Minutes from
Arizona Rural Quality Network Group Meeting
Wednesday, October 26, 2005

Agenda topics and discussion:

August 2005 ARQNG Planning Meeting Survey Results/Schedule for this Year

- Joyce went over the results from the survey conducted this past summer to plan for the FY 2005–2006 meetings
  - 24 percent response—8 out of the 34 surveys sent were returned
  - Best day—Wednesday
  - Best time—11:00 am
  - Length of call—1 to 2 hours
  - Frequency of meeting—quarterly
  - Format—guest speakers, hospital presentations, networking
  - Topics—8th Scope, Patient Safety, HIT, best practice protocols, culture of safety survey, medication reconciliation
  - Other comments—use video conference capability, when possible

- The schedule for the year's meeting was established: 11:00 am–12:30 pm, Wednesday, January 25, 2006; Wednesday, April 26, 2006; Wednesday, July 26, 2006. The RHO is going to experiment in having the January meeting scheduled through the use of the state's teleconferencing system. More to follow on that in the months ahead.

ARQNG Contact List

- Joyce reminded those on the call to let Jim know of any changes/additions to our list of members and their relevant information.

Hospital Survey on Patient Safety Culture

- Joyce reviewed Judith Richard's handouts. No one has seen the survey yet. Joyce will ask Judith to get a sample copy of what was sent to each of the hospitals.
- **Benson Hospital**: has not started to work on the survey yet; very interested in how the results will tie to the data being collected through the Stroudwater Balanced Scorecard project.
- **Carondelet Holy Cross Hospital**: A baseline survey was done at the hospital in August 2004 through Ascension Health [AH] and included all of the 69 AH ministries around the country. AH's survey is very similar to the one to be distributed by HSAG. In January 2006 the plan is to resurvey all of AH's hospitals in the country to see what changes have occurred. Also, AH plans to create bar graphs of the results on all AH hospitals.

CHCH had an 89 percent response rate; their goal was to have all departments respond; their approach to survey distribution was to hand deliver the surveys to each department; their combined score "goal" was to be 65 percent or better.

Activities done at **CHCH** included the following:

- Interventions were handled through the Quality Council
- Roundtables were held to identify safety issues
- Individual departments identified specific patient safety issues

A special survey is going to be created for the OR.

Overall, **CHCH** feels that safety is a big issue—more because of where they are located rather than what occurs inside the walls of the hospital.

Having "buy-in" is the most important thing to have to make this effort successful. **CHCH** provided education to all departments.

- **Banner** and **SAMC** are very committed to patient safety.

<u>CART Discussion</u>

- **SAMC** needs to update its version of CART.

<u>Hospitalist Discussion</u>

- **Benson Hospital** has developed a hospitalist program. It has three of its doctors involved—two clinic doctors and one ER doctor; they rotate every three weeks. The hospital has seen an increase in the percentage of patients admitted because of the hospitalist program and because it now has its own CT Scan machine.
- **CHCH** is considering the idea to hire a hospitalist but will pass on the information about how **BH** is using existing physicians to Rich Polheber, CEO.
- **SAMC** will start its hospitalist program in November 2005; it, too, will be using an ER physician and its two J-1 physicians. Staff, there, are for the program but physicians are a little reluctant. **SAMC** has also issued to patients a medicine card which they appear to be very enthusiastic about.

<u>Medication Reconciliation [MR]</u>

- What are people doing?
  - **Benson Hospital's** policy for MR has been approved; it is now training nurses and staff; a form was developed to track information; the hospital has seen some resistance from staff, but the physicians love it
  - **Copper Queen Community Hospital** asked for a copy of **BH's** policy (BH has complied, and a copy is attached to these minutes)
- What are hospitals tracking?
  - **SAMC**—tracking admissions and discharges
  - **BH**—tracking admissions and discharges; will look at a sample of charts; will track patients going from an acute to a SNF bed

- **CHCH—**tracking admissions, change in care, and at discharge; it uses the Meditech system to get a listing of the patient's pharmaceuticals; it first piloted the process in one area—med/surg to the OR to med/surg; it has established measurable goals; it did experience some resistance from the surgeons; at the hospital, a group was formed to monitor what is happening—it is called DIRT – Doctor Intervention Review Team; the hospital has already seen compliance improve. DIRT makes monthly reports to each department and the medical staff.

NEXT MEETING

Wednesday, January 25, 2006, 11:00 a.m.–12:30 p.m.
Proposed use of the state's Tele-Conferencing System

More to follow on the plan and necessary logistics to make this happen!!!!!!!

Respectfully submitted,

Joyce Hospodar
Senior Program Coordinator
Flex Program

BENSON HOSPITAL
MEDICATION RECONCILIATION
POLICY AND PROCEDURE

1.0 PURPOSE

The purpose of this policy is to reduce the number of adverse drug events by providing the most accurate list of prescribed and non-prescribed medications to all health care providers.

2.0 PROCEDURE AT ADMISSION TO THE HOSPITAL OR CHANGE IN STATUS

2.1 The admitting nurse may obtain the medication history from the patient and/or family members. If the nurse determines that they are not reliable historians she may contact the patient's physician, contact the patient's pharmacy, review documentation from transferring facilities when appropriate, review prior hospital records, and/ review the patient's medication bottles for information.

2.2 A nurse must complete the Medication Reconciliation Form within 24 hours of the patient's admission to the hospital or change in status. The nurse must use her discretion in determining which medications must be reconciled prior to 24 hours. Examples are medications that are due to be administered within a few hours of the patient's admission.

2.3 When the most accurate listing of medications available has been finished, the nurse will compare this list to the physician's admitting orders. Those medications that match the orders are considered to be reconciled and are checked "yes." Medications that do not match the orders require reconciliation and are checked "no."

2.4 The comment section can be used to indicate why a medication is not being reordered, why the route has changed, and/or why the dose has been changed. It can also be used for other helpful information.

2.5 The pharmacist can assist with the medication reconciliation process by obtaining the medication history, completing the medication reconciliation form, and reconciling medications with the physician.

2.6 Medications that require reconciliation must have a corresponding order written.

2.7 Oncoming nurses must be notified if the medication reconciliation form has not been completed.

2.8 The completed medication reconciliation form is placed on the top of the most current order sheet.

2.9 A new medication reconciliation form is completed at the time a patient's status changes from acute to skilled nursing or vice versa. The new form is placed in the newest medical record for the patient.

2.10 The admitting physician reviews the completed Medical Reconciliation form and signs it.

2.11 The completed medication reconciliation form is sent by facsimile to the primary care provider's office.

3.0 PROCEDURE AT DISCHARGE FROM THE HOSPITAL

3.1 The nurse will reconcile the medications ordered at discharge with the most current reconciliation of medications as a patient.

3.2 Medications that do not match the orders require reconciliation. Reconciliation must be completed prior to the patient's physical discharge from the hospital.

3.3 The medication reconciliation form is sent by facsimile to the primary care provider's office at the time of discharge.

Written	Dawn Reece	06/ 2005
Approved	Medical Staff	10/2005