Managing Patient Care

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Learning Outcomes

- Provide safe and effective nursing care through collaboration and coordination with the interdisciplinary team.
- Determine discrepancies between care provided & unit standards and why standards were not met.
- Be confident to participate in continuous quality improvement efforts.

Care Coordination

What is care coordination?

- Care coordination is “the **deliberate** organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services.”
  - Stated in the article: Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination)

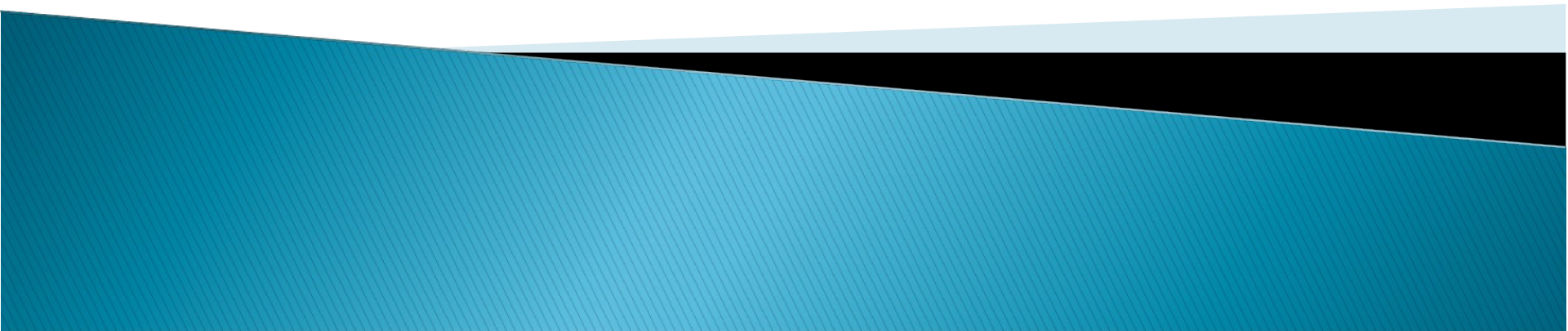
Case Manager

- Case Managers coordinate patient care
- Goal is to avoid fragmentation of care
- Knowledge expectations are extensive
  - The case manager must have advanced training and knowledge of the surrounding area and be a resource for all patients

The Case Manager:

- Does coding and billing for insurance
- Arranges for home medical equipment
- Schedules dialysis
- Works with insurance for payment
- Assists with financial aid
- Arranges for home oxygen
- Arranges for home health
- Schedules physical therapy
- Arranges for hospice/palliative care
- Arranges transfers to other facilities
- Arranges for transportation

Quality Improvement



Medical mistakes

98,000 people die each year from preventable mistakes....and those are just the ones we know about.

1 mistake = 1 life

Quality Improvement

- Process of improving care and reducing deficiencies.
- Measures performance against standards.
- Standards of care should reflect optimal goals and be evidence-based.
- JCAHO requires evidence of QI for accreditation status.

Continuous Quality Improvement (CQI)

- Proactive approach to improvement of healthcare.
- Emphasis on anticipating and preventing problems rather than reacting to them.
- Requires close and constant scrutiny

Care should be:

- Safe
- Effective
- Patient-Centered
- Equitable
- Efficient
- Timely

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems)

- Patient satisfaction surveys! How did we do??
- Used as a way to compare similar institutions
- Gives us an overall picture of how we are doing

There are 8 items measured

- Communication with doctors
- Communication with nurses
- Responsiveness of hospital staff
- Pain management
- Communication about medications
- Discharge information
- Cleanliness of environment
- Quietness of hospital environment

Development of Standards

- Predetermined level of excellence that serves as a guide for practice
- Must be objective, measurable, and achievable
  - Outcome standards
  - Process standards
  - Structure standards
- Must meet established benchmark

Steps in the QI Process

1. Standards are determined
2. Quality issues are identified
3. A team is developed to review the issue
4. Current structure/process is analyzed
5. Data is collected, analyzed and compared to benchmark
6. If benchmark not met, possible influencing factors are determined
7. Potential solutions or corrective actions are analyzed w/ 1 chosen
8. Education or corrective action is implemented
9. Issue is re-evaluated at a pre-established time

What can you do to improve quality?

- Serve on the policies & procedures committee
- Use reliable sources for information
- Be familiar with your facility's P&P's
- Provide care consistent with P&P's
- Document thoroughly and correctly
- Participate in review committee's
- Assist with education/training necessary
- Follow clinical practice guidelines
- Act as a role model

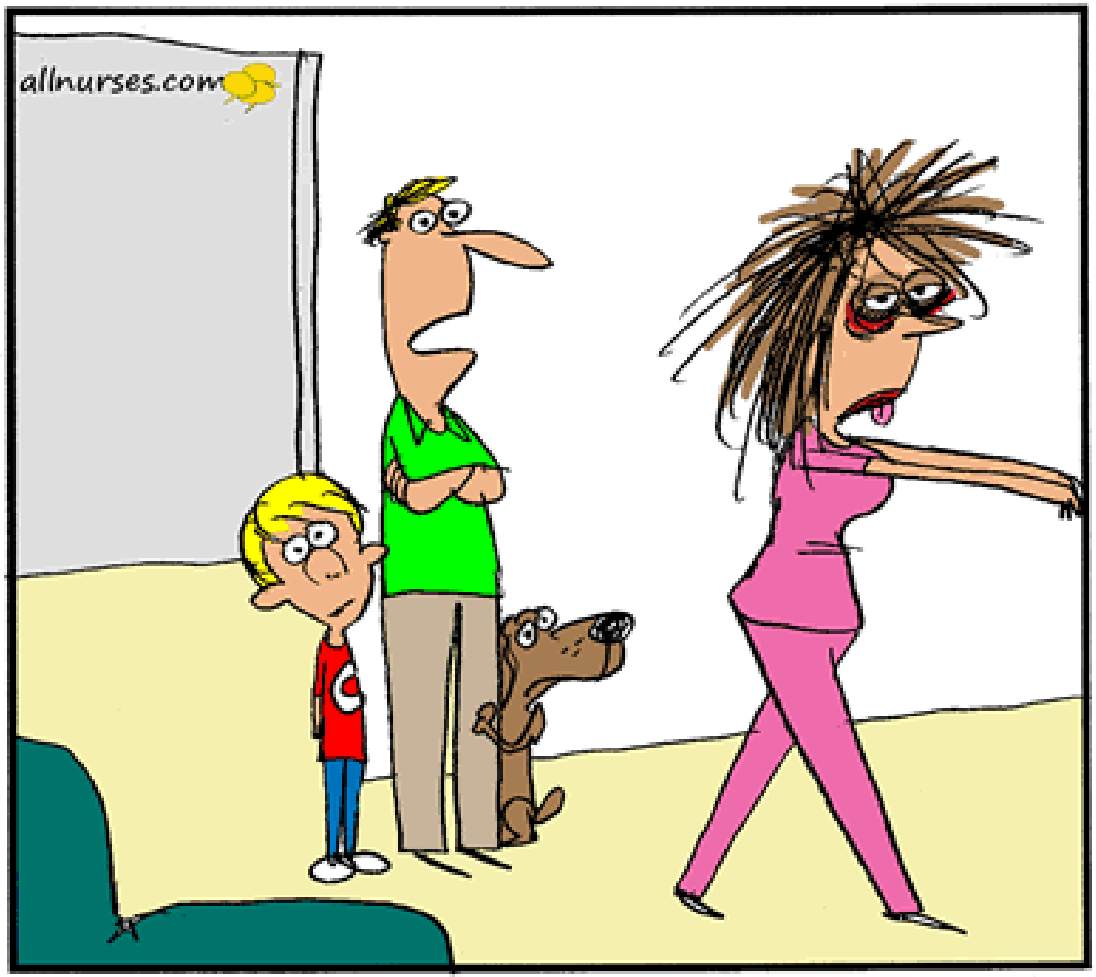
Clinical Practice Guidelines

- Provide diagnosis-based step-by-step interventions for providers to follow in an effort to promote high quality care and control resource utilization
- Also called standardized clinical guidelines
- Should reflect evidence-based practice

Audits

- Audits are routinely conducted to evaluate quality and if standards are met
- Outcome audits
  - Determine results of direct nursing care provided
- Process audits
  - Review how care was provided
- Structure audits
  - Evaluate factors outside of patient-staff interaction

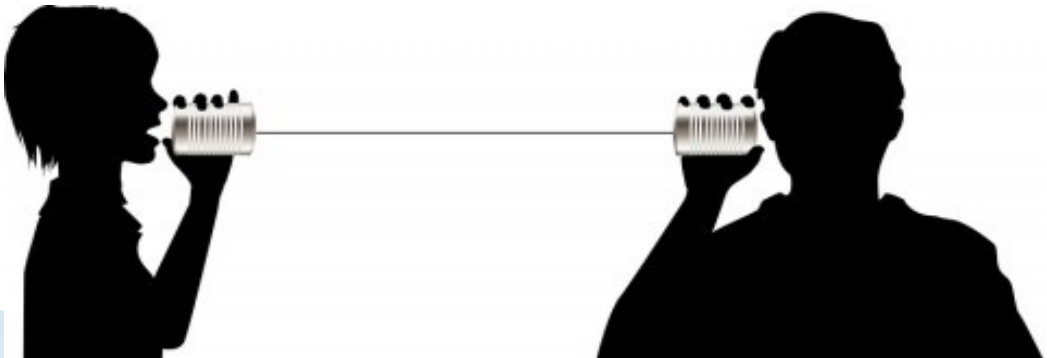
About a Nurse



"No, your mom isn't rehearsing for the next 'Night of the Living Dead' movie. She always looks like that after working four 12-hour shifts."

Issues faced in healthcare

- Patient discharge delays
- Care variation
- Avoidable medical errors
- Communication breakdowns between providers



It is beneficial to be a high-quality institution!

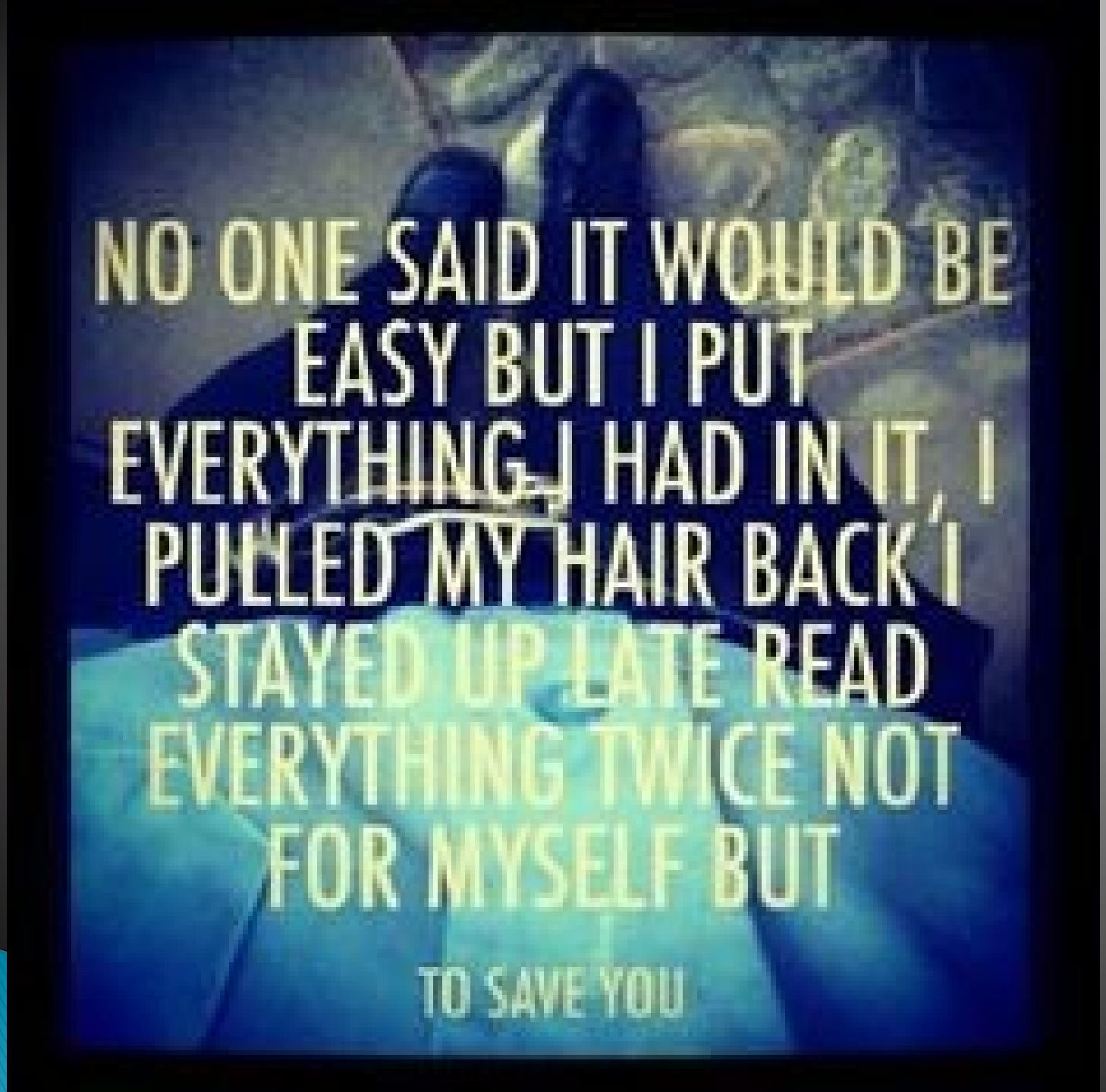
- The Leapfrog Group
  - Hospitals scored and rewarded financially.
  - Leapfrog has endorsed the use of bar-coding to reduce point-of-care-medication errors.
- ANCC Magnet status
  - Most prestigious award a health care organization can receive for quality of care and excellence in nursing.
  - Have a set criteria to measure strength and quality in nursing.
  - Only 6% of hospitals are able to achieve magnet status.

Table 1

Commonly Reported Quality Improvement Programs

Program and Sponsors	Description
Hospital Quality Initiative (HQI): Centers for Medicare & Medicaid Services (CMS)	Brings hospital members together with experts to impact evidence-based best practice. Hospitals report on 20 measures, which are reported to consumers and used for CMS regulation and enforcement activities.
Core Measures: The Joint Commission	Measures include initiatives in acute myocardial infarction, heart failure, ventilator-associated pneumonia, surgical care improvement, children's asthma, and pregnancy and related conditions. To meet the requirements for accreditation, hospitals must select three of these core measure sets.
5 Million Lives Campaign: Institute for Healthcare Improvement (IHI)	Aims to protect patients from 5 million incidents of medical harm over two years by encouraging hospitals to adopt 12 interventions to increase patient safety. Initiatives include deploying rapid response teams, preventing surgical site infections, preventing pressure ulcers and delivering evidence-based care for congestive heart failure.
Leapfrog	Gathers and reports information on hospital quality and patient safety efforts to help patients make informed decisions about where to receive hospital care.
University HealthSystem Consortium	An alliance of 97 academic medical centers and 153 affiliated hospitals that puts forth quality initiatives, core measures and benchmarks utilized by member hospitals.
Vermont Oxford Neonatal Network	A nonprofit voluntary collaboration of health care professionals aimed at improving the quality and safety of medical care for newborn infants and their families. Provides data on high-risk newborns to participating units for use in quality management, process improvement, internal audit and peer review.
Keystone Center for Patient Safety and Quality: Michigan Health and Hospital Association	Brings hospital members together with experts to infuse evidence-based best practice. Currently organizes initiatives around ICU care, stroke, organ donation, and hospital-associated infections.
Safest in America: Minnesota Hospital Association	A collaboration of 10 hospital systems in the Twin Cities and Rochester working to improve patient care by collaborating on process improvements. Priority areas include surgical site marking practices, medication safety and hospital-acquired infections.
COAP (Clinical Outcomes Assessment Program)/SCOAP (Surgical Clinical Outcomes Assessment Program): Washington State Foundation for Health Care Quality	COAP is a nonprofit, public-private partnership to provide a rigorous, evidence-based mechanism to promote internal quality improvement activities and produce clinical information needed to improve quality of care. SCOAP is focused on building a system to track and improve surgical care and outcomes to reduce errors.

Note: This table is intended to illustrate the variety of quality improvement programs in which hospitals in each of the four study communities participate. It is not an exhaustive list of programs in which hospitals participate but rather a selection of the programs that respondents most commonly reported when asked to discuss their hospitals' quality improvement activities.


NO ONE SAID IT WOULD BE
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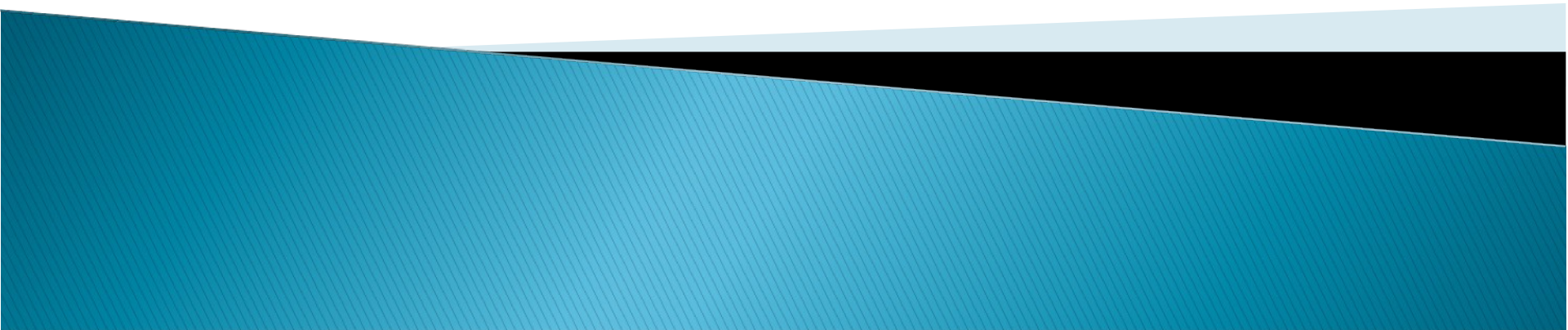
Risk Management

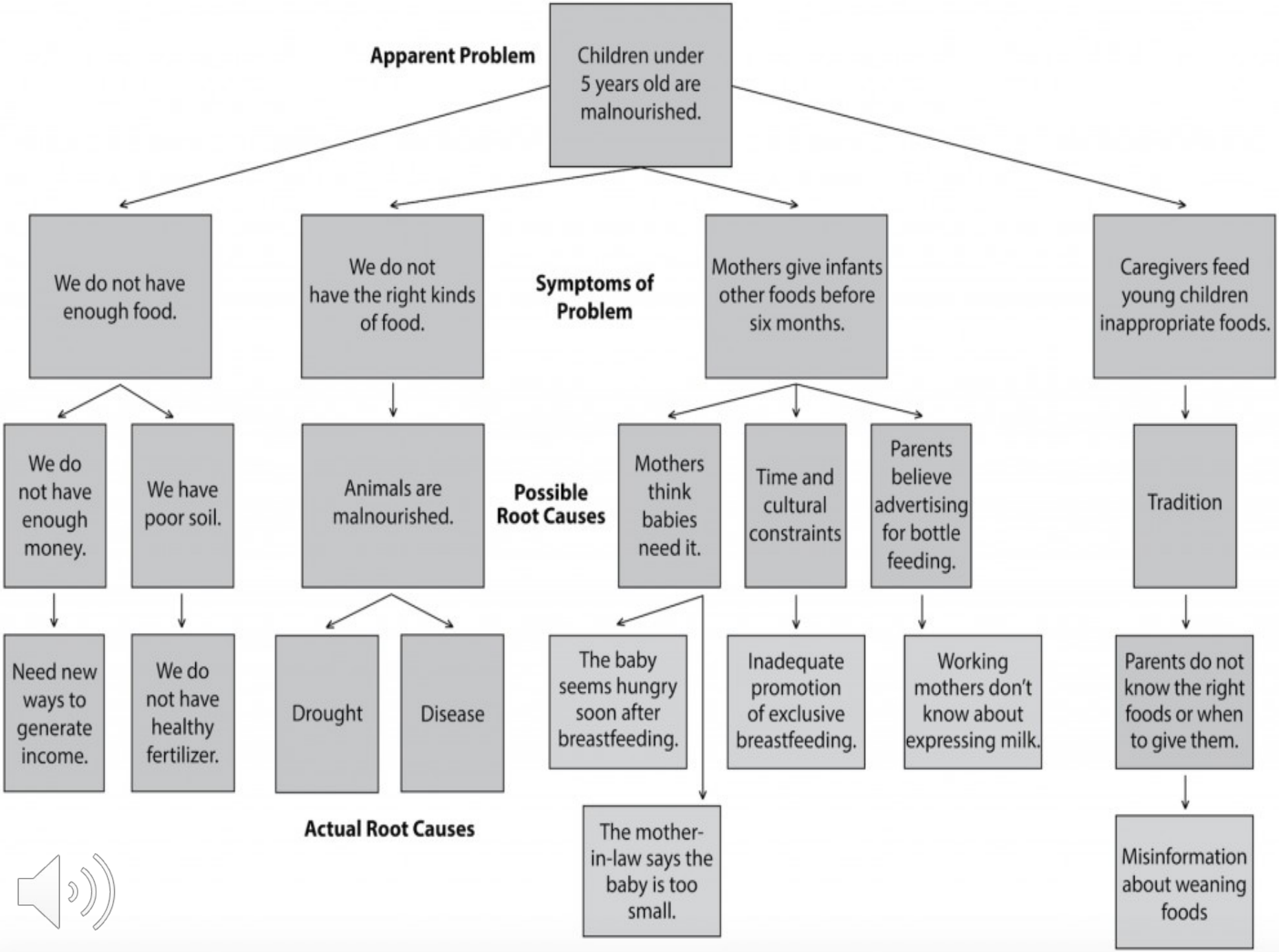


What is risk management?

- Component of QI Management
- Focuses on identifying, analyzing and evaluating risks
- Overall goal is to reduce risk to decrease harm to patients
- Patient records and incident reports used to track and analyze events (root cause analysis).

Root Cause Analysis

- Tracks events leading to error, identifies faulty systems and processes and develops a plan to prevent further errors.
- Get to the “root” of why
- JCAHO sets mandatory National patient Safety Goals to address particular risks.
  - Overall goal is to promote quality evidence-based measures to maximize health benefits.


Apparent Problem
Children under 5 years old are malnourished.
We do not have enough food.
We do not have the right kinds of food.
Symptoms of Problem
Mothers give infants other foods before six months.
Caregivers feed young children inappropriate foods.
We do not have enough money.
We have poor soil.
Animals are malnourished.
Possible Root Causes
Mothers think babies need it.
Time and cultural constraints
Parents believe advertising for bottle feeding.
Tradition
Need new ways to generate income.
We do not have healthy fertilizer.
Drought
Disease
The baby seems hungry soon after breastfeeding.
Inadequate promotion of exclusive breastfeeding.
Working mothers don't know about expressing milk.
Parents do not know the right foods or when to give them.
Actual Root Causes
The mother-in-law says the baby is too small.
Misinformation about weaning foods

National Patient Safety Goals

1. Improve accuracy of patient identification
2. Improve effectiveness of communication among caregivers
3. Improve safety of using medications
4. Reduce risk of healthcare-associated infections
5. Identify patient safety risks inherent in its patient population
6. Reduce the harm associated with clinical alarm systems.

Steps in Risk Management

- Four main categories/steps to risk management:
  - Risk Identification
  - Risk Analysis
  - Risk Treatment
  - Risk Evaluation

Example

- The CDC found that prolonged urinary catheter use is the leading risk factor in catheter associated UTI’s.
- A healthcare policy was adapted stating that physicians had to regularly evaluate the catheter and document a continued need for the catheter.
- The end result was a decrease in catheter dwell times and decrease in catheter associated UTI’s.

Identified High-Risk Areas

- Medication errors
- Complications from tests/treatments
- Falls
- Refusal of treatment
- Refusal to sign consents
- Patient/family dissatisfaction

We should always ask why…

- To just accept an answer teaches you nothing and most likely you are missing something. It is important to know the why behind things…
- “WHY” am I doing this?
- “WHY” do we do this a particular way?
- “WHY” does my patient look like this?

https://www.youtube.com/watch?v=U3w_eIa7Eq0

Sentinel Events

What is a sentinel event?

- A **Sentinel Event** is defined by The Joint Commission as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness, or the risk thereof.

- 2017 stats of sentinel events = 
Microsoft Word Document

Examples

- Infant abduction, or discharge to the wrong family
- Unexpected death of a full term infant
- Severe neonatal jaundice
- Fall
- Surgery on the wrong individual or wrong body part or object left in patient
- Rape in an acute-care setting
- Suicide in an acute-care setting, or within 72 hours of discharge
- Hemolytic transfusion reaction due to blood group incompatibilities
- Fire
- Radiation therapy to the wrong body region or 25% above the planned dose

https://www.youtube.com/watch?v=nZ2r6IVwm70


Questions

- At shift change, the off-going LVN reports to the oncoming RN that the newly hired CNA has not calculated the intake and output for several patients. Which of the following actions should the RN take?

  - A) Complete an incident report
  - B) Delegate this take to the LVN
  - C) Ask the CNA if they need help
  - D) Notify the nurse manager

- A nurse is participating in a quality improvement study of a procedure frequently performed on the unit. What information will provide data regarding the efficacy of the procedure?

  - A) Frequency with which the procedure is performed
  - B) Patient satisfaction with how the procedure was done
  - C) Incidence of complications related to the procedure
  - D) Accurate documentation of how procedure was done

- The nurse is assigned four patients. Which patient should the nurse see first?
  - A) A patient admitted four hours ago with AMS
  - B) A patient 12 hours post-op angiogram
  - C) A patient who had 3 emesis episodes in 12 hours
  - D) A patient that had their pacer wires pulled yesterday

- A nurse is preparing to transfer an older adult patient who is 72 hours post-op to a long-term care facility. Which of the following information should the nurse include in the transfer report? (Select all that apply)

  - A) Type of anesthesia used
  - B) Advance directives status
  - C) Vital signs on day of admission
  - D) Medical diagnosis
  - E) Need for specific equipment

- A nurse is participating in an Interprofessional conference for a patient who has a recent C6 spinal cord injury. The patient worked as a construction worker prior to his injury. Which of the following members of the Interprofessional team should participate in planning care for this patient? (Select all that apply)

  - A) Physical therapist
  - B) Speech therapist
  - C) Occupational therapist
  - D) Psychologist
  - E) Vocational counselor

- A nurse on a telemetry unit is caring for a patient who was admitted 2 hours ago for chest pain. The patient becomes angry and tells the nurse that there is nothing wrong with him and he is leaving now. Which of the following actions should the nurse take? (Select all that apply)

  - A) Notify the patient’s family of his intent to leave
  - B) After leaving, document that the patient left AMA
  - C) Explain to the patient the risks in leaving
  - D) Ask the patient to sign an AMA form before leaving
  - E) Prevent the patient from leaving until the doctor rounds

- The nurse receives an order to start a patient on 300 mg amiodarone by mouth daily. The patient is currently receiving a transfusion of amiodarone continuously via IV. What should the nurse do?

  - A) Administer the ordered oral dose of amiodarone
  - B) Start the oral amiodarone schedule the next day
  - C) Call the healthcare provider to clarify the order
  - D) Stop the infusion 2 hours after the first oral dose