

EMERGENCY DEPARTMENT PERFORMANCE IMPROVEMENT PLAN

PURPOSE:

The purpose of the Emergency Department Performance Improvement Plan is to ensure that the medical and professional service staff demonstrate a consistent endeavor to deliver optimal care in an environment of minimal risk.

In keeping with the hospital's mission, the Performance Improvement Plan allows for a systematic, coordinated and continuous approach to improving performance focusing upon the processes and mechanisms that address these values.

As patient care is a coordinated and collaborative effort, the approach to improving performance involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise performance improvement activities.

OBJECTIVES:

- Maintain a comprehensive, effective system for monitoring and evaluating the quality of patient care and services provided in a cost effective manner.
- Assure that patient care is provided and maintained at an optimal level consistent with the professional standards held in the medical community.
- Improvement of existing processes and functions through a systematic approach that includes identifying a potential improvement, testing the strategy for change, assessing data from the test to determine if the change produced improved performance and implementing the improvement strategy system-wide.
- Provide for a collaborative approach to review healthcare practices for their quality, cost effectiveness and positive outcome on the patients treated.
- Focus of quality improvement data at a central point for examination, analysis and documentation of ongoing activities. Data is to include use of statistically valid performance measures and quality control techniques.
- Provide for performance improvement assessment process that includes comparative data about the department's processes and outcomes over time, use of current sources about the design and performance of processes (such as practice parameters) and the performance of processes and outcomes in relationship to that of other organizations, including reference databases.
- Provide for established criteria that will allow for the setting of priorities for improvement activities. Such priorities will be based upon assessment of opportunities for improvement or the need to reduce or eliminate undesirable change in performance.

MEDICAL STAFF QUALITY MONITORING REVIEW

Abdominal Pain

ED# _____

MD# _____

YES	NO	NA	Criteria:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Chief complaint documented?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Onset and duration of pain documented?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Nature and location of pain documented?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Nausea, vomiting, diarrhea and appetite documented?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. History of similar episodes documented?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Orthostatic vital signs documented (tilt test)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Abdominal exam documented?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Rectal exam/stool guaiac documented?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Heart and lungs auscultated?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Pelvic exam, if indicated?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Were appropriate labs/x-rays done?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. LMP and B-HCG in females of childbearing age documented?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. If possible ectopic, was ultrasound performed, GYN consult obtained?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. If PID diagnosed, was GC, VDRL and Chlamydia culture obtained?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. If appendicitis suspected, was ultrasound ordered and reviewed?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. If question of early appendicitis, will patient be reevaluated in 4-6 hours?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Treatment and consultation timely and appropriate?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Was medication/treatment ordered for pain effective?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. If treatment refused, written informed refusal signed? If not, efforts to obtain informed refusal documented?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Aftercare instructions including diet/specific follow-up/specific instructions to return?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Disposition on discharge documented?

Chart Appropriate

Chart Not Appropriate (*Must fill out Severity Code and Standard of Care*)

Comments if Applicable:

Severity Code (All 2, 3 and 4 codes to committee)

- 1. Without significant adverse effect on patient
- 2. With potential for significant adverse effect on the patient
- 3. Significant adverse effect on the patient
- 4. Death

Standard of Care

- 1. Unexpected occurrence handled appropriately
- 2. May have been preventable
- 3. Probably preventable
- 4. Clearly preventable

Signature of Reviewer

Date

Documentation of Follow-up (if criteria not met):

Signature of Medical Director

Date

NURSING STAFF QUALITY ASSESSMENT REVIEW

Nursing Documentation

ED# _____

MD # _____

RN# _____

YES	NO	NA
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Criteria:

Triage of Patients Upon Arrival to ED

1. Triage of patients completed within 15 minutes of arrival?
2. Brought in by noted?
3. Accompanied by noted?
4. Presenting complaint?
5. Triage intervention?
6. Date/time?
7. Triage by RN?
8. Signature of Nurse?

General for Nursing Documentation

1. Mode of arrival documented?
2. Complete initial assessment documented?
3. Vital signs on admission (T - P - R - B/P)?
4. Vital signs repeated (at least once) appropriate to LOS in ED & diagnosis?
5. Weight documented on pediatric patients?
6. Immunization history on pediatric patients?
7. Disposition indicated on chart?
8. Aftercare instructions given?
9. Patient education instruction noted?
10. Condition of patient at time of discharge or transfer documented?

Chart Appropriate

Chart Not Appropriate (*Must fill out Severity Code and Standard of Care*)

Comments if Applicable:

Signature of Reviewer

Date

Documentation of Follow-up (if criteria not met):

Signature of Nurse Manager

Date

NURSE PROTOCOLS AND STANDING ORDERS

Abdominal Pain

POLICY:

The patient arriving at the Emergency Department with abdominal pain will receive the following care:

- Assure patient airway
- Obtain vital signs
- IV - Establish normal saline or physician preference
- Obtain venous bloods for lab
- Obtain urine same
- If available, do HCG with urine sample
- Keep patient NPO
- Obtain stool sample as applicable

Obtain history of:

- Mechanism of injury if trauma
- Any nausea, vomiting, diarrhea or constipation
- Vaginal bleeding
- Last bowel movement
- Previous abdominal surgeries
- Any weight loss
- Last menstrual period
- Pregnancy
- Color, consistency of stool
- Color, consistency of emesis

Assess for:

- Pain
 - Location
 - Quality
 - Radiation
 - Onset
 - Severity
- Bowel sounds
- Vital signs
- Any abdominal tenderness, distention
- Rigidity or guarding

Notify physician.

COBRA UPDATE

Initially enacted in 1986 and amended in 1989 and 1990, COBRA applies to all Medicare participatory hospitals regardless of accreditation, profit status, ownership, location, state, county or political boundaries. As of June 1998, HCFA has released updated interpretive guidelines with final EMTALA regulations due at a later date. Essentially, the new interpretations define terminology; they do not change requirements that are already in place. One issue which may be taken up in the final regulations is non-Medicare-participating managed care plans. Current, HCFA lacks statutory authority for some recommendations.

Although COBRA has been in place for years, many hospitals have become complacent due to the weak and intermittent government enforcement of the law. Responding to public pressure, HCFA now has every intention of following up on all violations.

Any transfer or discharge from an acute hospital can fall under COBRA, including in-house urgent care and outpatient clinics. COBRA also applies anywhere a patient presents for treatment on the hospital premises: L&D, the Volunteer desk, even the loading dock. All patients must have a medical screening exam to determine if a medical emergency exists.

SUMMARY OF HOSPITAL'S RESPONSIBILITIES UNDER COBRA:

- A log of all patients presenting to the Emergency Department must be kept, whether or not they are treated.
- A medical screening exam to determine whether or not an emergency condition exists must be done prior to asking about insurance coverage. This includes managed care enrollees.
- Triage is not a screening exam. The Medical Staff Bylaws or Rules and Regulations must specify who is qualified to perform a screening exam. The exam must include any resources necessary (EKG, ABG's, X-rays, etc.) to make the determination.
- Tax-exempt hospitals violating COBRA may place their exempt status at risk.
- Conspicuous signs must be posted in the ED which specify the rights of the patient under COBRA.
- Hospitals must maintain a list of physicians who are on-call to provide treatment necessary to stabilize a patient with an emergency condition.
- If the hospital determines that a patient has an emergency medical condition, the hospital must:
 - Provide further medical examination and treatment required to stabilize the medical condition, within the staff and facilities available at the hospital, including on-call physicians, **or**
 - Transfer the patient to another facility.
- If the patient refuses treatment, a hospital is deemed to have met its obligations to a patient if:
 - The hospital offers the patient further medical examination and stabilizing treatment, **and**
 - The hospital informs the patient (or his/her representative) of the risk and benefits to the patient of the examination and treatment, **but**
 - The patient (or his/her representative) refuses to consent to the examination and treatment.
- If a patient refuses transfer, the hospital is deemed to have met its obligations to the patient if: