JCAHO Requirements for Discharge Summary (JCAHO IM.6.10 EP7)

A concise discharge summary providing information to other caregivers and facilitating continuity of care includes the following:

- Reason for hospitalization
- Significant findings
- Procedures performed
- Care, treatment, and services provided
- Patient's condition at discharge
- Discharge Information provided to the patient and family, as appropriate, to include:
  - Medications
  - Diet
  - Physical Activity
  - Follow-up care

- Discharge information must be documented or dictated and authenticated within 30 days post discharge.
- Discharge Information must be completed on patients with length of stay greater than 48 hours (when patients seen for minor problems or interventions, a final progress note may be substituted for the discharge summary)

January 2007 Medical Staff Activities

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VAP Successfully Eliminated

Congratulations to the Respiratory Department, ICU nurses and physicians for successfully abating the incidence of Ventilator Associated Pneumonia (VAP) cases throughout the hospital for the months of August and September. Through achieving 100 percent compliance with the Institute of Healthcare Improvement’s VAP “bundle” (a series of interventions related to ventilator care that yield positive outcomes when implemented together) our Respiratory Staff has prevented the development of any new VAP cases at Touro for more than 2 months through Sept. 30.

VAP is the leading cause of hospital-acquired infections, generally occurring about 48 hours after a patient has been intubated. VAP prolongs the time spent on a ventilator, length of ICU stay, and the length of stay after discharge from the ICU. Statistically, about 15 percent of patients on ventilators get VAP, approximately half of which die from the condition. VAP adds an estimated cost of $40,000 to a typical hospital admission.

In addition to a recession in the number of VAP cases, Touro has also succeeded in reducing the number of acute inpatient mortality cases below our average for the past 6 months.

This is a REAL SUCCESS STORY for both the hospital and our patients - who are the ultimate beneficiaries of this accomplishment. Congratulations again to the Respiratory Department for this fantastic achievement.

**VENTILATOR ASSOCIATED PNEUMONIA (VAP) “BUNDLE” COMPLIANCE**

2006 Month: October

1. Head of bed (HOB) elevated 30-45 degrees
2. Sedation Vacation (SV) withhold sedation and assess extubation readiness
3. Peptic Ulcer Disease (PUD) prophylaxis
4. Deep Vein Thrombosis (DVT) prophylaxis

**VAP / 1000 Vent Days**

**Composite Bundle Compliance**

ANALYSIS:

VAP infection data has been confirmed through 9/30/2006. The VAP infection rate for September is 0. This is the second consecutive month we have achieved a 0 rate, which represents 96 days since our last VAP. The October composite bundle compliance score declined to 89% in October. This represents one patient whose bundle compliance documentation was omitted on one day. The patient has been discharged and a retrospective review of the medical record will be performed in order to determine if there was actual compliance with the bundle elements. Efforts continue for improvement with ongoing monitoring for bundle element and documentation compliance.

**Days since last VAP**

(as of 9/30/2006)

Last confirmed VAP: 7/29/2006
**Medical Documentation Update**

**VERBAL ORDERS**
The use of verbal orders is nationally recognized as an error prone process that poses an increased risk of miscommunication that could result in adverse effects, including medication errors, for patients. If verbal orders are used, they must be used infrequently. This means that the use of verbal orders must not be a common practice. When verbal orders are used, they must be used infrequently regardless of the patient's length of stay. When multiple practitioners are responsible for the care of a patient, there should be even fewer instances when verbal orders are necessary. Orders should be documented directly in the medical record by the prescribing practitioner either in writing or electronically. The use of verbal orders should be limited to those situations in which it is impossible or impractical to write the order or enter it into the computer. Verbal orders are not be used for the convenience of the ordering physician.

All orders, including verbal orders, must be legible, complete, dated and timed, and authenticated. Therefore, it would be necessary for a physician or other practitioner to date and time the authentication of a verbal order. The receiver should clearly record the order directly onto an order sheet in the patient's medical record or enter it directly into the computer. The receiver should date, time, “read back” and sign the verbal order according to hospital policy. The prescriber or another practitioner responsible for the care of the patient must then verify, sign, date and time the order as soon as possible in accordance with hospital policy, and State and Federal requirements (Touro Infirmary requires Verbal Orders to be authenticated / countersigned within 72 hours).

**TIMING OF MEDICAL RECORD ENTRIES**
The time of medical record entries is crucial for patient safety and quality of care. Timing applies to all medical record entries, not just to the authentication of verbal orders. This would include orders, progress notes, procedure notes, patient assessments, H&Ps, etc. Timing established when an order was given, when an activity, intervention, treatment or procedure is to take place. Timing and dating of entries established a timeline of events. Many patient interventions or assessments are based on time intervals or time lines of various signs, symptoms, or events.

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**Multi-Drug Resistant (MDR) Organism Prevention**

Multi-drug resistant (MDR) organisms are on the rise, currently effecting millions of patients worldwide. Once a MDR organism develops it can easily be spread between individuals or animals.

The Centers for Disease Control and Prevention offer several useful tips for preventing the incidence and/or spread of MDR organisms within a healthcare facility, including:

1) Regularly washing hands thoroughly between patients

2) Do not accede to patients' demand for unneeded antibiotics

3) Prescribing antibiotics that target only a narrow range of bacteria

4) Isolate hospital patients with multi-drug resistant infections

5) Familiarize yourself with local data on multi-drug resistance

These measures have proven highly successful in a number of circumstances. A recent Houston Chronicle article by Salatheia Bryant tells how at the Michael A. Debekey VA Medical Center in Houston incidence of the deadly MDR virus MRSA (methicillin resistant staphylococcus aureus) has ceased since the facility began taking measures to identify and isolate those infected.

Possibly the most important of these recommendations are those that stress responsible management of antibiotics. Many studies have demonstrated that the use of broad-spectrum antibiotics may play a huge role in the development of multi-drug resistance, even in organisms that may have never been exposed to a specific virus. Improper use of prescriptions by patients, misdiagnosis and unnecessary prescriptions were also identified as culprit.

A 2003 study published in Clinical Infectious Diseases, Volume 37, illustrated how a healthcare committee in Argentina was able to reduce multi-drug resistance in certain instances as well as promote antibiotic cost savings through the use of an antibiotic order form. The committee first devised a means of gathering the base-line date, than used the information gathered from the antibiotic order forms for education and the implementation of prescribing controls. The form, which provided an ongoing analysis of antibiotic use, assisted them in identifying drugs responsible for the development of MRSA, as well as helping the facilities achieve an overall cost savings of more than $900,000.
JCAHO Physician Conduct

The American Medical Association (AMA) has recently made effective guidelines for addressing physician conduct issues involving fellow doctors, hospital personnel, patients, family members or others that interfere with patient care. Physician conduct issues may include, but are not limited to the use of obscene language; rude, loud and/or offensive comments; failure to adequately address safety concerns or patient care needs expressed by those who may leave as a result of continued adverse incidents. In fact, legislation is increasing on this topic with legal action being directed at both the hospital and individual MDs.

Physician conduct issues are recognized nationally as a problem that is at its least unnecessary, exerting a deleterious effect on the morale of the healthcare team; at its worst it impacts directly on patient safety and is subject to discipline. Some costs associated with physician conduct issues may include defending lawsuits and recruiting replacement personnel for those who may leave as a result of continued adverse incidents. In fact, legislation is increasing on this topic with legal action being directed at both the hospital and individual MDs.

Other negative consequences that result may include a deterioration of patient care resulting from a loss of morale amongst the healthcare staff; a reluctance of the medical staff to speak their mind in the presence of the instigator, particularly in circumstances where the information is pertinent to patient care, and; a decline in the promotion of continued education, especially if the disruptive party serves as a mentor to trainees.

JCAHO guidelines set forth in 2001 state that behavior considered unacceptable in other professional setting should not be tolerated in hospitals or other healthcare facilities as well. Every healthcare facility is required to set forth a policy for identifying and addressing physician conduct. The principal objective of such a policy is to ensure that the highest standards of patient care are met as well as the preservation of a professional work environment.

The importance of respect among healthcare professionals is a means to ensuring good patient care. Physicians, in their role as patient and peer advocates, must recognize their obligation to speak out when faced with disruptive conduct. The most critical hospital retention tool for RNs and allied health professionals is not money - it is the acknowledgment, praise and guidance given by doctors.

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New Patient Relations Director: Here to lend a helping hand

Shari Weber, a recent edition to Touro's staff, has been appointed to the newly created position of Director of Patient Relations. A lifelong New Orleanian, Weber is a Loyola graduate with more than 20 years of customer service experience working in the hospitality industry.

The Patient Relations Department has been established to assist the medical staff to further develop Touro as a patient centered facility by serving as a mediator between the patient and the care provider to ensure that all patient needs are met. Weber is located on the fourth floor of the A building and constantly does sweeps of the various units throughout the facility to make certain that our patients are enjoying a satisfactory experience during their recovery.

“A hospital is just like any other service environment - perceptions are everything and first impressions are key,” says Weber. “My job is to help the medical staff reach out to patients and ensure that they have a comfortable, convenient and overall positive experience during their stay with us. Every patient we welcome to our facility should be made to feel like they are the most important person ever to walk through our doors.”

Weber is available to assist with a myriad of customer relations issues, including:
• Patient/family issues
• Receiving feedback from patient's small, in-house errands
• Receiving feedback from staff with ideas to improve our service
• Receiving feedback from physicians with ideas to improve service
• Assisting with advance directives if needed.

“If we fail to establish a good relationship with our patients, making sure that they feel welcome and attended to, even the best service will not ensure their return,” says Weber. “Everyone here makes an impression shaping and impacting the Touro brand every time they interact with a patient or member of the public. I hope to serve as the pulse of effective customer service, helping to guarantee a positive and continuing relationship is maintained with each patient so that they will feel at home returning to Touro whenever a healthcare need may arise.”

If you need us, we are there
Shari Weber, Director
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Webers@touro.com
Available Monday - Friday 8:00 - 4:30
Weekends by Cell or Email