Bridging a Great Divide – Communicating Across Care Settings

Recently a middle-aged man came to the emergency department one evening following an automobile accident. He was examined with an initially negative evaluation. At the patient's request, he received a CT scan of the chest, abdomen and pelvis as well as lab work. The findings were negative for trauma; he was treated and released with a recommendation to follow up with his PCP. Twelve hours later, he committed suicide.

In investigating this event, the hospital found that he had seen his PCP four hours before presenting in the emergency department and had received referrals for substance dependency programs and a psychiatric consult. They also learned that a friend thought the car accident had occurred because the patient wanted to commit suicide.

With the clarity of 20:20 hindsight, it is possible to see how this ending might have been prevented. What if the patient’s PCP had notification of the patient’s visit to the ED on arrival...what if the emergency staff and physicians had access to patients’ primary care information? Rather than an example of system failures within an institution, this case highlights the significant problems of the larger healthcare system in getting the right information to the right person at the right time.

While we recognize communication failures within the hospital and with patient discharges, we are less likely to identify failures pre-hospital admission. The Commission has received few reports in which a communication failure occurred between the physician and hospital, and many more describing gaps in care transitions within the hospital and at discharge.

Practice Spotlight: EMR Solutions

Moving from paper to electronic communications is an expensive undertaking fraught with frustration and, all too often, underutilization of the abilities of the system. Recognizing these problems, the Mayo Clinic embarked on an improvement initiative that linked providers and IT professionals to identify and solve problems that were preventing full utilization of system capacity.

Mayo identified seven major themes — training, workflow and processes, multiple system environments, navigation-viewing integration, patient-reported information, clinical problems management, and consolidated medication documentation— which are universal and applicable to any clinic or hospital's information system. See the Journal Brief below and a synopsis of their work at AHRQ Healthcare Innovations Exchange.
As an industry, our focus on care transitions has paid limited attention to the pre admission end of the care continuum. In fact, the National Transitions of Care Coalition (NTOCC) defines transitions in care as including “…a patient moving from primary care to specialty physicians; within the hospital it would include patients moving from the emergency department to various departments, such as surgery or intensive care; or when patients are discharged from the hospital and go home, into an assisted living arrangements or into a skilled nursing facility.”

Preventing needless adverse events that arise from a disconnect between outpatient and inpatient care requires both long-term and short-term solutions.

The longer-term solution is clear: statewide adoption of electronic health records (EHR) to Stage 7* (clinical information is readily shared via electronic transactions with all appropriate entities and providers). Interconnected systems of care, one of Oregon’s North Star goals, significantly increased between 2nd quarter 2008 and 4th quarter 2009. (For full description, see Hospital Patient Safety report on the Commission website). Despite this improvement, other states have moved more quickly, and Oregon fell from 17th nationally to 23rd. While a shorter term solution is less clear and its potential effectiveness variable, some activity to consider the implications of pre-admission communication failures is essential.

*See HIMSS Analytics

Recommendations:

Accelerate adoption of electronic health records, incorporating learnings from other hospitals to avoid known problems. (Strong: essential to increase timely availability of critical information)

Review areas of interface with primary care and specialty providers (e.g., day surgery) and identify potential communications failures; develop interim solutions, use to guide long-term EHR solutions. (Moderate depending on solutions identified)

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Journal Brief

Partnering with clinical providers to enhance the efficiency of an EMR.


Abstract

Implementing an electronic medical record to replace paper records and associated processes does not guarantee the benefits of an EMR will be achieved. Specifically, it can introduce steps into a provider’s work flow that adversely affect the projected benefits of efficiency, and, ultimately, quality and safety. At Mayo Clinic in Rochester, Minnesota, implementation of the Mayo Integrated Clinical Systems, or MICS, the organization’s EMR, is nearly complete. However, providers perceive inefficiencies in their work flow using...
MICS. In response, a study was undertaken to enhance MICS and associated processes to improve provider efficiency. Through direct observation and feedback from 101 providers, this study identified seven major themes for enhancements: training; workflow and processes; dual environments; navigation-viewing integration; patient-reported information; clinical problems management; and consolidated medication documentation. This paper reviews the methods used to collect and analyze the data and discusses how improvement opportunities can positively enhance efficiency in using an EMR.

PMID: 17299922

See also: Reforming hospitals with IT investment. McKinsey Quarterly AUGUST 2010 • Francois M. Laflamme, Wayne E. Pietraszek, and Nilesh V. Rajadhyax Source: Business Technology Office

"A provider that creates a best-practice IT platform to house and share medical records, to manage hospital resources more transparently, and to define precise guidelines for medically authorized tests and procedures can generate significant operating efficiencies. Such a platform minimizes paperwork, reduces the number of unnecessary treatments, and lowers the risk of drug and medical error...Healthcare providers will need to use new approaches to achieve an inclusive governance process with streamlined decision-making authority, a radically simplified IT architecture, and a megaproject-management capability."

Part of the article is at the following link. Registration (free) is required to read the whole article.
http://www.mckinseyquarterly.com/Health_Care/Strategy_Analysis/Reforming_hospitals_with_IT_investment_2653

James Bagian on Being Wrong

From Kathryn Schulz at Slate comes a series, The Wrong Stuff: What it Means to Make Mistakes. For her June 28 article, she interviewed James Bagian, director of the VA National Center for Patient Safety. An anesthesiologist by training and NASA astronaut, Dr Bagian has a clear sense of what works – and doesn’t – in making healthcare safer. Read his comments here.

Las Vegas Hospitals

“There's a running joke about hospitals here: ‘Where do you go for great health care in Las Vegas?’...The airport.” To see the series of newspaper articles about substandard care in Southern Nevada, follow this link:

Resources

Stop the Line Policy

Barnes-Jewish Hospital and St. Louis Children’s Hospital, along with Washington University School of Medicine, have developed a multidisciplinary policy as well as a PowerPoint presentation. They are willing to share the PowerPoint presentation as long as users credit the Washington University School of Medicine.
Stop the Line Policy (cont’d)

For the presentation contact either Mara Bollini mlb7ff0@bjc.org at St. Louis Children’s Hospital, Jody Woodward jad0557@bjc.org at Barnes-Jewish Hospital, or Mary Taylor taylorma@wusm.wustl.edu at Washington University School of Medicine. The policy is available online here.

Heard on the Net

Red Rules

A recent post to the NPSF listserve asked about “Red Rules” and how they are applied. Related to Stop the Line policies, Red Rules “…are ones that will always be supported by the entire organization. In other words, when someone at the frontline calls for work to cease on the basis of a red rule, top management must always support this decision.” For the full definition see AHRQ Patient Safety Glossary. A discussion of red rules in a just culture context is available at http://www.justculture.org/newsletters.aspx Scroll down to read An Examination of Red Rules in the Fall 2007 Just Culture Community Newsletter.

Did You Know?

In 2007, emergency department (ED) visits involving a diagnosis related to a mental health and/or substance abuse condition (MHSA), accounted for one out of every eight ED visits

MHSA-related ED visits were two and a half times more likely to result in hospital admission than ED visits related to non-MHSA conditions

ED visits billed as uninsured were two to four times less likely to result in hospital admission, depending on the type of MHSA condition.

Source: HCUP Statistical Brief #92 Mental Health and Substance Abuse Related Emergency Department Visits among Adults, 2007 (PDF file; HTML).
From the Commission

Commission Issues Report on Oregon Hospitals

This month, the Patient Safety Commission issued its report on patient safety and quality improvement activities in Oregon hospitals. The report summarizes findings about adverse events and medical errors, highlights some important patient safety efforts, and measures overall hospital progress since 2008. Read the report here.

Adverse Event Reports

The Commission received six adverse event reports in July (see pie chart below). From the beginning of the year through July, the Commission has received 47 reports. At the current rate, we project a significant drop in reports for 2010.

Adverse Event Reports – Synopsis:

Retained Objects (2) – in both a large and small hospital; one identified 30 minutes post op by X-ray in PACU, the other a month later because of wound drainage; both returned to surgery for removal. Actions Taken: work process changes - add interim counts, limit sponges in cavities to radio opaque items, attach clamp as visual reminder; implement post-procedure pause. Comment: unless taken before closure, X-Rays do not prevent retained objects, but identify them afterwards. AORN and VA recommendations include using count bags and performing cavity sweeps; consider as well audible comment each time sponge is placed/each time sponge is removed and bar-coding or RFID, as recent literature indicates potential to decrease retention.

Suicide (1) – see Bridging a Great Divide

Wrong Procedure (1) – second of two procedures on same patient by same surgical team without a second time out; poorly visible site marking and omission of usual second marking step. Actions Taken: change in practice to include time out with each new procedure and request to surgeons for better site marking process. Comment: While surgeon input is important, using a community standard is helpful, as surgical staff practice at different hospitals across the state. The Columbia River chapter of AORN has developed a consensus standard for site marking which should be seriously considered for adoption.

Wrong Surgical Material (1) – identical labeling and lookalike packaging: “virtually indistinguishable.” Actions Taken: treat all surgical materials as implants and use two-person verification; include in pre-surgical briefing and time outs; identify similar potentially confusing products and develop means to distinguish (shrinkwraps, bar-coding). Comment: this is a significant event and liable to occur again; changing the product packaging in some way is essential. We encouraged the hospital to report this also to the FDA via their voluntary reporting mechanism.

Care Delay (1) – change in recovery plans from pre-surgical screening, missed communications from OR and in post surgical recovery, and mismatch with patient acuity and staff skill mix. Actions Taken: begin staff rotation to assure appropriate skill mix, add provider staff for review of patient status and surgical “okay” the day prior to anesthesia. Comment: as this case shows, reviewing key concerns for recovery and management prior to the patient leaving the OR is essential, as is assuring that review is transmitted to the recovery area. One Oregon hospital has the review done in the recovery area by the surgeon, anesthesiologist, and circulating nurse.

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Changes – Jim Dameron Announces Retirement

After five years as Administrator of the Patient Safety Commission and 30 years in the healthcare field, Jim Dameron has decided to retire. Under Jim’s leadership the Commission built the nation’s first voluntary reporting program for adverse events and established a strong patient safety presence in Oregon. The Board of Directors has begun transition planning, with the goal of hiring a replacement by the end of the year. After retirement, Jim is planning to devote more time to writing (he’s a published essayist) and fishing every western trout stream of note. We will miss Jim’s passion and vision for patient safety.

Upcoming Events

Commission Meeting
October 12th from 12:30 to 3:30pm at the Wilsonville Training Center of Clackamas Community College. To request an agenda, please contact Linda Goertz. All Commission meetings are on the second Tuesday of even-numbered months. Click here for a listing of meeting dates.

Patient Safety Rounds
September 2nd from 12:10 to 12:55 – Preventing Retained Objects A monthly 45 minute case presentation and discussion of best practices. Safe Table Webinar format on the first Thursday of the month through December 2010. Click here to request password.

Other Events

September 27-29 – 2010 AHRQ 2010 Annual Conference, "Better Care, Better Health: Delivering on Quality for All Americans," in Bethesda, Maryland. Visit the Conference Home Page for more information. Registration

October 8, 2010 – OMA Patient Safety Convocation “Patient Safety: Better Together” at the OMA offices to register click here

October 13–16, 2010 – ASHRM Annual Conference and Exhibition Tampa Convention Center, Tampa, FL. For information, click here.

October 20-22, 2010 – ORHQN TeamSTEPPS Master Trainer Workshop, Ameritel Inn, Old Mill District, Bend Oregon. For information, click here

December 5–8, 2010 – 22nd Annual National Forum on Quality Improvement in Health Care. The Institute for Healthcare Improvement.; Orlando World Center Marriott Resort & Convention Center, Orlando, FL. Conference Information/Registration

August 1-15, 2011 – 8th US-Russian Nursing Conference Cruise. “US and Russian Nursing: Creating Collaborative Networks to Promote Global Health.” For early registration information contact: Marie Driever at mariedriever@comcast.net, (503) 706-7344. For more conference information, see: http://www.us‐russiannurses.com/

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