ED Focused Plan of Correction: ER Leadership Review

Action Plan Items:

1. **Pain assessment/re-assessments**
    - All ED patients must have an initial pain assessment.
    - Pain rating must be documented prior to the administration of any pain medication.
    - Pain ratings and sedation levels must be reassessed within one hour after administration.

Validation: (RNs and Paramedics)
re-assessments should be documented via the task on the activities band. (see attached screen shots). If documented via iView, staff should document "chart not done > task completed" on activities band to remove task. many pain medication parameters are ordered based on pain level so establishing a baseline pain level will guide the nurse on which medication to pick. Any intervention (medication administration, procedure, etc.) warrants a re-assessment to assess the success of the intervention.

Audit: Completed by our quality team retrospectively, 20 charts audited daily, goal to be 90% compliant with pain assessment/reassessment, 100% of follow up with outliers

Discern Report: Can be pulled at any time, The report will be pulled by:
- Manager would be to pull at beginning of shift and end of shift to catch outliers in real time
- CNC will pull at 0600, 1200, 1800, 0000

ED Pain Med Reassessment Compliance Report — **Emergency Department**

Real time monitoring:

1. **Pain Re-assessment (documenting through the task)**
   On the tracking board under the "activities" column they will have a "clipboard" icon for the 1-hour pain re-assessment. Clicking on the icon will take them to the power form to document pain level.

PRN Medication Response - TRAINPM, BOOKLYN

*Performed on: 01/11/2024 09:56 EST — By: Test, ED-RN

Intervention Info:
hydromorphone
Performed by Test, ED-RN on 01/11/24 08:58:00 EST

HYDROmorphone 0.5mg
IV, Antecubital Left pain

Pain - Post Assessment

Patient Stated Medication Effectiveness: Yes / No / Other
Temperature (F) | Temperature (C) | Temperature Method: Tympanic / Oral / Axillary / Core / Rectal / Skin Sensor / Temporal Scanner

Blood Pressure | Mean Arterial Pressure | Heart Rate

Medication administered for pain?: Yes / No

Pain Scale Used: 0-10 | Pain Rating: 0 / CNPI Score Completed | Goal for Pain Management: No pain 0

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2. EKG order to Complete (goal: within 10 minutes)

- EKGs for medically indicated patients should be completed in a 10-minute time frame.

Validation:
ED RNs may perform a 12 lead ECG without a provider order in cases of Chest pain, abdominal pain, shortness of breath or clinical suspicion of ACS symptoms (order will be placed later by provider) Any delay in identifying ACS symptoms increases mortality. A delay in obtaining the ECG could mean a delay in obtaining reperfusion therapy. Timely rhythm interpretation allows for timely intervention and allocation of resources.

Audit: performed by Quality team retrospectively, all outliers >10 minutes for key diagnosis (chest pain, syncope, SOB)

Real time monitoring: Red hearts on first net tracking board,

	FPOC	TA/+	To Gree	Alert	EKG	Spec	30	DC	Status	Bed	Sta
										RPOD,01 ISO	
▶					Req					RPOD,02	

3. Lab order to Collect (goal: within 30 minutes)

- Labs should be collected within 30 minutes of the order

Validation:
staff members can speak to repeat troponin time frames (initial, 3-hour, 6 hour) and repeat lactic acid collection (automatic order in 2 hours for initial lactate > 2 and then q 4 hours until lactic is < 2 or 24 hours have passed) timely collection of labs allows for quicker diagnosis and treatment of the patient. Leading to better outcomes.

Audit: Quality team performs 20 retrospective audits daily, focused on key labs (troponin, HGB, Lactic, K, and PT) Auditing

Real time monitoring: QlikView board, first net tracker

How to tell if you have lab orders:
On the tracking board, if you scroll over the "lab" column and hover over the number, you can see what labs are ordered and the status (dispatched, in-lab, complete, etc.)

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4. **Arrival to Triage for EMS and Front Entrance Patients (Triage) (goal: 10 minutes)**
    - Patients arriving to the emergency department must be seen, triaged, and care assumed by an RN within 10 minutes of arrival. This includes those who are on an EMS stretcher, even if the patient is not immediately assigned a room.
    - At Triage, registration time is "back timed" to actual patient arrival time. (via time stamped document)
    - Rapid triage performed at the triage desk, IPA RN will document full triage

Validation:
timely triage allows for proper allocation of resources. Getting the right patient to right place in the right time with the right resources is what triage is all about!

Audit: Quality team performs real time in person observations, provide feedback to staff and document finding in our audit tracker

Real time monitoring: Triage Assistance called by triage nurses and CNCs

How to "back time" registration
From the tracking board, the pencil icon lets you search for and register a patient. The next screen will ask about chief complaint and method of arrival, they have to scroll down and change the time under "arrive time" to the time that is listed on the time-stamped document.

Person Search

Name: train, br
MRN:
SSN:
Birth Date: **/**/****
Sex:
FIN NBR:

Name	Pronouns	SSN	MRN	Sex	Birth Date
[illegible]NPM, BRYCE			00-00-40-10-11	Male	03/09/2007
TRAINPCMFL, BRUNO			00-00-85-00-44	Female	06/30/2000
TRAINOR, BRENDEN			00-02-10-11-61	Male	06/15/1936
TRAINNSO, BRET			00-00-97-69-70	Male	05/25/1925
TRAINNICU, BROOK			00-02-10-21-94	Female	04/20/2023
TRAINNICU, BRENDA			00-02-10-21-65	Female	04/20/2023
TRAINLAB, BRANDON			00-02-10-13-81	Male	06/03/2017
TRAINLAB, BRANDON			00-00-50-10-36	Male	10/03/2016
TRAINED, BRENT			00-00-95-64-42	Male	07/08/1978

FIN NBR	Enc Type	Enc Type(s)	Med Service	Facility	Reg Date
401011003172	Inpatient			Mission Hosp	01/01/23 00

Encounter Information
*Admitting Physician: CMEM MD, Physician
*Attending Physician: CMEM MD, Physician
Patient Type: Emergency

Registration Date: 01/10/2024
Registration Time: 11:48
Arrive Date: 01/10/2024
Arrive Time: 11:48
Patient Rights Book Offered?:
Primary Care Physician:
Location

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5. **Telemetry (Cardiac Monitor)**
   - The RN (or medic/PCT if delegated) has 30 minutes from the time order is placed to begin cardiac monitoring patient.
   - For all patients placed on telemetry, a cardiac rhythm should be documented at baseline and with any rhythm changes (per policy)
     Policy: Physiologic Monitoring – Cardiac Telemetry Monitoring, Continuous Pulse Oximetry Monitoring, Non-Invasive Blood Pressure Monitoring (NIBP), 1PC.NRS.0001
   - Every time an order is placed, the order will also print to ED CMU
     - CMU will alert that an order is placed and will alert if not initiated in the 30-minute time frame
     - CMU will also alert when patient is off monitor, and for any tele abnormalities
     - DO NOT IGNORE CMU, if they are alerting you for an alarm it needs to be addressed, alerts will be escalated to the CNC if not addressed timely.
   - Document start/stop tele times in Cerner

Validation: (RNs)
"telemetry alert" pop-up that directs them to documentation. Like ECGs, ED RNs do not have to have an order to place the patient on the cardiac monitor initially if it is clinically indicated or there is any clinical suspicion of the need to monitor. The order cab be placed later by the provider, however, if the patient is not placed on a monitor initially and the provider orders it, they have 30 minutes to place the patient on the monitor and document it. Continuous ECG monitoring allows staff members to trend and recognize changes in real time.

Audit: Completed by our quality team retrospectively and in real time., CMU receives a report every 2 hours tells them every patient that has orders, they will review patients they are monitoring to ensure order is in place. CMU will reach out to nurse for follow up if no order present.

Real Time Monitoring:

Documenting Telemetry Rhythm

Under VS tab, document rhythm and ectopy (if any)

Vital Sign Data		
Temp F	DegF	
Temp C	DegC	
Temperature Method		
Heart Rate	bpm	110
Heart Rate Obtained		Monitor
Telemetry Rhythm		Sinus Tachycardia
Ectopy		PVC
Electrodes Changed		Yes
Central Monitoring Tele Report Reviewed		Yes

How to tell if you have continuous monitoring orders? Two ways: one from the orders tab, and two: from the tracking board, you will see a "monitor icon" on the left-hand side.

Order Name	Dose ...	Details	Start	Status
Vital Signs/Monitoring				
Continuous ECG Monitoring, ED		12/27/23 8:37:00 EST, Now	12/27/2023 08:37 EST	Ordered

FPOC	TA/+	Alert	EKG	Spec	Bed	DD	A	LOS	VI	Pro	Name	Age	AI	Reason for Visit	MD	MLP	TAP	RN	PC	NR	IV	Activities	Events
					AH,1A			0:29			D230, REGMAY MOTHER												

How to document your monitoring:

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If active order is found, once they click on iView, they will receive a "telemetry alert" pop up, clicking on the "telemetry alert notification" box will take them to the power form to document initiation of telemetry.

6. **CIWA**
   - Complete Assessment within 1 hour of patient arrival and begin treatment ASAP to reduce severity of withdrawal symptoms

Validation:
staff members can speak to:

- CIWA-Ar stands for Clinical Institute Withdrawal Assessment for Alcohol
  - An evidence-based tool for evaluating for early symptoms of alcohol withdrawal
  - Must be assessed for any patients who have been actively using alcohol
- Complete assessment **within 1 hour of physician order and begin treatment per protocol** to reduce the severity of withdrawal symptoms
  - *Help the patient to control their behavior, from escalating behaviors, and from the development of seizures and DT's*
  - *Support safety of all patients, visitors and staff*

Audit: VP of Emergency services performs retrospective audit on all fall outs, this includes chart review

Real time monitoring: 2/9/2024 at 0800 when a CIWA plan is ordered it will fire as a task, under activities hover over the green cross to see outstanding task.

Discern Report: Emailed Q6H, can also be pulled at anytime

Documentation:

The assessment evaluates for 10 domains of symptoms, indicating the risk and severity of alcohol withdrawal.

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7. **ER Provider response to Emergent Needs**
    - When patient needs are escalated to a provider the expectation is a response with closed loop communication on the escalation.

Validation:

- Staff members can speak to escalation process while on shift
- Staff members can speak to vigilanz process

Audit: Escalation opportunities are monitored through Vigilanz

Real time monitoring: Ensuring Q2H WebEx closed loop communication, responsiveness to staff escalations in real time

Cerner documentation for provider notification:

	01/11/2024 09:15 EST	09:14 EST
Notify Provider		
Provider Name		Test , ED-P...
Notification Method		On Unit
Notification Reason		Condition ...
Orders Received		Yes
Provider Notification Note		hypotensive
Non-Urgent Provider Com		

8. **Radiology Delays**
    - Timely execution of radiology orders ensures that providers are given important clinical information to make disposition and plan of care decisions in the best interest of the patient

Validation:

- Staff can speak to the radiology process and interventions required to prepare patient for timely imaging such as lab collection, IV placement, and clothing removed.
- Ensure that staff can also speak to proper documentation of IV placement

Audit: the radiology team is submitting a vigilanz for any CT order to start greater than 60 minutes to track and trend opportunities for improvement

Real time monitoring: Radiology team attends Q2H huddle as well as completes real time escalation of barriers in the WebEx

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9. **Consent to Treat- pediatric Orders**
   - All patients should have an informed consent on file.
   - Remember: It is critical to assess the patient and begin treatment as soon as possible. Do not delay care to obtain consent

Validation:

All staff can speak to:

- **Children may present to the emergency room without a parent or guardian present. When that occurs, we must still obtain consent to treat the child from the parent/guardian. This is usually obtained via telephone with a witness on the line**
- We will ALWAYS perform a medical screening exam (MSE) and treat the child for any emergent medical condition immediately. **We do not wait for consent to evaluate and treat an emergency!**
- Never discharge a child home unless consent has been obtained from the parents. Also ask the parent/guardian if you may provide discharge instructions to the person with the child, or if they want you to call them back to provide the discharge instructions over the phone.
- Minors may consent for themselves for treatment related to venereal disease and other STIs, pregnancy, abuse of controlled substances or alcohol, or emotional disturbance in the outpatient setting.
- If the minor becomes an inpatient in the behavioral health unit, consent must be obtained from the parent/guardian.
- Emancipated minors may consent for themselves. They should have a court-issued document declaring their emancipation.
- Children left in the care of others (e.g. the parents are out of town and leave the child in the care of another adult) should have a letter from the parents allowing the caregivers to consent for medical treatment. This should be a notarized letter indicating who can consent for the child, include any limitations on what they can consent for, and be signed by the parent.
- We will ensure that the **PARENT and PATIENT** are banded at time of arrival to the ER.

Audits: Registration and HIM are performing retrospective audits to ensure all charts have consent on file.

Realtime monitoring: Ensure staff and CNC can speak to consent process.

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10. Ligature Risks

- A ligature is defined as anything which could be used for the purpose of hanging or strangulation.

Validation:

Staff can speak to the following:

- When a patient had a moderate to high CSSRS, one intervention required is to assess the patient environment and remove ligature items that are not essential to patient care.
- Items that cannot be removed because they are necessary for patient care should be closely monitored by the team.
- The environment should be assessed:
  - When putting the patient in a room for the first time or as soon as they have a moderate to high CSSRS screening.
  - At change of shift
  - After visitors, if patient is not 1:1 observation (sitter)
  - Whenever there is a safety concern.

Audits: are being completed by PSA rounding team

Policy: Patients at Risk for Suicide in Non-Behavioral Health Settings: Identification and Monitoring 1PC.PSY.0102. **Policy has a suicide safe environment checklist** for the Emergency Room

Realtime Monitoring: ER leadership will continue their Q2H round on BH patients to ensure environmental safety. ER leadership will also monitor first net tracking board to ensure that appropriate interventions are in place based on.

- **New Icons for Tracking Board**
  - These icons will appear once the provider has completed the Overall Suicide Risk (OSR) assessment.

Documentation: The removal of ligature items is documented in "Pt. room safe environment action items"

Suicide Risk Reassessment
Wished dead/wished go to sleep-not wake
Actual thoughts of killing self
Thoughts about how you might do this
Thoughts with intention of acting
Start to work out details with intent
Start/prepare to do anything to end life
CSSRS Reassessment Numeric Score
CSSRS Suicide Risk Reassessment
Change from previous assessment
Pt room safe environment action items