Joint Commission looks at culture, improvements

After reading this article, you will be able to:
➤ Identify changes to Joint Commission culture
➤ Discuss updates to the National Patient Safety Goals
➤ Describe the status of medication reconciliation requirements for 2010
➤ Discuss updates to staffing effectiveness requirements

The Joint Commission has made significant steps to improve its performance and culture this year, the organization announced during its recent Executive Briefings in New York.

Ann Scott Blouin, PhD, RN, The Joint Commission’s executive vice president of accreditation and certification operations, discussed at length major changes the healthcare accrediting body has taken in recent months to improve the way it works with hospitals as well as its own internal processes. Among those improvements were the following:
➤ Refocusing surveyors. The Joint Commission has refocused its 500 hospital surveyors to balance their roles as evaluators and educators/coaches/mentors. This was received as an invigorating change by 95% of the surveyors, Blouin said.
➤ Adaptation. The Joint Commission is using Lean, Six Sigma, and change acceleration to change its culture. There is a new focus on customer service and simplification of processes, said Blouin. The Joint Commission has also changed its tactics on criticality. Now, only direct impact RFIs affect accreditation decisions.
➤ Postsurvey reports. The Joint Commission has promised to improve the time frame in which hospitals receive their postsurvey reports. A recent study within the organization found that hospitals were receiving their reports, on average, 16.4 days after survey, with massive fluctuations in that time frame, despite a requirement that hospitals receive this report within 10 days of their survey (not a 10-day average). A new process has been developed reducing the time to develop the report from 38 hours to 4.4 hours and trimming the average time frame to receive the report to 5.4 days.
➤ PPR. The Joint Commission is examining changes and enhancements to the PPR based on feedback from the field that the dates of submission are not working.

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“We are in the process of rolling these changes out. The old way we told you to do this wasn’t very helpful.”
—Pat Adamski, RN, MS, MBA

In addition, as was discussed earlier this year, there are no more automatic thresholds. There is “no magic

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tipping point,” said Blouin. The Joint Commission has also made a concerted effort to reduce costs.

NPSGs
Looking ahead to 2010, The Joint Commission is closely examining its National Patient Safety Goals (NPSG) to make sure accredited organizations are getting the most from their efforts to comply with these key requirements. Additional details on the NPSGs were released in an official announcement in October.

The Joint Commission released a version of the 2010 NPSGs in mid-September, at which time it announced to the field a major reduction in the number of NPSG requirements for 2010.

Hospitals contended with 20 NPSGs this year. That number will shrink to 11 in 2010. Additionally, no new goals will be added in 2010. Seven of the goals will be integrated into the standards, and one will be deleted outright, with medication reconciliation’s future still to be determined.

(Note: NPSGs 07.03.01, 07.04.01, and 07.05.01, which were phase-in goals about preventing multidrug-resistant organisms, central line-associated bloodstream infections, and surgical site infections, are now expected to be fully implemented, and facilities must comply with them by November 1, 2010.)

The Joint Commission is taking a hard look at NPSG 8, medication reconciliation. An update is expected from the accrediting organization in spring 2010. Medication reconciliation has been a constant battle for hospitals and one of the most cited standards. The Joint Commission has also committed to not citing facilities on medication reconciliation (hospitals will still be evaluated on medication reconciliation).

“We are in the process of rolling these changes out,” said Pat Adamski, RN, MS, MBA, director of the Standards Interpretation Group and the Office of Quality Monitoring at The Joint Commission.

The Joint Commission acknowledged that the requirements of this goal have not been effective in the past.

“The old way we told you to do this wasn’t very helpful,” said Adamski.

Questions? Comments? Ideas?

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However, The Joint Commission is interested in hearing from any facilities that feel they have a strong handle on medication reconciliation.

“If you do think you have a good program, we want to hear about it,” said Adamski, adding that such best practices would be welcomed by the field, and The Joint Commission would like to promote successful medication reconciliation programs and policies.

Many of the NPSG changes, including deletions of some elements of performance (EP) and some changes made to the Universal Protocol™ (UP), are effective immediately.

Universal Protocol deserves some attention on its own. In 2008, wrong person/site/procedure surgeries overtook patient suicides on the list of most frequent sentinel events.

Specifically, UP.01.01.01, EPs 1 and 2; UP.01.02.01, EPs 1, 2, 3, and 7; and UP.01.03.01, EPs 1, 5, and 6, will not be evaluated for the remainder of this year.

New FAQs concerning the UP are forthcoming, said Adamski.

NPSG.07.02.01, which required organizations to treat a healthcare-acquired infection as a sentinel event, was deleted because it is covered in the sentinel event policy; it will not be surveyed for the rest of this year.

**Staffing effectiveness**

A great deal of attention has also been lavished on improving the organization’s stance on staffing effectiveness. The Joint Commission plans to look at PI.04.01.01 and long-term care HR standards related to staffing effectiveness and develop new requirements for evaluating staffing.

On June 18, surveying of and requirements for staffing effectiveness compliance was suspended. New requirements with a focus on outcome data have been drafted.

A field review was conducted in the spring, and additional modifications have been proposed.

A second field review is currently under way, with the hopes that these revised requirements will be ready for the November Standards and Survey Procedures Committee.

If the committee approves the changes, they would take effect in July 2010.

“We’re not just looking at the numbers,” said Adamski.

The Joint Commission has intended these changes to keep a strong focus on the relationship between staffing and quality and safety, while removing requirements that eat up resources but do not have a significant effect on quality or safety. ■
In a world where consumers can collect encyclopedic knowledge on a car or home electronics purchase, the need for usable, measurable quality data grows every day, particularly in healthcare.

More regulatory and other organizations are focusing on quality data collection. Stephanie Iorio, RN, CPHQ, CPC, said during her presentation, “The Impact of Quality Data on the External Environment,” given at September’s National Association for Healthcare Quality conference in Grapevine, TX.

Current themes in quality measurement include an absence of standardization of measures and data element definitions, a need to harmonize measures across healthcare settings, a growing demand for measures of efficiency, and use of administrative and other electronic data. There has also been a movement toward “episodes of care,” Iorio said. Other themes include:

- Data quality, particularly self-reported data
- Pay for reporting and pay for performance
- Process versus outcomes measures
- Patient privacy and confidentiality
- The growing role of consumers

“Are we measuring the right processes?” said Iorio.

There are more than half a dozen regulatory or reporting agencies tracking quality data in the acute

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**What is ORYX?**

ORYX measurement requirements are intended to support Joint Commission-accredited organizations in their quality improvement efforts. Performance measures supplement and help guide the standards-based survey process by:

- Providing a more targeted basis for the regular accreditation survey
- Continuously monitoring actual performance
- Guiding and stimulating continuous improvement in healthcare organizations

Some accredited organizations are required to submit performance measurement data on a specified minimum number of measure sets or noncore measures, as appropriate, to The Joint Commission through a Joint Commission-listed ORYX vendor (also known as performance measurement systems). Data collected or submitted to The Joint Commission are reviewed during the on-site survey.
care setting—not just CMS and The Joint Commission, but such staples as the National Quality Forum, the Agency for Healthcare Research and Quality, the Institute for Healthcare Improvement, Leapfrog, and HealthGrades. And yet, “today you can find out more about a TV you want to purchase than about your own healthcare online,” said Iorio.

The crux of quality is data, she said. Data analysis reveals a great deal about quality and patient safety. Reviewing data can show trends in appropriateness of care, variations in practice and outcomes, and resource utilization.

Movement away from manual chart reviews, which are time- and resource-intensive, to the electronic record has revolutionized the availability and usefulness of administrative data, Iorio noted.

**The Joint Commission**

So where does The Joint Commission play into all this? This year, ORYX reporting required four measure sets. Additional measure sets are in development, and measures are being reworked for capture through the electronic health record system.

Also beginning this year, The Joint Commission considered introducing paired mandatory reporting requirements—that is, certain measures that would be tied together in required reporting. For example, if your facility reports cardiac care measures, either myocardial infarction or heart failure measures would also be required. Similarly, surgical services measures would mean Surgical Care Improvement Project infections would also need to be reported.

Most hospitals would meet the remainder of reporting requirements by choosing to report some combination of nursing-sensitive, pneumonia, children’s asthma care, and pregnancy measures, said Iorio.

Iorio pointed out the law of diminishing returns here: “If you’ve been reporting on the same measures [for some time], how many times can you do so before you max out on your potential?” she said.

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**Current measure sets**

<table>
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<th>Measure Set</th>
<th>Joint Commission only</th>
<th>Implemented with October 2009 discharges</th>
<th>Applicable to all stroke patients but required by primary stroke centers</th>
<th>Includes ischemic and hemorrhagic strokes</th>
<th>Expected implementation date: April 2010 discharges</th>
<th>Endorsed by the National Quality Foundation—based on current scientific evidence</th>
<th>Looks at domains of care: assessment and screening, prematurity, infant feeding, and continuity and transition</th>
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<td>Venous thromboembolism (VTE) measures</td>
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<td>Perinatal care measures</td>
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<td>Nursing-sensitive measures</td>
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**Stroke measures**

- Joint Commission only
- Implemented with October 2009 discharges
- Applicable to all stroke patients but required by primary stroke centers
- Includes ischemic and hemorrhagic strokes

**Emergency department (ED) measures**

- Joint Commission and CMS consider these measures informational
- An implementation date has not yet been established
- Looks at the following ED concepts: patient wait time, overcrowding, boarding, and diversions

**Nursing-sensitive measures**

- Joint Commission only
- Expected implementation date: April 2010 discharges
- Looks at multiple data sources: clinical abstraction, event reporting, administrative, workforce, and surveys
Greeley Survey Solutions

Taking a quick look at the 2009 NPSGs

Editor’s note: Bud Pate, REHS, is vice president of content and development at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. Each month, an expert from The Greeley Company will discuss a hot-button topic or challenging issue facing hospitals in the areas of accreditation, survey preparation, and more. Have a question for our experts? E-mail Senior Managing Editor Matt Phillion at mphillion@hcpro.com.

So far, so good. The release of the 2010 National Patient Safety Goals (NPSG) rolled back some of the difficult and unclear expectations introduced about this time in 2008. Requirements such as documenting hand hygiene education to all patients, even outpatients, are now gone—effective immediately.

We’re still waiting for the other shoe (or shoes) to drop. We’re expecting revised FAQs, and we would love to see the actual language of the goals that were moved to standards September 9. The good news in brief:

Many of the troublesome requirements introduced in 2008 are gone.
– Designation of an individual to participate in the identification process on behalf of the patient has been removed (NPSG.01.01.01).
– Documentation of patient education about hand hygiene, respiratory hygiene, and other issues at the time of admission is no longer required (NPSG.13.01.01). However, common-sense requirements about patient/family education remain in various locations throughout the standards.
– The immediate “pretransfer” checklist process has been removed from the Universal Protocol (UP.01.01.01). It has been replaced by language that allows the continued use of separate preprocedure forms by the preoperative nurse and the circulator as the patient progresses toward the procedure.

Seven goals were moved to the standards. The requirement will remain but will receive less emphasis during the survey.
– NPSG.02.01.01: Verbal/telephone order, critical test result read-back
– NPSG.02.02.01: Do Not Use entries
– NPSG.02.05.01: Handoff communication
– NPSG.03.03.01: Look-alike/soundalike medications list
– NPSG.09.02.01: Falls
– NPSG.13.01.01: Patient involvement in care
– NPSG.16.01.01: Rapid response

NPSG.02.03.01, cited on 38% of 2009 survey reports, has been relaxed. The requirement to monitor critical tests is gone, and the remaining language is intended to allow more flexibility in the way that timeliness of critical result reporting is monitored.

A few questions still remain, as detailed in the following list. We hope that most questions will be clarified in

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forthcoming FAQs from The Joint Commission, but we are disappointed that FAQs remain necessary.

➤ The Universal Protocol now applies to all invasive procedures, not just those that put the patient at more than minimal risk. On its face, this appears to cover many procedures not currently subject to the timeout. However, we also understand that The Joint Commission intends to ease back on the scope of the Universal Protocol.

➤ The Universal Protocol now requires that items in the procedure room be “matched to the patient.” We believe that traditional room setup practices will meet this requirement, but the language is a little confusing.

➤ For some reason, the requirement for active communication during the timeout was removed from UP.01.03.01. We don’t believe this was intentional.

➤ It is now clear that a second timeout is only required when the person performing the procedure changes (UP.01.03.01). However, we’re still a little confused about the requirement for a timeout before anesthesia. For example, must we document the timeout twice if it is done in two phases—once before induction/intubation and again immediately before the procedure?

➤ NPSG.03.04.01 now requires that solution labels include both quantity and volume. Volume need not be on the label if it is apparent from the container, but quantity must always be on the label. That does not make sense.

➤ We hear that The Joint Commission intends to relax its 90% threshold for hand hygiene compliance (NPSG.07.02.01), but we have yet to see this in writing. In the meantime, the new requirement for continued improvement element of performance 3 can be a problem.

Unfortunately, medication reconciliation remains in limbo until sometime next year. On one hand, the 2009 version of the language applies, and hospitals are expected to comply. On the other hand, it is not being scored during survey until the new version is released (intended for the second quarter of 2010).

Like we said, it’s mostly good news. From where we sit, The Joint Commission is moving in a very positive direction. But there is still much more ground to cover. Stay tuned!
Ever feel as though navigating the world of CMS changes is an uphill battle? You’re not alone. Survey coordinators across the country face this challenge every day, and few have mastered the ability to track every major and minor change that comes from the government agency.

To help navigate this sometimes murky and often confusing task, we spoke with Sue Dill Calloway, RN, MSN, JD, director of hospital risk management at OHIC Insurance Company, The Doctor’s Company, in Columbus, OH, who provided BOJ with her top sites for tracking CMS changes:

➤ The hospital’s CoP Web site, where the hospital manual, EMTALA rules, and other manuals are located. The hospital CoP can be found at www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf. There is a separate manual for hospitals and critical access hospitals. The hospital CoP is also referred to as the State Operations Manual (SOM). This term has been confusing to some hospitals, and this manual is effective in every state. CMS’ reason for renumbering all the tag numbers and leaving spaces in 2008 was so there would be room for frequent updates to be made.

In the past, hospitals would print the CMS hospital CoP from the CMS Web site, but it would not contain all the recent updates.

“It’s interesting. Last year, they weren’t updating them at all, and the site was really outdated. And this year, they’ve been posting the updated manuals there first,” says Dill Calloway.

CMS provides the following instructions:

– Each appendix is a separate file that can be accessed directly from the SOM Appendixes Table of Contents, as applicable.
– The appendixes are in PDF format, which is the format generally used in the SOM to display files. Click on the red button in the Download column to download a copy of any available file in PDF format.
– To return to this page after opening a PDF file on your desktop, use your browser’s “back” button, because closing the file usually will also close most browsers.


“This is the next place we tell hospitals they should go to help locate new changes and updates,” says Dill Calloway. “We’ve told everyone to go in once a month and check [for updates]. Save this Web site as a favorite and appoint someone in your facility who is responsible for doing the monthly checks.”

This page contains CMS survey and certification memoranda, guidance, clarifications, and instructions to state survey agencies and CMS regional offices. It is searchable by date and keyword.

➤ The CMS transmittals page, which can be found at www.cms.hhs.gov/transmittals.

“They’ll have transmittals that are just important issues,” says Dill Calloway.

According to the CMS Web site, program transmittals are used to communicate new or changed policies and/or procedures that are being incorporated into a specific CMS program manual.

The cover page (or transmittal page) summarizes the new and changed material, specifying what has been changed.
The hospital center page, which can be found at www.cms.hhs.gov/center/hospital.asp.

“If you’re working in a hospital setting, this is another good place to check for updates,” says Dill Calloway.

A quick check of recent updates to this page shows that most of the announcements this year have been related to payment systems, but other, more accreditation-related changes are also announced here.

The EMTALA page, which can be found at www.cms.hhs.gov/EMTALA.

On this page, you will find changes and updates to regulations, manuals, and appendixes, and links back to transmittals related to EMTALA and EMTALA survey and certification letters. There is also a series of links with related and helpful material.

The EMTALA interpretive guidelines were amended May 29, and, according to Dill Calloway, many hospitals are not even aware of the numerous changes in the new manual.

Recent updates

The other challenge to tracking CMS changes is the sporadic nature of the updates.

“Mostly what they did was added to the EMTALA Interpretive Guidelines are about on-call, community plan—you can see in red where all the changes were made from the edition from last year,” says Dill Calloway. “There were a lot of amendments.”

Dill Calloway mentions that the updates this year have been much improved from past updates.

“I thought they were much better this year—they were easier to understand, a lot of stuff we used to teach they’ve incorporated into the 2009 version,” she says.

Some of the topics addressed were patients being sent home with false labor and minors being brought to the emergency department, preempting state EMTALA laws (i.e., rules regarding parental consent). What consultants were frequently advising as best practices “was never in writing,” says Dill Calloway. “Now they basically have everything in black and white [in this latest update]. It’s better. I’m really happy with how they explained everything. I think we can understand a little better than before.”

The final Interpretive Guidelines are 64 pages. Every emergency department should be aware of the changes to the guidelines.

“Basically, every hospital with an ED needs a copy of this, needs to revise its policies and procedures to comply with new guidelines,” says Dill Calloway. Staff members should be educated on an ongoing basis on the EMTALA regulations.

Other news

The COP hospital manual was updated in June, but Dill Calloway notes that tag #450 was the only thing affected by the update.

“The only thing redlined is some resources for restraint and tag #450—updated time and date, preprinted orders,” says Dill Calloway. “It’s an important item.”

Most users have continued to use the October version of the manual, as it contains the redline changes from 2008, making tracking a facility’s updates and changes to policies more convenient.

Tip: Dill Calloway suggests continuing to work from the October manual, but attach the June memo updating tag #450, allowing you to view all changes in the past year.

“Most hospitals [I’ve spoken with] say they want the redline copy so they can see what’s been changed for four years,” says Dill Calloway. “Or, if you don’t care about redlines, just go to the manual and take the June 5 version.”
Q&A

Joint Commission stroke certification update

The following is an excerpt from the question and answer portion of the HCPro audio conference, “Joint Commission Stroke Certification Update,” presented by Lori Massaro, MSN, CRNP, acute care nurse practitioner at University of Pittsburgh Medical Center Stroke Institute, and Chris Thompson, quality coordinator at Texoma Medical Center in Denison, TX. More information on this audio conference can be found online at http://tinyurl.com/ycwl4yp.

Are there additional factors to monitor outside of the required stroke center measures?

CT: Yes, there really are some things to monitor in addition to the 10 measures. The first thing you need to do is look at the time frame requirements that are in the standards. Start with your emergency department (ED) processes and make sure you are monitoring door–to–computed tomography scan (CT) time, door-to-CT and lab results available, door-to-needle time that means door to when you start your [tissue plasminogen activator (TPA)].

LM: There is a robust tool on the American Heart Association Web site where you submit “Get with the Guidelines” information. You can run reports on all of these things. You can then incorporate them in your Joint Commission measures.

So a lot of the tools that are out there and available to you for collecting information can really help you with monitoring this, and what I found with stroke, more than anything else there, is so much beyond measures that we are looking at.

Another thing that we do is make sure your HR files are in good shape. As part of our tracer process, we also collect the names of the people we are talking to on the various units from the various disciplines, as well as the physicians, and we send that information to our HR team to pull those records and kind of check to make sure we have everything.

I think [additional factors should include] door-to-CT and door-to-needle time and also looking at whatever your program defines as its protocol and order sets.

Basically, when the surveyor comes, you have a period of time in the first hour where you’re going to share what your program is. You will want to have on hand what you call your order sets, what you call your protocols. Explain to them how you developed them.

They are going to look for evidence that you’ve used those order sets. They are going to look at the comparisons of that on the actual charts as they do their walk-through or the tracer throughout the hospital or chart reviews if you don’t necessarily have many inpatients during the actual on-site review.

CT: That is an excellent point. I mean, they get really detailed on that. If you say you do the National Institute of Health stroke scale on a certain time interval, you better make sure your staff is actually doing it that way.

Can you identify which stroke measures you struggled most with and what that struggle entailed?

LM: Probably the three that we struggle with the most are dysphagia screen, getting all patients screened...
Q&A

for dysphagia before giving them Tylenol or anything in the hospital or any food or fluids.

Stroke education is the second one. We had a little bit of a challenge with that. But when they went to the five components of stroke education, it actually threw our compliance down a bit.

So we are working with our electronic medical records team to build in some preprinted information that will print out at discharge.

And the third thing that we continue to struggle with—I’m actually overseeing two hospitals; one is a teaching hospital and one is a community hospital—is the LDL.

When patients have the LDL greater than 100, the compliance with them was either being discharged on a statin or having rationale in their chart as to why they were not being discharged on a statin. And those patients coming in with a statin, make sure they are being discharged on those as well.

So those are the three areas that I sort of targeted my data collector to be looking at every day because they are our trouble spots.

LM: I oversee the stroke programs in the two hospitals. I have a full-time data collector at the larger hospital, which is a 700-bed hospital. And I have a [full-time equivalent] data collector at the community hospital, which is a 350- to 400-bed hospital.

In terms of data collection, the good thing is that we have the same stroke team covering both hospitals. So my core physician is the same; it’s just that the actual facilities function a little bit differently.

One is a community hospital, which is where we run into problems because these patients are being admitted to non-neuro services so you are looking for them all over the hospital.

At our facility, we have a stroke service, so 95% of the patients that come in with stroke or TIA are directed to our service, and we are responsible for their care.

We have three hospitals in our system, and my question is: What kind of support do you have, as far as carrying out your stroke center?

LM: I oversee the stroke programs in the two hospitals. I have a full-time data collector at the larger hospital, which is a 700-bed hospital. And I have a [full-time equivalent] data collector at the community hospital, which is a 350- to 400-bed hospital.

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CT: I do work in a smaller community hospital, and at the time that we first certified, we were just getting our rapid response team off the ground.

We successfully certified without that in place at the time.

—Matt Phillion
Senior Managing Editor
BOJ

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Q&A (cont.)

We got two really good ED nurses on board with us, and they helped beef up the process and educate their coworkers in the ED about who they needed to call and getting things done quickly in the ED. In addition, we put the initial assessment of stroke symptoms into our basic nursing orientation process so that staff on all of the floors, not just our med-surg unit where we normally send our stroke patients but all of our staff did have that background in really quickly recognizing new onsets of stroke symptoms.

We had then and continue to have very, very good catches by our staff nurses on other units where we don’t normally send our stroke patients.

So if you are talking about a stroke called in the middle of the night, or the ED who orders the TPA, are the ED doctors ordering the TPA without a neurologist?

CT: In our institution, because we are somewhat smaller and are not a teaching hospital, our neurologists are committed to this whole thing and so they are part of that whole stroke activation process.

The first thing they do is call the neurologist, and it’s our neurologist that is starting the TPA in the instance of our institution.

Lori, you may have a different experience with your teaching hospital.

LM: Well, because we do have a core stroke team and six neurologists that are just on the stroke team and two fellows, nine times out of 10, it is one of our members there who is making the decision to treat and giving the order to treat.

In the instance and situation I work in, it is primarily coming from the stroke team. It’s not to say that the ED doctors are not involved or aware. When a stroke patient comes in, we have a stroke alert that goes out and we have an alert if they are coming in via EMS, a prenotification, and we have someone in-house most of the time who responds to the ER and becomes active in the care of that patient from the time they get here.

Have you seen a situation in which the ED doctor must perform the orders because he or she doesn’t have that backup?

LM: I’ve actually seen that in many instances, and I think it’s fine.

What I would say to you, in terms of advice, you need to include them as members of the stroke team and make sure they get the eight hours of continuing education per year and that they are included in the stroke group, whoever you report to, because I think you are going to need to show that they are actively involved in the process and that they are made aware of any QI issues and part of the resolution, especially if they involve the ED and administration or decisions.