Care Coordination Rounds
Kelley Blackburn, RN, DNP   Denise Cundy, RN, MSN

What are Care Coordination Rounds (CCRs)?
Care coordination rounding is a team approach to managing and coordinating a patient’s care during their hospital stay. They are completed with the patient and family at the bedside with the patient’s care team. They provide a structure for the deployment of care coordination and engage patients in their care. The care rounds focus on what is currently happening or changing with the patients’ medical condition, concerns or questions, and plan for discharge. Rounds are NOT just discharge plan focused.

Who makes up the care team?
- Patient & Family
- Physician or Provider
- Patient Care Facilitator
- Case Manager
- Social Work
- Bedside Nurse
- Pharmacist
- Any ad hoc members that are involved in the patients care such as Respiratory Therapy, Nutrition, CNS, PT/OT or Palliative Care.

What are the Benefits of Care Coordination Rounds?
- Improves the quality of care that we provide. CCRs allow the health care team to have a higher level of collaboration and decrease the risk of negative outcomes. This collaboration brings everyone together on the same page, and makes sure that everyone is giving and receiving the same messages.
- Enhances the patient experience by allowing patients to feel included in their care.
- Improves efficiency by enhancing the ability of identify barriers to progress and decrease the duplication of services.

What types of patients are we rounding on and how much time is spent?
While ALL patients can benefit from care coordination rounds, currently UPH is targeting patients that are at high risk to readmit (high lace scores), pulmonary diagnoses (COPD, PNA, PE, etc...), readmissions, long length of stay, complex discharges, and other complex medical/surgical patients.

CCR’s are short and succinct and should take approximately 5 min for each patient.

What units are currently participating in Care Coordination Rounds?
- IMMC - Younker 5, Younker 7, Younker 8, North 5, North 6
- ILH – 3 East, 2 North
- MWH – 4 West
- All adult inpatient units will be required to participate in rounding, implementation will continue phases to other units.

What is your role as a Physician or Provider?
The physicians in collaboration with the patients are the primary leaders of the health care team. It is essential that the physicians or providers be part of CCRs. The success of this collaboration, at UPH – DM, will build the desired foundation to increase our quality outcomes therefore improving the efficiency of care and patients’ experience. The Patient Care Facilitator on your patients’ units will contact you to provide you with CCR times and more information how to be a part of this great team!
Recent Practice Changes!

Peripheral IVs
Nursing staff are no longer routinely replacing peripheral IVs. This practice change is supported by the literature and is per Mosby Skills, the UPH-DM nursing procedure manual. This will not affect Blank Children’s Hospital patients, as this is their current practice.

Peripheral IV catheters will now be discontinued when therapy is completed. The decision to replace a peripheral IV catheter will be based on assessment and indications (e.g., condition of site, catheter patency, prescribed therapy, and patient condition), per provider order or if complications occur (e.g., infection, infiltration, occlusion, signs of phlebitis). Every peripheral IV site is assessed at a minimum every two hours.

A peripheral IV placed in an emergency situation under less than optimal conditions, should be replaced ASAP, but no later than 48 hours after insertion.

Indwelling Urinary Catheters
A nurse driven protocol for removal of Foley catheters will be available in Epic on September 9.

When the order “insert catheter” is placed two options are available:

1. Insert, Care, & Maintenance, Remove Indwelling Catheter per Nursing Protocol
   Includes a link to review the removal protocol that will be followed.
   The removal protocol includes a checklist to review indications for an indwelling urinary catheter. If any indication is This option is pre-checked.

2. Insert, Care, & Maintenance, DO NOT Remove Indwelling Catheter per Nursing.
   If this order panel is used a “Discontinue Indwelling Catheter” order must be placed to remove the catheter.
   If the patient is under the care of urologist or has a urology consult, the nurse driven protocol cannot be used, so an order to discontinue the catheter must be placed.

An Epic tip sheet, Nursing Catheter Removal Protocol Order Entry is available.

Avoidance of catheter use or when needed, early removal will decrease the risk of catheter associated UTI (CAUTI) in our patients.

Clinical Nurse Specialist (CNS)

A Clinical Nurse Specialist (CNS) is an advanced practice registered nurse practitioner (ARNP) educated at the graduate level. The role of the CNS is multifaceted and includes that of clinical expert, educator of patients, families and other nurses, consultant to nursing and medical staff, and researcher. S/he assesses, plans, and evaluates patients, nursing staff, programs of care and the processes of the organization. The focus is on the patient, the nurse and nursing practice, the health care organization and the system all coming together to influence patient outcomes.

The CNS generally practices in a specialty area that is population focused (pediatrics, geriatrics, women’s health), setting specific (CCU, ED), disease specific (diabetes, oncology, cardiovascular) or problem focused (pain, wounds, stress).

A growing body of research on CNS outcomes shows a strong correlation between CNS interventions and safe, cost-effective patient care. CNS practice has been directly linked to reducing hospital costs, LOS and frequency of ED visits, improved pain management practices,
increased patient satisfaction with nursing care and fewer complications in hospitalized patients. The role provides positive outcomes in 3 spheres of influence: patient and families, nurses and nursing practice, and on the organizational/systems level.

The Clinical Nurse Specialists at UPH include Sigrid Anderson, RN, MSN, CDE, Lisa Baumhover, MS, ARNP, GCNS-BC, Melanie Hermann, MSN, ARNP, RNC-OB, CNS-BC, Cheryl Lillegraven, MSN, ARNP, ACNS-BC, Sarah Pandullo, MSN, ARNP CCNS-BC.

Some CNS-led initiatives at UPH-DM that have had a positive impact on patient outcomes include:

**Healthy Skin Initiative:** Launched in July, 2014 to decrease hospital acquired pressure ulcers (HAPU’s). The result was a reduction in overall HAPU rate from 0.70 in 2014 to 0.61 2015 YTD. In addition, there was a reduction in Incontinence Associated Dermatitis (IAD) from 5.6% to 1.6%.

**Delirium Recognition and Reduction:** A CNS-led study looked at the development of delirium in hospitalized patients. Of 100 patients studied, 12 developed delirium with an increase in length of stay of 3.7 days and increase in total cost of $4000. Education of nursing has started regarding recognition of patient risk factors, early screening and implementation of strategies to prevent.

**Glycemic Management:** Provider and staff education on basal and bolus insulin therapy is currently being provided. Blood glucose levels first quarter 2015, prior to any education, showed 64.2% of glucose levels within range. Second quarter improved to 66.1%. Third quarter to date is up to 69%.

**Stepping On Program:** Initiation of the evidence based program targeted to older community dwelling adults to reduce falls. First program was held in May with 13 attendees. Another will be offered in September.

**Obstetric Initiatives:** Provider and staff education for patient management during second stage labor to improve neonatal and maternal outcomes. Continued work on the IHI bundles related to elective and medical inductions, augmentations, and vacuum deliveries. Maintain our low rate of elective inductions prior to 39 weeks gestation. Multidisciplinary implementation of patient administered nitrous oxide for pain control during labor at Iowa Lutheran maternity services.

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### Welcome to New Physicians and Providers

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<thead>
<tr>
<th>Ratna Priya Gangi, MD</th>
<th>UnityPoint Clinic Cardiology – Methodist Plaza</th>
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| Priya completed her medical degree at Osmania Medical College, Hyderabad, India. She then completed both her residency and fellowship at Creighton University. She is board certified by the American Board of Internal Medicine.  
Priya’s clinical interests include valvular heart disease, heart failure and women’s health in cardiology. When she isn’t at the clinic, you will be able to find her painting, hiking, reading, cooking and traveling. |

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<tr>
<th>Erin Rowan, DO</th>
<th>UnityPoint Clinic Family Medicine – Parks Area</th>
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| Erin completed her medical education at Des Moines University. She also completed a residency at Iowa Lutheran Family Medicine. She is board certified by the American Board of Family Medicine.  
Erin’s clinical interests include full-spectrum outpatient family medicine, from newborns to senior citizens. |

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<tr>
<th>Catherine Sandberg, DO</th>
<th>UnityPoint Clinic Pediatrics – Walnut Creek</th>
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| Catie completed her undergraduate degree at Central College before attending medical school at Des Moines University. She then completed her residency at Marshfield Clinic – St. Joseph’s Hospital Marshfield, WI.  
Catie’s clinical interests include pediatrics. When she isn’t at the clinic, you will be able to find her Spending time with her husband, their young children and dogs. |
### Mark Isaacson, D.O.  Total Joint Replacement and General Orthopaedics.  DMOS Ankeny

Dr. Isaacson is now seeing patients at Ankeny – Unity Point Health Prairie Trail.

An Iowa native, Mark Isaacson, D.O., joined Des Moines Orthopaedic Surgeons in 2015. Dr. Isaacson completed fellowship training in adult reconstruction at Houston Methodist Hospital at Texas Medical Center in Houston, Texas.

He specializes in total knee and hip arthroplasty, complex revision knee and hip arthroplasty, minimally invasive direct anterior hip replacement, knee and shoulder arthroscopy, adult and pediatric fracture care, partial knee arthroplasty, sports-related injury management, as well as workers compensation injuries.

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### Joseph Brunkhorst, D.O.  Sports Medicine and General Orthopaedics.  DMOS Ankeny

Dr. Brunkhorst is now seeing patients at Ankeny – Unity Point Health Prairie Trail.

Iowa native Dr. Joseph Brunkhorst completed fellowship training in sports medicine and arthroscopy at the University of Kentucky in Lexington, Kentucky. Dr. Brunkhorst developed his interest in sports medicine while competing as a NCAA Division I athlete during his undergraduate education at Iowa State University. Prior to joining Des Moines Orthopaedic Surgeons in 2015, he also served as a Captain in the U.S. Army.

Dr. Brunkhorst specializes in shoulder and knee arthroscopy, knee ligament reconstruction, shoulder arthroplasty, cartilage restoration, and joint injections. Dr. Brunkhorst also manages the care of sports-related injuries and conditions, as well as workers’ compensation cases. He is committed to continuing education and research, so he is able to offer the most advanced and state-of-the-art treatments to his patients.

Outside of seeing patients, Dr. Brunkhorst enjoys hunting, snow skiing, traveling, and spending time with family.

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### Amanda Langager, MD  UnityPoint Clinic OB/GYN – Ankeny

Mandy completed her undergraduate degree at the University of Iowa and her medical degree at the University of Iowa College of Medicine. She then completed her residency at the University of Cincinnati Medical Center. She is board eligible for the American Board of Obstetrics & Gynecology.

Mandy’s clinical interests include high-risk obstetrics, diabetes during pregnancy, laparoscopic and robotic surgery and menstrual disorders. When she isn’t at the clinic, you will be able to find her reading, theater, music, movies, traveling and spending time with family and friends.

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### Austin Baeth, MD  UnityPoint Clinic  Internal Medicine – Lakeview

Austin completed his medical education at the University of Iowa. He also completed a residency at the University of Colorado. He is board certified by the American Board of Internal Medicine.

Austin’s clinical interests include heart disease, depression, palliative care, preventive medicine and health care policy. When he isn’t at the clinic, you will be able to find him traveling internationally, fishing, playing volleyball, writing and community development.

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### Collette Henningsen, ARNP  UnityPoint Clinic – Hospitals at Methodist

Collette received her BSN degree from the University of Iowa and my Acute Care Nurse Practitioner from Saint Louis University. She was a staff nurse at the University of Iowa in the Surgical Intensive Care Unit for 5 years. Her experience as an ARNP includes Emergency Department, Hospital Medicine and Cardiothoracic Surgery.

My hobbies include spending time with family. I am married and have two children: a 2 year old and 2 month old.

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### Kenna Willey, PA-C  UnityPoint Clinic Family Medicine – Norwalk

Kenna completed her undergraduate education at Simpson College and her medical degree at Des Moines University. She is board certified by the National Commission on Certification of Physician Assistants.

Kenna’s clinical interests include patient education, wellness, diabetes and acute care. When she isn’t at the clinic, you will be able to find her spending time with family, turbo kickboxing, cooking, sports and reading.
Diane Thi Tran, M.D. Sports Medicine and General Orthopaedics. DMOS Carroll Office

Carroll-native and Carroll High School graduate Diane Thi Tran, M.D., has returned to Carroll and is now seeing patients at the DMOS–Carroll office, located in Suite 285 at St. Anthony Hospital.

Dr. Tran is a fellowship-trained orthopaedic sports medicine surgeon and the latest addition to the DMOS physician team. Dr. Tran earned her medical degree from the University of Iowa, and completed her sports medicine fellowship at TRIA Orthopaedic Center in Bloomington, MN. Specializing in knee and shoulder arthroscopy; joint replacement of the hip, knee, and shoulder; sports injuries; and fracture care, Dr. Tran is dedicated to returning her patients to their active lifestyles. Dr. Tran also focuses on the importance of preventative medicine for injuries and chronic conditions so that her patients can participate in the activities they enjoy without interruption.

Dr. Diane Thi Tran began seeing patients at DMOS – Carroll, Tuesday, September 1st.

To schedule an appointment, please visit www.dmos.com or call 712-792-2093.
Directions in Quality: DNV Survey Results for IMMC/MWH 2015

By Jan Freese, Accreditation Specialist

The annual DNV survey was conducted May 19-21. Three nonconformities (NC) from 2014 carried over to 2015 = NC-1s

**Wound assessment & care plan**: 2015 wound audit data was not presented during the survey. Jan-Apr 2015 wound care audits showing improvement from Feb 2015 was reviewed by Nursing leadership. One finding removed because it was not applicable for surgical flap closures. **Action taken**: Present audit findings to CQIC & expand audit tool to other nursing units that provide wound care.

**Immediate Post-operative notes**: Medical records lacked complete documentation of the immediate post-operative note. Some surgeons did not use the standard template. Circumcisions & C-sections lacked complete post-op notes. **Action taken**: Provide education about required elements of procedure notes and definition of “surgery”. Develop a circumcision template. Surgeons & obstetricians will use standard templates for post-procedure notes that include all required elements.

**Anesthesia/sedation**: Pre-anesthesia evaluations lacked required elements. Endoscopy sedation evaluation lacked airway & Mallampati assessment. **Action taken**: Educate anesthesiologists about required elements in pre-anesthesia evaluations. Add sedation template to surgeon’s templates. One finding removed because appropriate documentation existed in two Diagnostic Services charts.

**Important Message from Medicare (IMM)**: IMM beneficiary notice given too late after admission and not given again within 2 days of discharge. **Action taken**: Examine current process for giving IMM notices, analyze root cause(s), develop a new compliant process, and educate those assigned to give the IMM. Adjust Patient Access staffing to support new process for IMM delivery. Case managers will receive communication of discharges in real-time. Functionality of Epic notice is being reviewed.

**Advance Directives**: Lack of documented follow-up with family to bring copy of patient’s advance directive; lack documentation that patient who did not have advance directives declined information about advance directives. Unable to find PACU patient’s advance directive status; lack of staff knowledge about the process. **Action taken**: Document reminder given to patient/family to bring an advance directive. Document information provided to patients who do not have advance directives. Monitor records for presence of advance directives. Provide advance directives education to PACU staff.

**Restraints**: Restraint policy lacks definition of “prolonged use” of restraints or face-to-face assessment for non-violent behavior. Policy does not include documenting in medical record that patient deaths with soft wrist restraints are entered in the hospital’s internal log. Late restraint orders were not correctly entered in Epic or authenticated by physicians; some restraint orders incomplete or incorrect; 24 hours in restraint policy (correct) vs. 36 hour orders in Epic for restraints. **Action taken**: Revise restraint policy to include definition of prolonged restraints. Educate RNs and case managers on policy revisions and chart documentation. Obtain restraint order within 1 hour of applying restraints. Educate staff on policy revisions for correct orders and documentation. Educate Case Management about documenting in the patient’s E.H.R. if patient’s name is on hospital’s internal restraint death log. Continue monitoring for restraint policy compliance.

**Infection Prevention**: Mixed storage of dirty/broken equipment, clean suction tubing without packaging; dust on fans; undated Oxyide disinfectant cleanser; observed staff wearing contaminated gowns when leaving contact isolation patient rooms. No documentation of weekly sterilizer cleaning and filter checks. String mop heads used for floor cleaning; rust on IV stand bases. **Action taken**: Place signage on clean utility room. Patient care items will remain in protective wrap to indicate they are clean and ready for use. Educate EVS staff on fan cleaning. Educate EVS and Nursing on 24 hour shelf life of diluted Oxyide product, immersion method and tracking first use/expiration date. Educate at unit meeting about isolation procedures. Update forms for weekly sterilizer cleaning, daily filter cleaning/check and weekly safety pump enzymatic cleaning. Use string mop heads whenever massive amounts of body fluids get on floor; trial using microfiber mops in other situations. Replace rusty IV poles.
**Life Safety:** Lack of annual inspections of fire sprinkler heads. Lack of 5 year sprinkler standpipe flow test. Equipment/cabling wiring lying on top of fire sprinkler lines in 3 locations. One set of fire-rated doors did not close & latch properly. A mechanical room missing an exit sign. A battery backup emergency egress light in Generator Room was burned out. The fuel tank storage room exit light bulb was burned out. A fire extinguisher in sub-basement Generator Room last inspected Oct. 2014. Mechanical thumb latch dead bolts on egress pathway doors in main lobby and ED. **Action taken:** Contractor will document visual inspections of all sprinkler heads on annual report. Do a 5-year sprinkler standpipe flow test. Equipment/cabling/wiring will be rerouted. New door hardware ordered to be install-ed. New exit light will be installed. Bulbs replaced. Exit light will be repaired. New fire extinguisher installed and added to fire extinguisher inventory list. Deadbolt locks removed during inspection. DNV required clarification on completion dates; work will be completed by July 20, 2015.

**NC 2s**

**Control of Documents:** Lab policies included in Document Control policy, and available in paper. Policy allows electronic and/or paper or both. CAP requires a paper back-up policy. **Action taken:** Finding not applicable, successfully appealed.

**Corrective & Preventive Action:** Use of flammable skin prep in surgical areas addressed in June 2014 DNV corrective action plan. The corrective action was being implemented during July 2014 when a vapor fire occurred in Surgery that was reported to DIA. Corrective action for wound care shown to surveyors lacked any 2015 data, which showed improvement in wound care compliance. Surgical wound closure does not require measurements or staging; thus finding was not applicable and was appealed. Lab policies in paper; finding was appealed. **Action taken:** August 2014 corrective action plan from July 2014 surgical fire (no injuries) provided to DNV, showing all plan details being implemented. Extensive fire safety education and simulation exercises were done with Surgery staff and medical staff providers. Surgery monitoring all specialties for correct use of electrosurgery and surgical prep dry time. Jan. through April 2015 wound audit results submitted with corrective action reports. Audit of wound care will begin on other applicable nursing units in September 2015.


**Safety Management:** Breaker schedule in emergency electrical circuit breaker panel incorrect. EVS cart contained “Scrub and Shine” product, but no gloves or eye protection available when product was used. Eye wash bottle in Mechanical Room expired. Full and empty oxygen cylinders in same storage rack in 2 areas without signage indicating which bottles were full and which were empty. Lab refrigerator log missing some daily inspection entries. **Action taken:** Breaker box will be secured when work is completed by Facilities. Facilities will verify after contractor’s work. Protective eyewear will be placed on each service cart that has Oxycide. Non-required eye-wash bottles will be removed. Expired water testing chemicals removed. Permanent signage will be installed on e-cylinder oxygen storage racks to indicate which cylinders are empty or full. Work flow and forms for Histology redesigned; audits done weekly.

**Utilities Management:** Relative humidity (RH) allowed to drop below 35% periodically in anesthetizing locations. IMMC did not have lower limit alarm for all anesthetizing locations to ensure relative humidity does not drop below 35% lower limit. CMS waiver for hospitals permits lower RH limit to drop to 20% RH if hospital does a required analysis to determine if equipment and supplies are capable of sustaining the lower RH level. Central sterile decontamination room had positive pressure instead of the required negative pressure. **Action taken:** Hospital raised the set-point to alarm at 35% as the lower limit. Hospital plans to reengineer and rebalance HVAC system, requiring capital investment and outside contractor to do replacement of manual dampers with automated dampers and put in differential control monitors to control pressure within each space. IMMC has an option to approve a CMS 20% RH waiver if required analysis is done.
Quality in Motion: RL Solutions Monthly Featured Forms

Watch for the Monthly Featured Form, this month’s reportable events found under 2 more RL Solutions Event forms.

Quality in Motion: September – Sepsis Awareness Month

By Evelyn Schnoor, Clinical Quality

Sepsis is on the rise internationally. According to the STOP Sepsis Collaborative (United Hospital Fund & Greater New York Hospital Association), sepsis is the tenth leading cause of death in the United States. Sepsis carries an extremely high mortality rate, nearly 40%! More than 750,000 (that’s 3 quarters of a million U.S. citizens) a year develop sepsis as the result of infections that turn deadly from a variety of sources. Severe sepsis is one of the most common causes of death for patients in critical care units.

Not only are these numbers frightening, but severe sepsis also comes with a high price tag for multiple parties. In addition to the financial cost to our nation, estimated at more than $16.7 BILLION dollars a year, the cost to the patient, family and friends can be calculated in more than just dollars and cents. It’s evident in the pain and suffering that occurs as a result of identification and treatment of the underlying infection. A successful outcome would be that the patient gets well and returns to a normal life with no or minimal change. But, besides death, sepsis can also result in the loss of a limb, fingers or toes, a kidney, etc. All of these are unexpected and untimely for the person and family it affects. When life changes for our patients and their families like this, it can change their social structure, ability to earn a living and provide for their families, and may affect their dreams for their futures.

Evidence demonstrates that early identification and rapid intervention are critical in preventing sepsis from becoming so severe that the body begins to fail. Lower mortality rates associated with sepsis can be achieved if we act promptly. Statistically significant drops in mortality rates have been reported in the literature, directly related to the use of sepsis protocols based on screening and early intervention. Sepsis screening is critical as an early alert system to prevent a chain of events from starting that could rob someone of their lifestyle or their life. Nurses are purposefully positioned to activate the alert system – they are with the patient 24 hours a day! If identified early, evidence-based guidelines of what must be done to ensure the best patient outcome can be initiated. Time is a critical factor! These “bundled” interventions must occur within the first 3 - 6 hours of the presentation of sepsis.

The UPHDM Sepsis Action Team (SAT) has been actively involved in improving care for the patient with sepsis for more than 5 years! They were active in helping build the previous paper-based sepsis order sets and then ensured these evidence-based order sets were represented during the Epic build of sepsis related order sets. They actively participated in the development and revisions of the current sepsis screening tool used in Epic today. Over the last 2 years, the SAT has brought you multiple learning opportunities to help you understand how to identify and intervene in sepsis and demonstrate WHY this is important. SAT members have made “house calls”, rounding on nursing units and in clinical care areas during our declared
Sepsis Awareness week. During this time front-line staff have been involved in sepsis teach back activities on an informal basis with SAT members. STOP Sepsis cards and information was handed out along with some sugar treats! Stop Sepsis pledge posters were displayed last year where staff could sign the pledge to help stop sepsis. These activities have correlated with Sepsis Awareness Month (declared by the Global Sepsis Alliance) – which is September – thus the name “Sepsember”!

International Sepsis Awareness Day is recognized every September 13th and we’re making plans to address sepsis education again this year!

What you can expect this year – well, it’s no secret - it will be all about sepsis! We are designating the week of September 6-13 as Sepsis Awareness week at UPHDM. Activities are being planned at this time. More to come, so stay tuned to Outlook emails and other publications for this information, but here’s a sneak peek to keep you in the loop:

1. CMS has introduced a new measure bundle, known as the Sepsis Bundle Project (SEP) or Early Management Bundle, Severe Sepsis/Septic Shock. Starting with October 1, 2015 discharges, we will begin submitting specific information to CMS about severe sepsis and septic shock. This is a complicated measure bundle – with more than 60 specific data points! Manually abstracted information from the medical record, based on provider documentation and other variables will give us a picture of sepsis care, practice and outcomes, at UPHDM. We have much to learn about the CMS process; and everyone, including CMS, has much to learn about how sepsis is currently being managed in the United States. Watch for more information and details about this.

2. Education: Unit-based, provider-focused, organizational presentations. **We'll have it all**
   a. Sepsis Fact Sheet
   b. Outlined 3-6 hour bundles of sepsis care (CMS information) and what YOU can do to stop sepsis
   c. Sepsis cue cards
   d. Etc.

**FACT:** Internationally, 1 person dies of sepsis every 3 seconds!!!

*How many people died from sepsis while you were reading this reminder?*