

Quality Improvement Activities Resulting from Case Review

Case Example #1

Summary

In a Medicare beneficiary complaint case, a patient in a large, acute-care hospital received plasmapheresis. Several problems developed including a port on the central line not functioning, swelling developing around the catheter site, decreasing blood pressure and overall deterioration requiring emergent intervention.

Following the QIO's review of this case, the facility received assistance to identify problem areas and implement process and quality improvement activities. It was a collegial and cooperative effort that resulted in major systems changes protecting not only Medicare beneficiaries but all patients who receive care in this facility.

Concerns identified by the QIO

The facility did not carry out an established plan in a competent and timely manner as evidenced by:

- The failure to appropriately, and in a timely manner, address the patient's facial and neck swelling, oozing from the catheter site and associated changes in condition
- The failure to appropriately address the patient's decrease in blood pressure (115/44 to 67/42)
- The failure to notify the physician of the patient's decreased blood pressure (75/44) at the time of notification of the swelling to the patient's chin
- The failure to reevaluate the patient's blood pressure after return to the nursing unit
- The failure to adequately monitor the patient following plasmapheresis
- The failure to call a code situation when staff was unable to detect a blood pressure and the patient was experiencing respiratory difficulties

Quality improvement activities that resulted from QIO review

QIO physician reviewers met with key hospital staff members (including the administrator and the medical staff officer) to discuss the care rendered to the beneficiary in this case and the hospital's quality improvement process. At this meeting, the hospital provided documentation of extensive process and quality improvement that had occurred following the QIO's case review, including:

- Initiation of case review and root cause analysis
- Education of staff regarding central line management, MD notification and documentation
- Verification of staff competencies
- Evaluation of hospital-wide quality review and reporting processes
- Change of processes including relocating admission of all dialysis/pheresis patients to a common unit

- Establishment of criteria to identify high-risk patients
- Revision of template orders to include critical labs and defined reporting values
- Appointment of a medical director to the apheresis service
- Implementation of process changes regarding reporting of clinical variances
- Initiation of internal peer review and counseling of involved staff
- Revision of staff hiring practices
- Revision of contract for the dialysis/pheresis services

After discussion regarding the case and the implemented process improvements, the QIO physician reviewers made some additional recommendations including:

- Creation of a pre-procedure checklist
- Creation of a post-procedure orders/checklist
- Initiation of a 100 percent audit of apheresis records for six months, with a report of findings submitted to the QIO
- Clarification of roles for facility staff, contract staff and the involved physician

The QIO's recommendations were accepted by the facility, and monitoring of quarterly reports has indicated 100 percent compliance. The QIP was closed with recommendations to continue the activities that resulted in better management of the patients and increased patient safety.

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