, Heparin, or Lovenox but not assessing the patient’s risk, so we were not sure if they were getting the proper med at the proper risk level.”

That’s where the order set came in. “We redeveloped our order set so you had to do an assessment first and assign a high-, medium-, or low-risk level, and we developed appropriate dosing for each level. This made it easy for the doctor to follow the flow.”

Unfortunately, this was not a perfect system, because some doctors still skipped over the step. “This is where we had to use people as gatekeepers,” says Loughery. “As soon as the doctor turned in the chart, they were either chased down the hall or, after we gave them time get to the office, we would call and note that they had not completed the form. We’d tell them, ‘I’ll fax it to you; I can’t give the patient meds until you fill it out.’”

Every week Loughery runs a report telling her which patients did not get a risk assessment done. “If it is an end-of-life situation, or if they are on a

therapeutic dosage, you can put those two on to indicate a reason why it was not done,” she notes. This initiative was started in October 2009; in that month, there were 19 charts on which the assessment was not done; in November there were 18, in December 16, and by January it was down to 11. “I hope in February we’ll be at five, and by March, which will be the six-month point, we should be at zero,” says Loughery.

Loughery says that for some indicators her facility is already at zero, while some others will never be. “For some, if we said we were at zero we’d be lying,” she notes, “But we do all that we can. For example, hand washing has got to be the hardest. For January we were at 95.8% with 504 observations monitored. But, we had started at about 50%.”

All medical data are reported “unblinded,” notes Loughery, so that it can be determined which staff member is not following a given process. “We immediately pull them aside — myself or another nurse or physician,” she notes. “We have made it a comfortable culture for everyone; we’re not punitive, but educative. I would say, ‘Did you realize that just now you didn’t wash your hands? What can we do to make this entrance to the room safer? Do we need to move the Purell dispenser, or couldn’t you see the sign?’”

“We try to set expectations at very specific levels at a certain period of time, moving up the quality ‘pyramid’ in progressive hard wiring,” adds Steele. “We try to spend less and less time educating and more time using the tools and methods we know will work.” (For more on the quality pyramid, see story on page 39.)

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TJC report shows quality continues to improve

Some measures still show room for improvement

There was mostly good news for quality professionals in The Joint Commission’s latest annual report on quality and patient safety. For

example, between 2002 and 2008, compliance with the quality measures improved to 96.7% from 86.9% for heart attack care; 91.6% from 59.7% for heart failure care; and 92.9% from 72.3% for pneumonia care. In addition, hospitals showed steady improvement on surgical care measures, and more than 99% achieved the asthma care measures. From a global perspective, 90% of American hospitals achieved greater than 90% performance on eight of 28 measures tracked during 2008. In addition, these latest figures continue a year-over-year improvement pattern, which becomes increasingly difficult the higher the compliance rate achieved in the previous year.

The report looks at performance by accredited hospitals on 31 care measures for heart attack, heart failure, pneumonia, surgery and children's asthma.

"What's gratifying is that we continue to see improvement," says **Jerod Loeb**, PhD, executive vice president of The Joint Commission's division of quality measurement and research. "We see excellent performance on the part of a lot of hospitals — particularly with those [measures] that do connect to salutary effects on health outcomes. We felt this was significant because what we're trying to do, to the extent possible, is create highly reliable care, and with performance at the 90% level, the fact that most, if not all, patients are receiving evidence-based treatment is important to care quality."

What does he think makes it possible for hospitals that are already at a high level of quality to continue to improve? "A relentless focus on processes of care we know are linked to good outcomes," Loeb replies. "Most of these measures are related to specific processes of care, specific medications, prophylactic antibiotics, or timing issues. [Improvement occurs when] all of these are areas of focus, reminder systems and checklists are created, and you have an infrastructure where all processes are related."

When the curve "flattens out," he notes, it does become a bit harder to achieve perfection. "If you look at performance in the years immediately following the start of public reporting in 2002, the slope of improvement was large, which was

Key Points

- Cardiac, pneumonia care see significant boosts in compliance rates.
- Highly reliable care is a major goal of The Joint Commission.
- When curve "flattens out," other areas of focus should be considered.

probably not a surprise," he continues. "Part of the answer [for why improvement has continued] is that hospitals realize it is not just these processes but others that may not be reported as much as these that are important."

Does only what's measured improve?

Loeb's comments raise an interesting point: Are hospitals improving only in those areas that are reported publicly, linked to accreditation, or to pay-for-performance models? "All of the above," says **Patrice L. Spath** of Brown Spath Associates, Forest Grove, OR. "If you look at it from the government's standpoint, you want to get the biggest bang for your buck, so they tend to pick high-volume, high-cost diagnoses, but as a consumer, if I do not have [one of those conditions] does that mean I don't also deserve high-quality care?"

There are two different ways of looking at care choices, she continues. "During the health care reform debate, some were looking at population-based thinking while others used individual-based thinking, which led to the 'death panel' comments. On an individual basis you would not like it if someone decided it was not worth \$20,000 to give you a pill to extend your life for one year. But if we look at it from a population-based standpoint, can we afford that extra year for more people and not afford to vaccinate our kids? Medicare, for example, operates from a population-based focus on right diagnoses to improve quality; but as an individual, if I have pancreatitis, I should still get high-quality care."

"To some extent I worry about the same thing, because what gets measured gets improved,"

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concedes Loeb. “But we know that these particular measures represent not only things hospitals should do, but also the bread and butter of American acute care.”

Loeb continues: “Because of the importance of some of these measures in terms of incentives, pay for performance, public reporting, and so on, there is a focus, in part, at least because there is an incentive payment linked to it. The point is well taken that there are a lot of other areas where we know there is variability of care and where that care can be improved.”

On the other hand, he notes, “It is also a very fair statement that these measures we focus on have the greatest potential for mortality, which is the other piece of the puzzle.”

Part of the challenge in addressing even more measures, Loeb notes, is that “this places a fairly significant burden on the hospital in terms of data collection; if we all had [a national] electronic health record, we might be able to do a lot more.”

Speaking of data collection, Spath notes that this may also play a role in some of the improvement found in the report. “Some of this could be reflecting improved documentation of the care actually provided; there’s no way to tell,” she offers. “For example, smoking cessation counseling may have been occurring in the past, and now people are documenting that so they can capture that piece of information. However, things like giving certain medication do not reflect documentation; either it is given or it isn’t.”

Check your data

While there are a number of best practices that can be adopted to institute and maintain improvement, Spath warns that the adoption of best practices in and of itself will not guarantee that improvement. “The Joint Commission and others have shared best practices with us that helped improve the numbers, but you need to focus on how your hospital did better,” she notes. “First of all, best practices tend to improve performance when viewed as a team activity, with everyone needing to be involved instead of just delegating responsibility to a case manager or quality director. Then, one of the most important lessons to learn from these improvements in quality is for people to step back and say, ‘What worked and what didn’t? Did it work to hire a nurse to audit charts and get things done? Is that

what contributed to the improvement?’ If it did, the next thing we want to improve we should use the same model. But if we did that but the doctors did not change practices, then we have to change the model.”

Spath continues: “The biggest indicator of success was when people viewed improved performance as everyone’s responsibility and looked at how they could change the system to ensure patients got the care they needed — and did it in a collaborative way.”

What if your performance is already very high in a number of key areas? How can you continue to improve? “In industrial quality control, they would say the energy it takes to get from 95% to 100% is so much greater that you’re better off using that energy to tackle another problem,” notes Spath. “I’m not sure that’s acceptable from the standpoint of CMS or The Joint Commission. In other industries, when you reach a tolerable level of quality, you do not try to go beyond that but rather move on to improve other areas. The hospital board should probably be involved in deciding at what point you are going to be satisfied.”

Loeb notes that hospitals wishing to improve can learn from high performers. “If a hospital wanted to do better, they could go to sites like our Quality Check and learn which hospitals, for example, excel in terms of prophylactic antibiotics, and see how they handle that,” he suggests. “Plus, one thing we’re doing in 2010 is becoming engaged in a process through which we hope to build a solutions database — identify those particular high performers and have them populate a database that will be searchable. With this database, hospitals that are not doing well would be able to match themselves to those that are doing well, see what they’ve done, and implement it in their institution.”

However, he cautions, it may not be as simple as that. “If hospital A has done X and gotten good results, hospital B can’t simply implement X and assume they will get the same results,” he explains. “That’s something [Joint Commission President] Mark Chassin has been emphasizing. We need to understand that a solution put into place in one institution to solve a problem does not necessarily indicate a one-size-fits-all solution. The problem may be the same, but the way in which it manifested in one hospital may be entirely different. There could have been a whole bunch of root causes, so the solutions for the two hospitals could be really different.” ■

Research looks at children in the ED

Guidelines call for coordination

Recognizing and re-emphasizing the fact that children are a distinct population of patients in the ED, the American Academy of Pediatrics, the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA) have released a joint policy statement that includes guidelines for the care of children in emergency departments. The statement was published online in the journal *Pediatrics*.¹

“We wanted to draw attention to the role that children play in the overall scheme of the ED,” says **Alfred Sacchetti**, MD, FACEP, chief of emergency services at Our Lady of Lourdes Medical Center, Camden, NJ; a spokesman for ACEP; and a member of the committee that developed the guidelines. “The Centers for Medicare & Medicaid Services, The Joint Commission, and others have been establishing sets of standards for adult patients, and part of this effort was to say that we also want to have the same attention focused on the children — in other words, don’t let the kids get lost in the overall avalanches of protocols being launched by other organizations.”

The guidelines should be particularly helpful for EDs in community hospitals, adds **AnnMarie Papa**, MSN, RN, CEN, FAEN, president-elect of ENA for 2010. “When you think about pediatric care, most children’s care for emergencies is done in community emergency facilities,” Papa says. In light of the fact that the Institute of Medicine has called care of children “uneven,” “We wanted to address that,” she says. “Hopefully our statement provides a good overview about what a basic community hospital needs.”

Well-known children’s hospitals in major metropolitan areas might not need these guidelines as much, “but most children in the country do not get their care there,” Papa says.

Creating new positions

While the guidelines do not hold many surprises, one of the more creative proposals involves the establishment of two new positions in the ED: a physician coordinator and a nurse coordinator. “This allows you to say that this is

Key Points

- Groups come together to create guidelines for pediatric population in EDs.
- One of the more creative proposals involves the establishment of two new positions in the ED: a physician coordinator and a nurse coordinator.
- The medical director, nursing director should be hospitalwide liaisons.

the one person in the department who will have an area of interest in the care of kids,” Sacchetti explains.

The physician coordinator should be chosen by the ED medical director, and the nursing coordinator should be selected by the nurse manager, he says. However, Papa takes a different approach. “I see both the physician coordinator and nurse coordinator being appointed jointly by the medical director and nursing director,” she says. “In my experience, I worked collaboratively with the medical director.”

The selection process should not be a difficult one, Sacchetti says. “It’s almost a natural choice in any department,” he explains. “In any ED, you have someone who’s really into cardiology, or toxicology, and the same is true for pediatrics.”

They might not have done fellowships in the area, says Sacchetti, but they will have demonstrated an interest in pediatrics. “You will almost always have someone who follows the pediatrics literature a little more closely than anyone else,” he observes. “They come to doctors’ meetings, or nurses’ meetings, and say, ‘Did you know that they changed the definition of ‘X,’ or there’s a new drug for ‘Y?’” The bottom line, he says, is that “you should take advantage of that one individual in your department.” **(Your entire staff should meet certain core competencies when it comes to pediatric care. See the story on page. 45.)**

The medical director and nursing director should not only understand pediatrics, but they also should have great communication skills, Papa says. “That’s because they have to be the liaison to the rest of the hospital, so that surgery, respiratory therapy, and other departments understand the unique needs of the child,” she says. In other words, Papa envisions those people facilitating hospitalwide programs.

Sacchetti says, “They would certainly be responsible for ongoing performance improvement activities that address pediatrics.” To

address the joint guideline that covers support services for the ED, the ED manager, nurse coordinator, or physician coordinator — or all three — will need to sit down, for example, with radiology managers to discuss implementation of the recommendations, he says.

The coordinators also should be responsible for the pediatric aspects of surge management and disaster planning, says Papa. “It’s much more difficult than it is for adults, especially if they are separated from their parents,” she explains.

Does the creation of these new positions require additional staffing? “There could be a number of ways to do it, depending on your budget,” says Papa. “Most people will identify someone in the department who has those skills and then take them off the clinical side for a certain number of hours.”

Depending on the ED’s volume, “that could be anywhere from 20% to 40% of the time that the person would be doing administrative work,” she says. For the nursing coordinator, most often that time would be spent doing data collection, while the doctors would be spending more time on analysis, Papa says.

Reference

1. American Academy of Pediatrics Committee on Pediatric Emergency Medicine, American College of Emergency Physicians Pediatric Committee, Emergency Nurses Association Pediatric Committee. Joint Policy Statement — Guidelines for Care of Children in the Emergency Department. Accessed at www.pediatrics.org/cgi/doi/10.1542/peds.2009-1807. ■

Staff competencies are a key concern

Joint guidelines from the American Academy of Pediatrics, the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA) cover several major areas including staff competencies; improving patient safety; policies, procedures, and protocols; transfer agreements; support services; and equipment, supplies, and medications.

Satisfying nearly all of these guidelines requires an ED staff that is competent in the specialized care children need. What core competencies should be required? “The ED manager has to work in cooperation with the pediatric coordina-

tors to identify them,” says **AnnMarie Papa**, MSN, RN, CEN, FAEN, president-elect of ENA for 2010. “Typically, what you do when you develop competencies is you look at things like the population base, as well as the types of injuries that are common in your area, since they’re all different.”

However, there are some common considerations that must be taken into account, Papa says. “No. 1 is safety,” she says. “That includes airway management, and recognizing a child is sick before they start getting sicker, because kids can go downhill real fast.”

For nurses, there are some important certifications, such as pediatric advanced life support (PALS), Papa says. “Also, ENA has an emergency nursing pediatrics course, or ENPC, that nurses have to take every four years,” she says. “It covers airway management, identifying burns, resuscitation, dehydration, and sepsis.” Any nurse that cares for a child should have this course, Papa says. “Some think PALS is enough, but that only addresses airway management,” she adds.

In addition, she says, it’s important to have the ability to bond with parents and to listen to them. “If a parent says their kid is sick, then they are sick until proved otherwise — and you have to have people who are sensitive to that,” Papa says. “You need to partner with them and trust the parent to tell you what has worked in the past, say, for Tommy’s asthma.”

There is no substitute for this relationship with the parents, she emphasizes. “You can have every certification, have every piece of equipment you need, and be a top clinical nurse, but if you can’t develop trust and bond with the parents in the first two minutes, it’ll be all downhill,” Papa warns.

The pediatrics coordinator should handle all of the competency training or train the trainers, she says. “That gives nurses in the department to opportunity to grow,” Papa says. The coordinator also should handle competency evaluations, she adds.

It’s important when training your staff to advise them against becoming intimidated by caring for children, notes **Alfred Sacchetti**, MD, FACEP, chief of emergency services at Our Lady of Lourdes Medical Center, Camden, NJ; a spokesman for the American College of Emergency Physicians (ACEP); and a member of the committee that developed the guidelines. “Overall, we tend to underestimate the quality [of care we provide], and as a result, these people

tend to be intimidated by children when they shouldn't be," he says. "Once you become intimidated, you basically back away from doing the right thing, and inappropriate intimidation in itself may lead to suboptimal care." ■

Lack of adherence in heart failure therapy

Educate and monitor to improve results

When research suggests changes in standard medical practice, the public health community expects physicians and hospitals to adopt the new way and help improve patient outcomes.

But occasionally, as one study recently found, the medical community is very slow in adopting new treatment recommendations.

A good example of this is what has happened with hospitalized heart failure patients who are eligible for aldosterone antagonist therapy, according to a large database study, published in the *Journal of the American Medical Association* late last year.¹

The study found more than 12,000 patients who were eligible for this therapy, which research has shown would have improved their health outcomes. But only about one-third of these patients had received the therapy, which was recommended in several national guidelines.¹

The research was limited by what physicians had documented with regard to contraindications, says **Nancy M. Albert**, PhD, CCNS, CCRN, NE-BC, FAHA, FCCM, director of nursing research and innovation in the Nursing Institute, and a clinical nurse specialist at the Kaufman Center for Heart Failure in Cleveland.

"Maybe a patient had a contraindication, and the doctor knew it but didn't document it," Albert says. "If they didn't document a contraindication with therapy, we would assume the patient was eligible to receive therapy."

The analysis began in January 2005, and continued through December 2007, and there was a steady trend from baseline of improvement in the guideline-recommended use of aldosterone antagonist therapy from 28%, when the study began, to 34% when it ended, Albert says.

"The American Heart Association and

American Cardiology Association gave their stamp of approval for using aldosterone in patients in 2005," Albert says.

So investigators expected to see increased use of aldosterone antagonist therapy after the guidelines were updated. But they were surprised it was only a small increase, she adds.

This lackluster response to changing to using aldosterone antagonist therapy might have been due partly to a small discrepancy in how the guidelines were worded in 2005, Albert says.

"The guidelines should have said the treatment was recommended, but instead said it was reasonable to use an aldosterone antagonist, and that doesn't have as strong a connotation," she explains.

Although a correction was published in 2006, it's possible that many physicians didn't see the correction, she adds.

Also, none of the national performance measures for hospitalized heart failure patients include aldosterone antagonist therapy as a core measure yet, Albert notes.

"It could be that hospitals were so focused on doing what they had to do based on The Joint Commission's performance measures and other expectations that they didn't take the next step of doing what was right based on the guidelines," she says.

Another factor is that one aldosterone antagonist is a generic drug that has been available as a potassium-sparing diuretic for years, Albert says.

"When we use it as an aldosterone antagonist, it's at a different dosage and it's for a different reason," she says. "Because the drug has been available for many years, there has been no drug company marketing of the drug, so maybe lack of use is that it's out of sight and out of mind."

Some physicians might have been reluctant to prescribe aldosterone antagonist therapy because of the drug's side effect profile, Albert says.

If the patient is already on some other therapies that are used to treat heart failure (such as an ACE inhibitor or angiotensin receptor blocker), they might have a higher risk of increased serum potassium and creatinine levels, she explains.

"So, maybe some health care providers were focusing on providing ACE-1 or ARB therapies, and maybe they had intended to start aldosterone antagonist therapy after the patient went home," Albert says.

The database did not yield information about therapies initiated after discharge, she adds.

The point is that while there are numerous reasons why providers might not have followed the national guidelines, the fact is that for most patients deemed eligible for the treatment, the guidelines should have been followed, leading to improved patient outcomes over time, Albert says.

Since this is an area that has fallen through the cracks, it would be a worthwhile quality improvement project for discharge planners to raise awareness about the treatment and include information about aldosterone antagonists in discharge planning paperwork for patients who meet criteria for use, he notes.

“Hospitals could monitor the use of the therapy in patients with systolic heart failure,” Albert says. “If you have a registry or database, then you could keep track of your own data, and over time you should see the frequency of aldosterone antagonist use increase in patients who meet recommended criteria for receiving it.”

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1. Albert NM, Yancy CW, Liang L, et al. Use of aldosterone antagonists in heart failure. *JAMA*. 2009;302(15):1658-1665. ■

Tips on long-term steps to improve discharge planning

Work with community partners too

When Spartanburg (SC) Regional Medical Center began a process to improve its discharge planning process, it began with improving collaboration from both within the hospital and within the larger medical community.

The hospital system has a long-term acute care hospital, and the goal was to improve collaboration with this facility, says **Angie Roberson**, RN, BSN, CPUM, director of case management.

Previously, hospital staff had the attitude that

the long-term care facility wouldn't take some patients, and there were misunderstandings about why this occurred, Roberson notes.

“It was an ‘us’ against ‘them’ kind of thing,” she says. “We’ve overcome that to the point where case managers now work off the same piece of music.”

Case managers now accept the fact that sometimes the long-term care facility cannot take certain patients, because it's not appropriate, Roberson says.

Here are more examples of how the hospital has improved its discharge planning and collaborations:

- **Develop a good relationship with nursing home staff:** “We also have a nursing home collaboration, and we have the same spirit with our outside partners as we do with other hospital units,” she adds. “We place a lot of patients in nursing homes, so we have to have a good relationship with nursing home staff.”

The hope is that if hospital professionals working in discharge planning treat the nursing home staff well, then this will make an impression and lead to a better collaboration in finding beds for hospital patients, Roberson says.

“If you want them to work with you, they need to know you and feel like you're there for them — it's all about collaboration,” she explains. “So, we try to employ that collaborative spirit.”

So far, the collaboration between the hospital and nursing home has led to success in decreasing the LOS of patients transitioning to the nursing home, Roberson says.

- **Designate a liaison between hospital and nursing homes:** “We have one geriatric case manager who is a liaison between us and the nursing homes,” Roberson notes. “This case manager doesn't carry a case load, but she works with unit-based discharge planners, coordinating between them and nursing homes.”

For example, the liaison case manager stays up to date on data related to nursing home placement.

“Each day, the nursing homes send out a list in

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an e-mail, saying, 'I have this many female and male beds available,'" Roberson explains. "Based on that list, we know what's available when we work with our patients every day."

When the hospital has a complex patient to transition, the liaison case manager will call the nursing homes and describe the patient's situation to find the best place to transition the patient.

The key is the liaison knows the facilities firsthand.

"She knows which place works well with dementia populations and which do well with wound care," Roberson says.

Her work helps both the hospital and nursing homes, because her advance information gives nursing homes a better picture of the patients they'll be seeing, she adds.

• **Improve communication with physicians and families:** Discharge planning nurses and case managers need to be sure they're communicating regularly with physicians, Roberson says.

They need to ask a physician when he or she anticipates a particular patient will be ready for discharge, she adds.

"We have to keep physicians involved," Roberson says. "It's all about communication and having everybody on the same page."

This also means that discharge planners should

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keep patients and families abreast of their plans, including them in the discharge planning process, she says.

Part of improving communication is learning the ways to express transitions and discharges without raising concerns in patients and families.

For instance, discharge planners should frame the discharge planning process in terms of improving patients' quality of life.

They might say to a patient: "It's important to us that we get you better as soon as possible and get you back home to your regular routine as fast as possible," Roberson suggests. "So, at the very beginning, we talk about what they're going to need at discharge, so they won't think we're trying to kick them out before they're well."

• **Keep a communication board in each patient room:** "We want to have dry-erase boards in every patient room, so we can put on their anticipated discharge date," Roberson says. "It's a challenge, and we haven't quite gotten there yet."

When discharge planners use this method to keep the discharge goal in everyone's mind, then it'll be even more important to be careful about how this is discussed with patients, she notes.

The idea behind the dry-erase boards is to keep the discharge date visible to family members, so they can make plans and juggle their schedules to be available on the day when their family member is returning home. ■