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What's up for quality in 2014's IPPS proposal?

Providers will need more education on changes

No one expects everyone to read through the 1,000-plus pages of the Centers for Medicare & Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) proposals for 2014. But there are parts of the proposal that impact quality departments, and they demand some study.

Among the changes of consequence to hospital quality managers are new quality measures and penalties for new categories of readmitted patients, and the much-talked-about "two midnight rule," which defines an inpatient as one who has stayed in the hospital over two midnights. Other components of the proposal include changes to the hospital readmissions criteria to make more allowance for planned readmissions within the 30-day window, and adding exacerbation of COPD and elective total knee and total hip replacements to the 2015 readmission reduction program. Currently, it includes heart attack, pneumonia, and heart failure.

Experts say you can start preparing now for the final rules, which should be released in the early fall. Here are five tips.

1. Teach providers to document better.

"With the continued emphasis on value-based purchasing, there is a lot that is dependent on appropriate documentation," says Lisa Roat, RHIT, CCS, CCDS, manager of HIM product development and compliance at Tampa-based J.A. Thomas & Associates, Nuance Communications. "There are so many things that factor into the equations for value-based purchasing surrounding hospital readmissions. If you don't document and code comorbidities, the hospital could end up losing money due to a readmission that might not have anything to do with the original hospital stay. Think of a surgeon who writes that there was a post-operative complication, she says, meaning that it happened in the post-operative time period, not that it happened because of the surgery. "You have to be careful the way things are worded."

Getting providers to understand the proper way to document can be difficult, she says. Many were trained using just a DRG code. Now there is pressure to document everything carefully and fully in a way vastly different from what they learned. "You may have to create a documentation

improvement program or hire outside consultants to do some training of providers,” says Roat.

2. Look closely at data.

It’s possible that your data could show a spike in a negative data point, like hospital-acquired conditions or another patient safety indicator. But it might not be a problem in need of a quality improvement project. Roat says to investigate

anomalies that don’t make sense with an eye to documentation. You may find you just need to educate a provider or two on better documenting the care they provide.

3. Understand the “two midnight” rule.

Roat says that the presumption is always going to be that a patient who does not stay in the hospital over two midnights was inappropriately admitted. “It’s a red flag to auditors,” she says. But approval is as easy as the right documentation and support from the medical record. “I can’t emphasize enough how significant this is. RAC auditors are really pushing on this.”

As a corollary to the two midnight rule, providers need to understand, too, that if a patient is deemed to have been inappropriately labeled inpatient and would have been better documented as an observation patient, there are financial repercussions not just for the hospital, but for the patient, Roat notes. The portion of the bill the patient is responsible for is greater for observation status than for an admitted inpatient, she says. Patients will complain if they are billed more money when they feel they shouldn’t be. This can affect patient experience scores.

4. Educate leaders about the finance/quality intersect.

While a lot of quality departments feel the righteousness of their job — providing quality is always the right thing to do — for many hospital executives, the quality department has long been viewed as a cost center that doesn’t do anything to help the revenue stream. But **Scott Hodson, MBA**, a principle at Miami-based Maverick Healthcare Consulting, says that with value-based purchasing and the readmission reduction program, there is now a way to demonstrate the financial benefit of investing in quality programs.

“This is a vehicle for you to say ‘We are important,’” he says. “I have a client that made \$10 million more than it would have because of investments they put into the quality department. This included more people and technology that made data gathering easier.” That \$10 million was a powerful incentive for the hospital leadership to continue to invest in a department that has long been considered a financial burden. “Use this as the start to a meaningful conversation at the nexus of quality and finance. You really can show value beyond just doing the right thing, that more quality is better than less.”

5. Preach the gospel of communication.

It’s no longer a hypothesis that better com-

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munication across the continuum of care is better for patients, says Hodson. “It clearly works. In Maryland, one client has seen a 25% reduction in readmissions because they are working better together across the various levels of care,” he says. “The reward is getting more money even though admissions are going down. Who would do anything to reduce admissions if this was still a fee-for-service system?”

The complete proposal is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Proposed-Rule-Home-Page.html>.

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Ten steps for making surgery safer

Simple steps for improvement

Wrong-site surgery: 20 times a week. Wrong surgery on a patient: 20 times a week. Object left in a patient: nearly 40 times a week. Surgical “never events”: more than 4,000 times a year. Those statistics were reported in a study published in April in the journal *Surgery*.¹ With such statistics, there will never be a single solution that makes surgery safer.

But **David Young, MD**, medical director of presurgical testing at Advocate Lutheran General Hospital in Park Ridge, IL, and founder of the surgical consultancy Surgical Directions, has come up with 10 things that could help make a dent in never events and make surgery safer for patients. (*For complete list, see box on page 88.*)

Some items on the list relate closely to culture and leadership issues, such as having medical directors who have the support of leadership and a just culture that encourages everyone to speak up when something doesn’t seem right and to report errors and near misses.

Others require resources that some may not

have, such as having a pre-anesthesia testing center staffed by hospitalists. But among Young’s must-dos are things that any hospital can implement.

- **Have a single way to schedule surgery.** This may not seem intuitively to be something that can impact safety, but there is anecdotal evidence that it does work. (*For more on surgical scheduling, see story page 89.*) At Advocate, that means that there is no scheduling over the phone, says Young. All scheduling must be done via computer or fax to limit errors related to transcription errors. Places can be reserved over the phone, but without confirmation in writing, there will not be a surgery.

- **Manage documents.** Scheduling and document management go together, Young says. Having a single point of entry for scheduling helps with better document management — there are fewer loose pieces of paper, sticky notes and crumpled faxes to keep track of. Having a system that can convert faxes into computer documents, and that uses information from one sector — say scheduling — to populate other documents is required.

- **Make sure your sterile processing is superb.** This sounds obvious, but often central sterilization departments are out of sight and out of mind. Be sure the staff are educated and well supervised and make sure there are outcomes related to what they do. For instance, a data dashboard should include the percentage of surgical trays undergoing immediate sterilization and surgical-site infection rates.

- **Implement World Health Organization checklists.** The lists are available at http://www.who.int/patientsafety/safesurgery/ss_checklist/en/index.html. And encourage people to speak up if steps are skipped.

Other checklists are also a key part of safe surgery, says Young. A presurgical checklist involves reviewing with patients why they are there, their name, and date of birth. The anesthesiologist will use a checklist to look at issues with nurses such as airway, implants such as pacemakers, and the potential need for transfusions. Anesthesiologists will also talk with the surgeon, using a checklist to go over similar questions as were discussed with nursing, as well as information related to equipment used. The time-out checklist is robust, he says, including information on comorbidities, allergies, and special needs of the patient, as well as what the procedure type is.

• **Make error reporting a habit.** And don't limit reporting to what has happened. Log near misses, too. This involves creating a work environment where everyone feels safe in speaking up. Aggregate the information, do root-cause analyses, and be transparent about your findings.

• **Talk amongst yourselves.** The daily huddle is the one thing Young says you should do if you are going to do nothing else. A huddle takes place for every case. Before surgery, the team talks about expectations, special patient needs or concerns, and how they expect things to go, says **Alecia Torrance**, RN, MBA, vice president of perioperative business operations at Surgical Directions. Post-surgical huddles involve reviewing what went right and what didn't. A final group meeting mid-afternoon involves going over the current day and a look at the day and the week ahead.

These are not necessarily fits or fixes for what ails your surgical department. Young says you can ascertain your specific needs by looking at a few data points. Look at cancellations and delays. Young says if a patient is well-prepared, the surgery will go off as scheduled. If you have a lot of cancellations and delays, it could be due to an issue with documentation, presurgical testing, or scheduling problems.

He also suggests you ask staff members at all levels where they see problems. "If they are engaged and empowered, they will feel free to tell you what they really think," says Young.

Human errors will always occur in a healthcare industry staffed by people, he says. "But we can focus on system errors and put practices in place to minimize them. By giving people tools and

empowering them to act and speak up, we can also train people to prevent problems. It is when they have no voice, when they feel they can't say anything to the surgeon because they will get into trouble that you will have ongoing problems."

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Studies show limits of surgical checklists

Are improvements possible?

Checklists are often touted as the potential cure for the ill that is patient harm. If it works for the aerospace industry, why can't it work for healthcare? Indeed, there is ample evidence that some checklists can make a big difference in patient safety.

But two recent studies point out potential limitations — and possible improvements — to checklists designed for making surgical procedures safer.

The first, published in April in the *International Journal for Quality in Health Care*¹ looked at compliance with the WHO surgical safety checklist at a Swedish county hospital. The authors videotaped 24 surgical procedures to see if a time-out really could improve communication, thus reducing medical complications and creating a better safety culture. The procedures were analyzed, and reasons for non-compliance with the checklist and time out ascertained.

The checklist worked best as a tool to ensure the right patient was in the room, the kind of procedure the patient needed was what was scheduled, and that the proper antibiotics were

10 Steps for Safer Surgery

1. Single path for surgical scheduling
2. Medical Directors with Surgical Services Executive Committee support
3. Pre-Anesthesia Testing Center with standardized protocols/Hospitalists
4. Document Management system for scheduling and PAT
5. Excellent Sterile Processing
6. Crew Resource Management
7. Implementation of WHO/Safety Checklist
8. Daily Huddle
9. Error Reporting
10. Just Culture

on board. But site of incision and imaging information had the lowest compliance. Team member introductions occurred only half the time, and the time-outs were dominated by the surgeons and anesthesiologists.

The authors noted that the checklist wasn't always used as it was intended, and the very things that are supposed to foster better communication — introductions, for instance — don't always occur. In the small sample, there was a lack of team feeling in the time-outs. One possible solution is to re-educate staff on the relevance of the checklist and why fostering a culture of safety is important.

The second study, also in the April issue of the *International Journal for Quality in Health Care*², looked at patient hand-offs and whether checklists work at these high-risk junctures in healthcare. In particular, the researchers looked at whether a checklist for hand-offs between the anesthesiologist and post-anesthesia care unit would lead to better information being available on the patient.

Hand-offs for 120 patients were recorded, with a third of them happening before a checklist was implemented, and the rest happening after. The post-checklist patients were randomized into a checklist group and a group for whom the checklist wasn't used.

The authors looked at the duration of the hand-off, as well as how many specific "items" were part of the hand-off. With the checklist, the number of "items" handed over increased from a median of about a third to nearly 50%, and the length of time for a hand-off increased from about a minute and a half to over two minutes. Even with instructions about what should be handed over, if there was no checklist, there was no associated increase in items handed over.

Given the importance of hand-offs in ensuring quality care and patient safety, using checklists in the post-surgical environment might be helpful.

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The scheduling/safety intersect

Outcomes improve with scheduling program

Talk about surgical safety and people will automatically think of issues like objects left in a patient after closing or operating on the wrong site. Surgical-site infections are a hot topic. But surgical scheduling? Put that in the PubMed search engine and not much comes up. Add the term "patient safety" and you get a single, lonely article.

But there is a clear link between having a good scheduling program and providing high-quality, safe care to surgical patients, says **David Young**, MD, founder of the Chicago-based surgical consultancy Surgical Directions and medical director for presurgical testing at Advocate Lutheran Hospital.

Hospitals often allow a bunch of different ways for patients to schedule surgery — telephone, paper, fax, electronic, or even dropping off a document. Young says having a single path to scheduling is the start of safer scheduling. "We don't care how we get it, but we have to written documentation. You can make a reservation by phone, but not actually schedule a procedure."

The rationale is that information heard on the phone may be written down incorrectly, he says. Oral information offers a point at which mistakes can enter the system.

Even faxed forms can be illegible, says **Katrina Speers**, MA, manager of business and informatics at Advocate Good Samaritan Hospital in Downers Grove, IL.

"From a clinical perspective, using an electronic scheduling program means we have fewer rejections related to issues like antibiotic selection," says **Lina Munoz**, RN, CPAN, manager of pre-surgical testing, surgical pavilion and the post-anesthesia care unit at Good Samaritan. Choosing the right antibiotic is a core measure and part of the Surgical Care Improvement Program (SCIP), she says. "We don't have to deal with that using electronic scheduling. There are prompts for the physician order to make sure that the right selection is made."

Currently, that core measure gets a perfect score, Speers notes, while before, there were often issues with that metric.

Munoz says another advantage is to cue physi-

cians and nurses when special care needs to be taken, like when there is a bowel prep. “That can cause renal insufficiency if the patient isn’t well-hydrated, so now there is an alert in presurgical testing to initiate a fluid and hydration protocol.

Laterality of surgical site also has a dropdown box, Speers says, cuing a check of the patient record to make sure the right site gets the right surgery. “It adds a layer of safety to recheck that.”

Good Samaritan implemented the new scheduling program a little over a year ago, and the results have been significant and positive. Cancellation rates went from 7.7% last year to 0.37% in June. This is a boon to patient and provider satisfaction. There may be outcomes benefits, too, as patients don’t have to deal with anticipation and worry of a surgical procedure that doesn’t happen, and then gear themselves up all over again.

Presurgical testing is also completed with about two weeks to spare, where before there was just a week of cushion. Munoz says this means there is more time to deal with issues such as comorbidities that may have to be brought under control before a surgical procedure can occur.

The new program was rolled out to the surgical offices after a Lean event at the hospital that found a large amount of front-end waste. “There was a lot of calling back and forth between offices to collect and correct information,” Speers says.

Speers and Munoz met one-on-one with the office schedulers and showed them how to use the program. The program vendor tagged along, tweaking the system with almost every comment. “It was really a seamless implementation,” says Speers. Within six months, 90% of the scheduling was electronic. Now, it is being rolled out at other Advocate hospitals and within Good Samaritan to interventional radiology and the cath lab. “Everybody loves it.”

Before the implementation, some 960 forms a month were rejected. That’s been decreased by 90%. What was a full-time employee’s worth of wasted time has mostly disappeared.

Next up Speers and Munoz want to leverage the surgical scheduling program to help reduce surgical-site infections and MRSA by adding a screen that includes MRSA colonization test results and antibiotic orders if necessary.

It’s not just a matter of putting a name in a time slot, says Speers. It’s about making sure that the correct patient information is in the right place in time for surgery, which makes it easier to provide safer surgical care.

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How does the evidence rate?

Knowing what’s good and what’s not

If you read it in a peer reviewed journal, it must be right — right? And if there is an evidence-based practice, then the evidence must be stellar. Not so fast, says **Lisa Spruce**, DNP, RN, ACNS, ACNP, ANP, CNOR, director of evidence-based perioperative practice at the Association of peri-Operative Registered Nurses (AORN) in Denver. Spruce is a big advocate of healthcare stakeholders becoming critical readers and understanding exactly what kind of data makes for good evidence. Doing so can make anyone better at determining what practices to mimic or adapt to local needs, and what can just be ignored.

AORN has some 30 different recommended practices, with new ones written as the need arises. All of them are based on a specific set of actions, Spruce says. First, the author of a proposed practice will sit down with a librarian and go over topics, key words, clinical questions, and the scope of those questions. “We might be looking at interventions, education, or existing best practices about something to see what the evidence shows.”

AORN has adopted the Johns Hopkins nursing evidence appraisal tools, she says (available at <http://www.nursingworld.org/Research-toolkit/Johns-Hopkins-Nursing-Evidence-Based-Practice>). Each appraisal starts with an initial literature search that may bring up between 200 and a thousand articles, says Spruce. All have to come from peer-reviewed journals and may have to be within a particular time period. Usually an author and an

appraisal reviewer — usually a doctoral-prepared nurse — read through the abstracts to see what might be applicable. Any studies that speak to the proposed practice are then gathered and read in full to evaluate the strength and quality of the study and its data.

She explains that studies that are randomized and controlled receive the highest rating — level 1. Quasi-experimental or non-experimental studies get lower scores. The reviewers will look at the sample size and whether it applies to the population for which a proposed evidence-based practice is being considered — a study of children in Africa wouldn't be useful if the practice relates to vitamin D deficiency in older women in Northern Europe. They look at whether the results are consistent and clear, and whether they use a good methodology.

Reviewers each give each study reviewed a quality grade of A, B, or C, she says. "If there is disagreement on the grade, a third person is brought in to give an opinion." Each resulting recommended practice will include a list of articles that support its use and the strength and quality associated with each of them. "The idea is to be completely transparent about the process," Spruce says.

The practices are all given a rating, she says. Most recently, AORN has been using the Oncology Nursing Society model (available online at <http://www.ons.org/Research/media/ons/docs/research/outcomes/weight-of-evidence-table.pdf>), but Spruce says AORN is developing its own model to rate practices. Some may have strong evidence, some may have moderate evidence. There are some that have no evidence — possibly because you can't ethically run the kind of experiment you'd need to collect good data. Still, if the benefits of doing the practice outweigh the harm, then even a practice with no evidence behind it can get a strong recommendation, Spruce says.

For instance, there is a recommendation that anyone having throat surgery with electrocautery and oxygen both in use should have wet packs packed in the throat to prevent the risk of fire. "It's not supported by high levels of evidence," she says. "But you can't do an experiment where you see if you start a fire in a patient's throat when you don't have wet packs."

This isn't hard to do, she says. And doing it even once gives you a much clearer view of the maxim that you shouldn't believe everything you read. How a study was done, who paid for it, and the quality of the data can all be eye-opening. It may

prove to you that the way you've always done something is still the best way, or it could show you that the new method is safer or faster or has better outcomes. "New evidence becomes available, and we need to think of that as we care for our patients. You need to learn to critically assess what you do and why you do it." Spruce says once you've gone through the process you'll "read articles differently every single day."

If you want more information on how to do your own research for evidence based practices, she suggests looking to specialty societies and other organizations that promote evidence-based protocols. "Look at posters at conferences," she says. "Often they give you a clearer idea about how research is done. Most importantly, read journal articles. Start a journal club or join one, where you can learn how to read research with a critical eye."

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You can use a time-out, too

Surgical tool can help outside the OR, too

Every parent of a toddler knows that a time-out isn't so much a punishment for the child as a moment to breathe for the parent. It's this moment of calm that is the basis for the use of time-outs in a variety of fields, including surgical medicine. It's a chance to stop and make sure the path you are on is correct. And it's a tool that anyone can use, says Vicki Hess, RN, MS, principle at Catalyst Consulting, based in Baltimore, MD.

Hess says that no one says, "I want to go to work and be engaged today." They think they want to have a good day, they want to be productive and make progress. Those elements, however, are just what can make an engaged employee.

But not every day is good. Sometimes, something bad happens — Hess calls those things "pows" — and taking a time-out can help you turn that bad event into a positive outcome. "I might take a personal time-out if I'm hit with a challenge to think of different options." If a partic-

ular report isn't ready, rather than rant and rage, a better idea is to take a moment. "I check myself, take a deep breath to calm down, make sure I'm in a positive frame of mind," she says.

If something bad happens at work, taking a minute before you approach your team will help you ensure they don't get hit with the "pow" themselves. You can set the tone for their reaction, Hess notes.

Then gather the team in a huddle and tell them what has happened. Ask them to take a moment of time, too. Hess created a checklist to guide that time-out she calls the SHIFT — Stop, Harness reactions; Identify and manage negative emotions; Find new options, and Take one positive action.

The surgical time out and use of a checklist when used outside the operating theater can have the same kind of positive impact, Hess says. "You don't want to approach a problem with a knee-jerk reaction, or shouting, pouting or lashing out."

Think of it in surgical terms. Someone comes to the OR with a problem to be fixed. You don't want a panicked surgeon trying to fix it. You want a doctor who is calm, focused, and has a plan of action that will help you. It's the same with a non-surgical team.

Further emulating the surgical scene, a key element in dealing with a problem is to make sure you want to foster a culture that doesn't engage in blame, but where everyone can report a problem and know the team will come together to find a solution without pointing fingers.

"Fear and blame bring things further into a spiral," Hess says.

In a forthcoming book, *Six Shortcuts to Employee Engagement*, Hess addresses the health-care industry by suggesting ways to "shrink team pows, grow wows, and shift pows to wows" — a wow being the opposite of a pow in her parlance.

"Don't be afraid to call a pow a pow," she advises. "It won't disengage you. You can rally us around a problem and we'll respond. Acknowledge the crummy feelings, and don't ignore the problem. Your team will appreciate the realism." But that doesn't give you permission to pout, she says. That's what the time-out is for — to master the initial bad feelings, and put them away so a problem can be solved.

For more information on this topic, contact Vicki Hess, MS, RN, principle, Catalyst Consulting, Baltimore, MD. Telephone: (888) 797-6700. ■

Joint Commission to study HIT risks

Measuring harm from HIT key to reducing it

Late in 2011, the Institute of Medicine (IOM) released a report outlining the potential benefits of health information technology, as well as the potential perils associated with it. "Health IT and Patient Safety: Building Safer Systems for Better Care" (available at <http://www.iom.edu/Reports/2011/Health-IT-and-Patient-Safety-Building-Safer-Systems-for-Better-Care.aspx>) included specific recommendations, including that the government should find an independent organization to determine what use of technology could potentially harm patients and how to prevent those scenarios.

Last month, the Office of the National Coordinator (ONC) chose The Joint Commission (TJC) to fulfill that role. Sentinel events related to health IT are reported to the commission on a voluntary basis, which gives TJC some insight into the root causes of various kinds of health IT dangers. The commission will also look at other literature and gather expert opinions to flesh out knowledge of the kind of problems that technology has caused.

Technology-related sentinel events could happen with many types of technology, including hardware — implanted devices and dispensing systems, for instance — or software programs — such as speech recognition or electronic health record systems. Errors in either might result in the wrong medication, wrong dose, wrong treatment, or wrong-site surgery.

TJC will spend about a year studying the potential for error and coming up with possible fixes, says **Ron Wyatt, MD, MHA**, medical director of the division of healthcare improvement at The Joint Commission. He says there is no clear idea of how common technology-related sentinel events are or what percentage of overall errors they represent. "All we know is that errors in general are vastly under-reported." The hope is that they will know more by the time the study is complete.

The commission will also develop tools and educational programs to help providers understand the risks, determine ways for providers to more easily report problems, and come up with guidance on how to avoid situations in which sentinel events are possible. "We hope this gives us a

better idea of how this kind of event occurs, ways to analyze them, and strategies to use technology while providing safer care,” Wyatt says.

Right now, there are multiple systems in most hospitals, and most don’t work well together. Wyatt says an example might be a pharmacist who has to work on two different systems. Whenever he or she has to exit one system and move to another, there is the potential for error. Maybe the pharmacist misspells a name in the second system, or misremembers a medication dose or allergy. Such errors can lead to harm.

In early July, Wyatt heard a report of a patient who caught a potentially fatal mistake: the wrong dose of potassium in his drip. “If the nurse had hung the IV bag and delivered the dose, it could have killed him,” Wyatt says. It wasn’t the nurse’s error, but an error made up the line in a computer order. “You can have the best IT systems out there, but there are still human beings using them.”

Fatigue, distraction, noise, lighting — these are all things that impact the human beings who deliver medical care, and they are the ones using technology, Wyatt says. “We are hoping to find a way to catch these when they are near misses or precursor events so that they never reach that sentinel event point.”

For more information on the ONC contract, contact Ron Wyatt, MD, MHA, Medical Director, Division of Healthcare Improvement, The Joint Commission, Oakbrook Terrace, IL. Telephone: (630) 792-5175. Email: Rwyatt@jointcommission.org. ■

AMA, TJC recommend strategies for reduction

The American Medical Association’s Physician Consortium for Performance Improvement and The Joint Commission have come up with ways to reduce five commonly overused treatments — use of antibiotics for viral infections like colds, over-transfusion of red blood cells, placing tubes in ears for middle ear infusion, early elective delivery, and elective percutaneous coronary intervention (PCI).

The suggestions were published in a paper in July, “Proceedings from the National Summit on Overuse.” It was the result of a meeting held last September. At the meeting, attendees defined overuse as a treatment that has little or no benefit for

patients and which can drive up healthcare costs. For example, it is estimated that adults who get antibiotic treatment for viral upper respiratory infections alone lead to over \$1 billion every year in unnecessary healthcare costs.

More than 100 professional organizations and associations worked to develop strategies to reduce such over-treatments. Among the specific recommendations are:

- Antibiotic use for viral upper respiratory infections — develop clinical definitions for viral and bacterial upper respiratory infections; educate the population at large on the issue.
 - Appropriate blood management — develop education materials for physicians on how to avoid transfusion and promote alternatives; develop a separate informed consent process for transfusion that outlines the risks and benefits.
 - Tympanostomy tubes for middle ear effusion of brief duration — develop performance measures for appropriate use of tubes; study how often they are used inappropriately in otherwise healthy kids.
 - Early-term non-medically indicated elective delivery — come up with a standard calculation for gestational age; make exclusion list for early delivery as comprehensive as possible; educate patients and physicians about risks.
 - Elective percutaneous coronary intervention — encourage standardized analysis/interpretation of non-invasive testing for ischemia; educate patients and physicians on the risks and benefits.
- The paper and complete recommendations are available at http://www.jointcommission.org/assets/1/6/National_Summit_Overuse.pdf. ■

Checklists available for PfP program

The Health Research and Educational Trust (HRET), an affiliate of the American Hospital Association (AHA), has created a series of checklists as part of the Partnership for Patients (PfP) campaign of the Centers for Medicare & Medicaid Services (CMS) that, if implemented, might help reduce patient harm by 40% and unplanned hospital readmission rates by up to 20%.

The HRET/AHA initiative includes more than 1,600 hospitals in 34 states that participate in webinars and other intensive training initiatives that focus on 10 areas deemed to have the potential for the most impact. They are:

- Adverse drug events (ADE)
- Catheter-associated urinary tract infections (CAUTI)
- Central line-associated blood stream infections (CLABSI)
- Injuries from falls and immobility
- Obstetrical adverse events
- Pressure ulcers
- Surgical-site infections
- Venous thromboembolism (VTE)
- Ventilator-associated pneumonia (VAP)
- Preventable readmissions

The collaborative also provides technical assistance in implementing quality measurement goals and systems for tracking progress toward them. It includes a fellowship program to help build “a cadre of quality improvement leaders across the country” who can design, test, and spread interventions through their hospitals. So far, more than 900 people have taken part in the program, which is offered in Chicago, Denver, Orlando, and California.

The checklists are available at <http://www.hpoe.org/resources/hpoehretaha-guides/1398>. Further information on other aspects of the Partnership for Patients program and AHA-affiliated educational opportunities can be found at <http://www.hret-hen.org/events>. ■

Better metrics needed to determine quality

There has been an intense focus on reducing unplanned readmissions in hospitals. Payers are refusing to pay for them, and increasingly the public believes that they are a determinant of the level of quality of care a particular facility provides to patients. But a study in the June issue of *Health Affairs*¹ indicates that looking at this single data point doesn't tell the whole quality story.

The authors looked at readmission rates for hospitals at two points — 2009 and 2011 — to assess change, as well as other measures commonly associated with quality: mortality rates, rates of process measure adherence for conditions like heart attacks and pneumonia, and patient volume. The additional measures came from data collected through Hospital Compare and the American Hospital Association.

The correlation between quality indicators and readmission rates turned out to be “weak or

inverse,” the authors found. “There were no significant differences in mean readmission rates across all quartiles of mortality rates for heart attack and pneumonia,” the study notes. “For heart failure, mean readmission rates were significantly higher for the hospitals in the lowest mortality quartile. Results comparing the change in readmission and mortality rates longitudinally, which controls for time-invariant hospital confounders, showed a weak correlation between the two outcomes for all three conditions.”

One possible explanation is that hospitals with low mortality rates have more patients who can be readmitted, and those with high rates have fewer. But the authors note there is not any correlation between readmission rates and other quality indicators, either. It could also be that transitions of care to sectors outside the hospital setting could influence readmission rates, while the quality measures the authors chose are all the purview of hospitals.

Regardless, the notion that you can determine quality by looking at this single 30-day period for an unplanned readmission seems inadequate.

REFERENCE

1. Press MJ, Scanlon DP, Ryan AM et al. Limits Of Readmission Rates In Measuring Hospital Quality Suggest The Need For Added Metrics. *Health Aff* June 2013 vol. 32 no. 6 1083-1091. ■

Reducing measurement to improve quality

It is well known that healthcare organizations have access to a vast amount of data, and that a lot is unused and more is of little use. But what can be done about it? A June workshop at the Institute of Medicine (IOM) called Counting What Counts came to some conclusions and may mark the start of a new initiative to streamline data collection and make better use of what is collected.

Participants discussed current challenges, such as the inability to compare data at more than one level, a lack of coordination among those asking for data, and the unwieldy quantity of data collected. They discussed potential fixes, which extended beyond reducing the number to a core set. Among their other suggestions were prioritizing measures so that what is collected relates to the most important issues; creating systems that capture and exchange the data; and creating systems that are flexible

enough to adapt to new technologies.

Rather than start afresh, the IOM hopes to piggy back onto existing efforts by an alphabet soup of organizations — CMS, AHRQ, NCQA and NQF, among others. The impact could be substantial. Along with reducing the data collection burden, participants of the workshop felt that such efforts would foster better collaboration and allow true comparisons of best practices across organizations.

The IOM didn't specify when the further study mooted at the meeting would begin, but they did produce an infographic related to it, which can be seen at <http://www.iom.edu/Reports/2013/Core-Measurement-Needs-for-Better-Care-Better-Health-and-Lower-Costs/Counting-What-Counts-Graphic.aspx>. ■

Remaking healthcare – again

Hospitals are barely keeping up with the last round of changes in healthcare, but already there are people calling for another overhaul. In an online piece in the *New England Journal of Medicine*, names better known from government — Thomas Daschle, Pete Domenici, William Frist and Alice Rivlin, now leaders of the Bipartisan Policy Center Health Care Cost Containment Initiative — riff on a report they released in April, “A Prescription for Patient-Centered Care and System-Wide Cost Containment.”

It contains 10 recommendations. Some are out of the ambit of hospitals and other healthcare organizations to consider and rely on government will and Congressional acquiescence to implement. An example of those kinds of solutions are suggestions to alter accountable care organizations and the SGR formula for physician reimbursement so that there is more incentive for Medicare providers to participate in new payment models and to create a standard minimum benefit for Medicare Advantage plans.

Several, however, would involve healthcare organization participation, such as consolidation of quality measures, study the potential cost savings for preventive medicine, and figuring out ways to deliver services to dual-eligible patients through a single program.

The entire piece can be read at <http://www.nejm.org/doi/full/10.1056/NEJMs1306639>. ■

CNE QUESTIONS

1. The two midnight rule means:
 - a. Patients have to stay over two midnights for readmissions not to count against the hospital.
 - b. Patients have to wait for two midnights to pass before they can return to the hospital.
 - c. Most patients will only count as inpatients if they stay over two midnights.
 - d. Patients are billed more for staying over two midnights.
2. Objects are left in patients how many times a week according to a recent study?
 - a. 20
 - b. 4,000
 - c. 40
 - d. 200
3. Electronic scheduling has led to what percentage decrease in rejected forms?
 - a. 96
 - b. Two-thirds
 - c. 60
 - d. 90
4. What is the least desirable form of study in evaluating evidence-based care?
 - a. Placebo controlled
 - b. Quasi-experimental
 - c. Randomized controlled
 - d. Non-experimental

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

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

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at <http://hospitalreport.blogs.ahcmedia.com/>. *Hospital Peer Review's* executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute. ■

COMING IN FUTURE MONTHS

- The downside of too much data
- Accreditation field reports
- Most-wired hospitals: what they're doing that you should
- Unit-based surgical site infection control program
- PSO participation requirements

CNE INSTRUCTIONS

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

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