Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

EARLY EXPERIENCES WITH CLINICAL PRACTICE GUIDELINES SPONSORED BY THE AGENCY FOR HEALTH CARE POLICY AND RESEARCH

CASE STUDIES

JUNE GIBBS BROWN
Inspector General

September 1995
OEI-01-94-00251

OFFICE OF INSPECTOR GENERAL

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INTRODUCTION

We have conducted an inspection that focuses on the early experiences of healthcare organizations that have used the clinical practice guidelines sponsored by the Agency for Health Care Policy and Research (AHCPR). In that inspection, we examined the extent to which healthcare organizations have used AHCPR guidelines, the ways in which they have used them, and any obstacles they have encountered in the process.

To collect information for that inspection, we sent a mail survey to 380 healthcare organizations: 150 randomly selected nursing homes, 150 randomly selected non-teaching hospitals with no more than 100 patient beds, and all 80 of the health maintenance organizations with staff-model components. We received responses from 64 percent of the organizations surveyed.

We present our findings in a companion report entitled "Clinical Practice Guidelines Sponsored by the Agency for Health Care Policy and Research: Early Experiences in Clinical Settings," (OEI-01-94-00250).

In this report, we offer supplementary case descriptions of the ways in which healthcare organizations have used the AHCPR guidelines. These descriptions were developed from interviews that we conducted with clinician-managers in organizations that responded to our survey.

These descriptions are more detailed than those provided in our companion report. We report the information as organizations reported it to us, without further review or confirmation on our part. We present the case descriptions, without additional analysis, as background information for the Agency to use as it chooses.

CASE 1: A RURAL, COUNTY-OWNED HOSPITAL'S USE OF THE PRESSURE ULCER PREVENTION GUIDELINE

ORGANIZATION PROFILE

This is the only hospital within a 35-mile radius. It is located in a county with a population of just under 10,000. Seventy percent of its patient population is geriatric.

The hospital, which has an elected governing board, is a 49-bed, acute-care facility with 39 in-service beds and a few swing beds. It has 6 family-practice physicians, 1 general surgeon, 1 physician assistant, and 1 family-nurse practitioner. The hospital offers 6 specialty clinics several times each month.

MOTIVATION FOR USING THE GUIDELINE

Shortly after the hospital received its copy of the pressure ulcer guideline from AHCPR, a patient with stage-4 pressure ulcers came into the hospital from a long-term care facility. The plight of this patient, who subsequently died, raised staff interest in better understanding effective means of treating pressure ulcers. At that point, the hospital did not systematically assess patient risk for pressure ulcers. The nursing quality-assurance committee identified the need for an effective assessment tool and protocol, and its members set out in search of information.

WAYS OF USING THE GUIDELINE

New policy and procedures. In the fall of 1993, hospital staff attended meetings on pressure ulcers at different sites around the State. The staff also formed a task force to review relevant information that it gathered from professional journals. It rewrote its protocol for nursing assessment of pressure ulcers and incorporated the AHCPR-recommended Norton assessment scale into its protocol. The hospital also established an algorithm for care of patients at increased risk of pressure ulcers; this algorithm was derived from the AHCPR guideline.

Use with clinicians. The hospital distributed the pressure ulcer guideline to all clinical staff. Additional copies are kept at the nursing station and in the hospital library. A skin-care product company provided additional information and training for staff. The company held all-day training sessions for nurses on prevention and treatment of pressure ulcers and it held luncheon lectures for physicians. It demonstrated care techniques on the floor. Physicians and nurses trained one another to perform the recommended procedures. In addition, pressure ulcer prevention and care have been addressed in monthly staff meetings.

Use with patients. The hospital has not used the AHCPR patient guides, but intends to do so as part of patient teaching with those of its at-risk patients who are able to understand the material.

COMPLIANCE AND EVALUATION

The hospital quality-assurance reviews address pressure ulcers; patient care in the swing-bed unit is reviewed each week. Originally, feedback was provided to staff as a group. Now, when failure to comply with the new hospital policies and procedures is identified, clinicians are addressed on an individual basis.

The hospital has not yet conducted an evaluation of the effects of guideline use. The small patient population has limited the hospital's capacity to perform a statistically sound assessment. A representative noted, however, that hospital patients seem to have been faring better with regard to pressure ulcers. He added that the guidelines have been helpful in terms of both achieving better patient outcomes and standardizing clinical practice.

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CASE 2: A RURAL, NON-PROFIT HOSPITAL'S USE OF THE PRESSURE ULCER PREVENTION GUIDELINE

ORGANIZATION PROFILE

This rural, non-profit hospital has 74 beds and approximately 225 admissions each month. It also has two long-term care skilled-nursing facilities with a total of 170 beds and a residential-care facility with 45 beds. The hospital also has a large home-health program and a hospice. The hospital manages a health maintenance organization (HMO) as one of its departments. In addition, the hospital owns and manages 14 physician clinics, including 6 rural health clinics. The hospital employs approximately 700 staff, including 111 registered nurses and 28 licensed practical nurses. The hospital employs 27 physicians and has about 50 consulting physicians.

The HMO serves approximately 1900 members. About 60 percent of the hospital patients are Medicare beneficiaries; 25 percent are covered by Medicaid; 15 percent are self-pay, and a few are covered by private insurance.

MOTIVATION FOR USING THE GUIDELINE

The hospital's director of quality improvement learned about the pressure ulcer guideline from the hospital's chief executive officer and from a meeting she attended in 1993. The hospital reviewed the guideline when it standardized the assessment and treatment of pressure ulcers across all components of the organization.

WAYS OF USING THE GUIDELINE

New policy and procedures. The hospital used information relevant for its practices to revise its policy and procedures in the winter of 1993/94.

Use by clinicians. The director of quality improvement explained the AHCPR guideline and the new policy and procedures at regularly scheduled staff meetings. She gave copies of the guideline to physicians, directors of nursing, and nurse managers. She also sent out a hospital-wide notice announcing the availability of all of the AHCPR guidelines that had been published to date. In response to this memo, the social services department requested a copy of the guideline on depression. The hospital education department has held in-service educational sessions about the pressure ulcer guideline for nurses and nursing assistants.

The hospital used the guideline--and specifically the Norton and Braden scales it references--to develop a new pressure ulcer risk-assessment tool for the nurses. The hospital instituted a new risk-assessment form for use in its acute-care unit. The risk assessment was also incorporated into the form used to assess all patients for admission and on a daily basis thereafter.

Use with patients. The organization has not distributed the pressure ulcer guideline as a regular part of patient education. The director of quality improvement believes that hospitalized patients who develop pressure ulcers are too ill to understand them. Nonetheless, the pressure ulcer guideline is used to educate patients and their families in the hospital's home-health service.

OBSTACLES TO USE

The hospital interpreted the pressure ulcer guideline as recommending that patients be turned every hour, and the staff have found that this goal is difficult to achieve in a long-term care facility such as theirs. The hospital policy is that patients be turned every two hours.

The hospital considers the AHCPR guideline to be general and adaptable to local conditions. Adaptation, however, has been an expensive and time-consuming process.

The hospital had planned to use the acute pain management guideline as well as the pressure ulcer guideline. Facility-wide use of the pain management guideline was put on hold when it became apparent that each of the organization's many components had developed its own pain assessment and treatment procedures and did not want to change systems.

COMPLIANCE AND EVALUATION

Recently, the hospital assigned a nurse on the medical/surgical floor to spend one shift each week evaluating pressure ulcers to ensure that care plans are appropriate and are being implemented. In the long-term care unit, assessment of pressure ulcers is conducted on a monthly basis.

The hospital has not measured clinicians' compliance with the guideline, but it has measured their compliance with the new policy and procedures. The hospital has measured incidence of pressure ulcers as one of its quality-improvement indicators, and it has developed a quarterly report on pressure ulcer incidence. The director of quality improvement has also used the report to identify patient characteristics that correlate with pressure ulcers. The hospital expects the report will show a downward trend in the incidence of pressure ulcers, especially in the long-term care unit.

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CASE 3: A RURAL, COUNTY-OWNED HOSPITAL'S USE OF THE PRESSURE ULCER PREVENTION GUIDELINE

ORGANIZATION PROFILE

This county-owned hospital in a rural, farming community is licensed for 42 beds (including 8 swing beds); 34 of these are now occupied. The hospital provides general-medical, surgical, pediatric, and obstetric services, and it has an intensive-care unit.

The hospital is staffed by 25 registered nurses and 6 general-practice physicians, 3 of whom have been with the hospital for over thirty years and 3 of whom have joined during the past 5 years. In addition, a radiologist visits the hospital 4 days a week; and a pathologist and a general surgeon each visit the hospital 1 day a week. The hospital's home health program is staffed by 55 nurses and nursing aides, who conduct about 2500 home visits a month.

Approximately 60 percent of the patients are Medicare beneficiaries.

MOTIVATION FOR USING THE GUIDELINE

The hospital has used three of the AHCPR clinical practice guidelines: acute pain management, pressure ulcer prevention, and urinary incontinence. This discussion addresses the hospital's use of the pressure ulcer guideline.

One hospital physician has been the medical director at a nearby nursing home that was cited by State surveyors for unsatisfactory care of pressure ulcers. The State asked the hospital to help the nursing home improve its performance. In so doing, both the hospital and the nursing home began to use the pressure ulcer guideline.

Even though the hospital had launched a skin-integrity quality-improvement initiative several years earlier, the hospital had made little progress. The biggest problem was that its pressure ulcer indicators were calibrated such that they failed to register improvement. In addition, each physician had his own way of managing pressure ulcers; the hospital lacked a consistent approach to the problem.

Recognizing these problems, the nursing director wanted to develop new policy and procedures for the hospital's treatment of pressure ulcers. Her goals were to decrease the incidence, severity, and duration of pressure ulcers and to increase consistency among staff in treating the condition. Reducing the costs of treating pressure ulcers was not a specified goal, although the director suspects that costs have gone down due to less variation in the supplies purchased.

In seeking information from which to build new policy and procedures, the director reviewed materials from neighboring hospitals and looked for a public standard for measuring skin integrity.

WAYS OF USING THE GUIDELINE

Use with clinicians. The nursing director distributed handouts describing the new policy and procedures and explaining pressure ulcer assessment and treatment. The hospital held informal skills-training sessions for staff about pressure ulcer care. This skills training addressed, among other things, the use of a camera in documenting pressure ulcers. To keep staff from falling back into their old routines, the director has held review sessions at staff meetings.

The hospital changed its clinician-patient encounter forms, which are now used on a daily basis. The hospital also expanded the options listed on its laboratory culture-order form for pressure ulcers, but these changes were not made in response to the AHCPR guideline.

Use with patients. For the past year, the hospital has used the pressure ulcer guideline in its home-health classes to educate patients and their families about ways to avoid and heal pressure ulcers. It has not distributed the pressure ulcer guideline to hospital patients because those most at risk for pressure ulcers lack the capacity to understand the material and/or to act on it.

OBSTACLES TO USE

The hospital's physicians anticipated that a clinical path for pressure ulcers could be developed in one week, but it took longer. Implementing the guideline throughout the hospital took about six months.

Staff have been unclear about how to score the Braden scale for assessing risk factors. The hospital found that the guideline does not explain how to calculate a total score by combining the score on the Braden scale with the 24-hour assessment. The hospital has sought guidance from AHCPR on this subject.

COMPLIANCE AND EVALUATION

The hospital has conducted quarterly skin-integrity quality-improvement studies to determine improvement in preventing and caring for pressure ulcers. These studies have examined the extent to which patients' pressure ulcers have been assessed at both admission and discharge and have reviewed treatment, including photographs and measurements of the ulcers, and documentation of improvement or deterioration in the patients' condition.

The nursing director has reviewed indicators of patient care and status and, in instances in which the indicators demonstrate a negative trend, she has reviewed more

extensive information. When clinicians' care of pressure ulcers has not met the new standards, the nursing director has provided feedback on a one-to-one basis. She has also provided feedback to the staff as a group in staff meetings.

The nursing director noted that the incidence and severity of pressure ulcers have decreased in the hospital. Patients who have entered the hospital with stage one or two ulcers now leave with none. She also noted the benefit to patients of having both the hospital and nursing home staffs adhering to the same standards of care.

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CASE 4: A RURAL, PRIVATE, NON-PROFIT HOSPITAL'S USE OF THE PRESSURE ULCER PREVENTION AND PAIN MANAGEMENT GUIDELINES

ORGANIZATION PROFILE

This rural facility, which is run by an independent, private, non-profit organization, has fewer than 50 beds and an average of 14 patients. The hospital is staffed by 3 physicians, a nurse practitioner, and other nursing staff. The acute-care unit has 7 registered nurses, 11 licensed practical nurses, and 20 nurse aides. The emergency room has about 220 visits a month.

In the past two years, the hospital has established two health clinics from the three physician practices that it acquired and has opened a home-health agency.

Approximately 80 percent of the hospital's patients are either Medicare or Medicaid beneficiaries.

MOTIVATION FOR USING THE GUIDELINES

The hospital administrator introduced the staff to the acute pain management and pressure ulcer guidelines after he become aware of important inconsistencies in the treatment of pressure ulcers and potential abuses in the treatment of pain. For pressure ulcers, physicians had used their own, sometimes "home-spun" and untested, remedies. For pain management, physicians had sometimes inappropriately prescribed Schedule-2 narcotics for headaches. At the same time, the hospital's insurance company requested that the hospital begin to grade its physicians' clinical performance at the time of their annual recredentialing.

WAYS OF USING THE GUIDELINES

New hospital guidelines. The administrator obtained copies of the two AHCPR guidelines and drafted brief summaries (each less than two pages) for the hospital's use. The physicians and the hospital's governing board approved them.

Use with clinicians. The administrator presented the new guidelines at a few staff meetings. The hospital bought a taped series on pressure ulcer care for the hospital staff and home-health agency employees. In addition, the physical therapist conducted in-service training on pressure ulcers for the nurses and nurse assistants. Skills training on pressure ulcers has been conducted as part of the regular orientation for new staff.

The hospital's guidelines called for a new patient-turning chart. This chart lists the times that each patient's position must be changed, and it requires a sign-off by the nurses to indicate that the turning has been accomplished. Patient-turning is also

noted in the patients' charts. The physical therapist must assess pressure ulcer patients three times a week.

To implement the new pain management guideline, a new emergency room encounter form was developed specifically for pain patients. This form informs patients of the hospital's policy with regard to pain medication. Thus far, the form has prompted no comments and has resulted in a less frequent use of narcotics. The administrator noted that patients hoping to receive narcotics often walk out of the emergency room after reviewing the form; they no longer even try to get the medicine.

OBSTACLES TO USE

The administrator noted initial difficulties in getting all the staff to adhere to the new policies on a consistent basis. For instance, the emergency room staff sometimes forgot to use the new pain form with patients. The administrator responded to these difficulties by reinforcing the importance of the forms in staff meetings and in personal meetings with staff members. He indicated that tact has been an important component of his strategy to achieve successful implementation of the new policies.

COMPLIANCE AND EVALUATION

As part of the recredentialing process, the hospital now reviews physicians' pain-management and pressure ulcer management practices against the new guidelines. In addition, deviations from the new guidelines are discussed in monthly staff meetings.

As a result of the new pressure ulcer guidelines, physicians have relinquished care of pressure ulcers to the physical therapist.

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CASE 5: A RURAL HOSPITAL'S USE OF THE PAIN MANAGEMENT GUIDELINE

ORGANIZATION PROFILE

This rural hospital has 74 intermediate-care beds and 53 acute-care beds. Some of the acute-care beds are swing beds. An independent-living unit that houses 33 seniors is also part of the hospital.

The hospital is staffed by 5 general practitioners, 2 internists, and 2 general surgeons, 35 acute-care nurses, 10 intermediate-care nurses, and 12 home health/public-health nurses.

MOTIVATION FOR USING THE GUIDELINE

The facility has used three AHCPR guidelines--pain management, depression, and pressure ulcer prevention. This description focuses on the use of the pain management guideline.

The hospital's nursing research committee first began to consider practice guidelines a few years ago as a way of improving quality of care. A literature review uncovered the AHCPR guideline, which was suited to the hospital's needs.

WAYS OF USING THE GUIDELINE

Use with clinicians. The hospital has placed primary emphasis on treating pain after surgery, and, to a lesser extent, on managing pain in cancer patients. The hospital has fully implemented a patients' self-assessment pain scale.

OBSTACLES TO USE

The hospital has been educating its physicians to make them more comfortable with PCA (patient-controlled analgesic) pumps. A young, newly-trained surgeon who is familiar with the pumps has been working with other physicians. Several physicians have continued to use Demerol, even though the guideline encourages use of morphine for better pain control.

The physicians have been receptive to writing patient orders that allow different approaches to pain control. The director of nursing believes that they would be even more receptive to options if the nurses would ask for them. She noted, as an example, that the guideline presents a range of dose levels and a range of lengths of time for medication. Many nurses, however, are used to administering injections every 4 hours and have not considered other ways of controlling pain.

Staff nurses initially found the guideline overwhelming; they did not have time to read it all. Each nurse manager, however, has been involved in in-service training.

COMPLIANCE AND EVALUATION

The hospital has assessed the effects of its change in pain-management practice in two ways. First, the hospital has conducted audits of patient charts to determine how often pain assessments are conducted, pain is reported, medication is administered; and the length of time between the administrations of pain medications. The hospital aims to prevent pain from exceeding 5 on the 1-to-10 scale. Second, the hospital has added a question, "Was your pain adequately controlled," to the hospital's patient satisfaction questionnaire.

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CASE 6: A MID-SIZED TOWN HOSPITAL'S USE OF THE PAIN MANAGEMENT GUIDELINE

ORGANIZATION PROFILE

This hospital is located in a town of about 30,000 people. The hospital has a capacity of 70 beds, but operates only 34 beds. Overall, the hospital has about 200 employees, including 80 nurses and 15 physicians on the active medical staff.

MOTIVATION FOR USING THE GUIDELINE

The nursing staff conducted an overall review of their protocols for treating different conditions, including acute pain. During that time, the nursing director attended a seminar, at which she received information about the guideline. She presented this material to the nursing staff during an in-service training session. Then, the hospital incorporated the guideline into its new policies.

The hospital has been using the pain management guideline for 15 months.

WAYS OF USING THE GUIDELINE

Use with clinicians. The nursing staff developed their own 5-point pain-assessment scale, based on the AHCPR guideline's 1-to-10 point scale. They also developed a second, modified scale by assigning colors to the different pain levels: these colors range from red, which connotes the most severe pain, to white, which indicates no pain. The color scale has been especially useful with pediatric patients.

A new flow-charting system helps staff determine when to offer different medication to patients. One benefit of this system has been getting physicians to increase use of patient-controlled analgesic (PCA) pumps. Originally, the PCA pumps were only used post-operatively. They are now routinely used with cesarean-sections, kidney stones and severe back pain.

Use with patients. Recently, the hospital began to distribute information routinely to patients on admission. This information is tailored to each patient's needs. When appropriate, materials include the consumer pamphlets on the pain guideline.

OBSTACLES TO USE

The director of nursing suggested that physicians have been somewhat resistant to changing established practice. Despite this resistance, however, physicians have followed the modifications in clinical procedures. She noted that, while there has been no formal approval of the modifications by the medical staff, there have been subtle changes in practices.

COMPLIANCE AND EVALUATION

The hospital has not undertaken a formal evaluation of the effects of its guideline use. Informally, staff nurses have told the nursing director that patients have been more comfortable, have been less likely to complain about a lack of medication, and have been more ambulatory. They have reported no added cost as a result of implementing the guideline.

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CASE 7: A RURAL, COUNTY-OWNED HOSPITAL'S USE OF THE INCONTINENCE GUIDELINE

ORGANIZATION PROFILE

This county-owned, frontier hospital is located in a town of 9,000, about 120 miles away from the next hospital. The hospital has 35 acute-care beds (medical/surgical and pediatric), 5 intensive-care beds, and 10 long-term care beds. The staff consists of 54 registered nurses, 12 licensed practical nurses, and 7 nurse assistants. In addition, the hospital has 12 physicians on staff, including 5 for the emergency room. The hospital performs 100 surgeries per week and sees about 1,000 patients in its emergency room each month.

Forty percent of the hospital patients are Medicare beneficiaries; nearly 8 percent are Medicaid beneficiaries; and 3 percent receive workman's compensation.

MOTIVATION FOR USING THE GUIDELINE

In 1994, the hospital's chief executive officer of 12 years resigned, along with the senior financial staff. The new administrative team has begun to change hospital operations, and has added new home-health and cardiac-rehabilitation services. As part of these changes, the hospital has adopted the AHCPR guidelines on acute pain management, urinary incontinence, pressure ulcers, cataracts, and sickle cell disease. This discussion addresses the hospital's use of the urinary incontinence guideline.

WAYS OF USING THE GUIDELINE

New policy and procedures. The director of nursing first learned about the incontinence guideline at a seminar in 1993. At that time, the hospital had no standards of care for stress incontinence. The director got additional copies of the guideline and brought them to the clinical practice committee, which was composed of nurse managers and a few staff nurses. This committee used the guideline to create its first standards of care for stress incontinence and quickly rewrote the hospital's policy and procedures to make them consistent with the guideline.

Use with patients. The hospital does not routinely provide the guideline to patients or teach them about the recommended care. Physicians must order guideline education for their patients. When incontinent patients are discharged from the hospital, however, the discharge planner gives them a copy of the guideline.

The hospital has held educational sessions about urinary incontinence at senior centers and at health fairs. It distributes copies of the guideline at these sessions and may present a video it has developed.

Use with clinicians. After the clinical practice committee adopted its new policy and procedure on incontinence, each nursing unit received ten copies of the clinical practice guideline. In addition, each nurse manager took information on the new policy and procedures back from the committee meetings to discuss with staff.

No training was provided for the nursing staff when the new policy and procedures were introduced. Consequently, many nurses failed to comply with them. The nursing director found that she "had to do a lot of educating of the nursing staff about stress incontinence and bladder training. . . . I had to go back to basic anatomy and physiology to educate the nurses." To determine the focus for this training, she solicited from each nurse an assessment of her training needs.

Ultimately, the hospital's education department coordinated five in-service sessions on incontinence that were mandatory for nursing staff. Some additional lectures and demonstrations were incorporated into regular staff meetings. Some staff, including members of the skin care committee, attended seminars off-site to learn about incontinence.

The hospital's physicians received information about the new policy and procedures on incontinence only once--at a monthly staff meeting. The nursing director explained: "I don't want to bug the doctors."

The hospital has completely computerized its patient records, including all nursing notes, physician notes, and care plans. The guideline recommendations have also been built into the system as reminders to clinicians. When a nurse brings up a patient's chart on the computer, for example, the system will display recommended treatment. If the nurse chooses not to follow it, she must explain her decision in the chart.

In response to the AHCPR guideline, the hospital has expanded its medical-profile data-collection for newly admitted patients. Previously, patients were asked only one question related to incontinence: "Are you incontinent?" Now, more detailed information is gathered with a 12-question admitting and monitoring instrument. In addition, the hospital has developed a new bladder-training form for educating patients and has changed the instructions given to patients at discharge.

OBSTACLES TO USE

Uncertainty about how to implement the guideline was an obstacle. Initially, the nursing director sought information from other hospitals about their plans for implementing the guideline. She found that "many hospitals haven't heard of the AHCPR guidelines." The hospital had to figure out how to use the guideline by itself.

COMPLIANCE AND EVALUATION

The computer system has provided easy access to patients' files for quality-assurance reviews. The system has a quality-improvement component that provides patient-care and outcome data to nurse managers. This component allowed the hospital to identify the initial failure of some of the nursing staff to comply with the new policy and procedures on stress incontinence. After the intensive training effort, further review revealed that staff were in compliance in 93 percent of the cases. The hospital is planning another compliance review in 1995.

The hospital has not monitored individual clinicians' compliance with the guideline. It may do so, however, because the hospital's human resources department has been urging hospital leadership to develop criteria for evaluating clinician performance. To date, feedback has been provided only to groups of clinicians, not to individuals.

The hospital has used a satisfaction questionnaire to assess patients' perceptions of their care. In addition, staff have telephoned stress-incontinence patients after their discharge to make sure that they understand how to manage their incontinence and to make sure that their home care is going well. The questionnaires have revealed that patients have been satisfied with the new care, especially with the follow-up calls.

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CASE 8: A RURAL, PROPRIETARY NURSING HOME'S USE OF THE PRESSURE ULCER PREVENTION GUIDELINE

ORGANIZATION PROFILE

This facility has 70 beds, 6 of which are skilled-nursing beds. The facility was acquired a few years ago by a national, proprietary firm that owns many nursing homes across the country.

Since the acquisition, a new administrator and a new director of nursing have been hired. The day staff includes two registered nurses, seven certified nursing aides, and one restorative aide. The facility has two primary care physicians, each of whom visits one day a week.

About one-half of the facility's patients are Medicaid beneficiaries; the other half are private pay.

MOTIVATION FOR USING THE GUIDELINE

The facility has used AHCPR guidelines for acute pain management, urinary incontinence, pressure ulcer prevention, and depression. Most of its experience has been with the pressure ulcer guideline.

A State survey recently found deficiencies in the homes's management of pressure ulcers. State law requires nursing homes to turn patients at least once every two hours and to take other steps to prevent and treat pressure ulcers. Medicare also imposes requirements.

When the national firm took over the nursing home, it found that many patients had severe skin problems. Its own skin-care policies, which reflect the AHCPR guideline on pressure ulcers, are at least as strict as those of the State and Medicare. The national firm has been working with the local home to correct the problems.

WAYS OF USING THE GUIDELINE

Use with clinicians. The home has posted turning schedules for patients on their headboards as reminders to nurses and aides. The home has also begun to use the Briggs patient-encounter forms, which are more detailed than the forms used previously.

Feedback on pressure ulcer care has been provided during monthly nurse and nursing aide meetings. In addition, the director of nursing has made rounds of the units and has provided individual feedback in that context.

Use with patients. The facility conducts little patient teaching about pressure ulcers. The director of nursing explained that most residents are unable to understand information about pressure ulcers and that most are unable to control their movements--so they cannot act on the information. The home does do a little patient teaching with those residents who can both understand the information and act on it. The home also does teaching with family members.

OBSTACLES TO USE

Before the home was acquired, relationships among physician, nursing, and administrative staff were strained. After the acquisition, the new director of nursing held a reception for physicians and has made a concerted effort to win their cooperation. This effort seems to have been successful.

When the new firm took over, the facility was "way over budget," and budget constraints remain problematic. The nursing director has submitted a budget that will enable the home to address the pressure ulcer problem in the facility.

COMPLIANCE AND EVALUATION

The home's quality-assurance program has involved seven annual, in-depth internal surveys of each department. These reviews, intended to simulate the State survey, address all aspects of care, including skin care.

As part of these reviews, reports on pressure ulcers are prepared for every pressure ulcer resident every night by the night nurse. These reports are reviewed by consultant nurses. Because the home's medical records are mostly computerized, these reviews (and others on weekly, monthly, and quarterly bases) can be conducted very easily.

The review reports are sent to the regional administrator and the corporate specialist on a monthly basis. In addition to the seven annual reviews managed by the facility itself, the parent firm conducts its own annual survey.

The nursing home requested that its name not be released in this report.

CASE 9: A LARGE NURSING HOME'S USE OF THE PRESSURE ULCER PREVENTION GUIDELINE

ORGANIZATION PROFILE

This nursing home has about 150 skilled and 240 intermediate beds. Ninety-six percent of its patients are covered by Medicaid. Most are elderly, and some are mentally handicapped. Most patients are moderately to severely limited in their ability to perform the activities of daily living.

MOTIVATION FOR USING THE GUIDELINE

In June 1993, State nursing home surveyors cited the home for shortcomings in its care of pressure ulcers. The home then conducted its own 3-month study of pressure ulcers care and found the incidence, although having remained stable for 5 years, was higher than anticipated. The nursing director established goals to reduce both the incidence of pressure ulcers and the variation in treatment approaches. The director also hoped to reduce costs by reducing the amount of nursing time needed to treat pressure ulcers and by eliminating the costs associated with ineffective treatments.

WAYS OF USING THE GUIDELINE

New policy and procedures. A staff nurse brought the AHCPR pressure ulcer guideline to the attention of the nursing director. To develop the revised policy and procedures, he researched books, articles, and product information. He discussed pressure ulcer prevention and treatment with nursing and administrative staff in regularly scheduled meetings. In addition, he consulted with the assistant director of nursing, the nursing supervisors, the infection control nurse, the quality assurance nurse, the dietician, the social services department and the activities department.

The new policy uses a modified Norton Scale with additional nutritional risk factors. It was introduced to the home on a pilot test basis and has been in full use since early 1994.

Use with clinicians. The nursing director placed a copy of the complete guideline and the quick reference guide in each nursing unit. He then held a series of three in-service training sessions for nurses. Administrative staff attended off-site seminars on pressure ulcer treatment. Gaining acceptance of the guideline interventions was relatively easy once staff were able to agree about causes of pressure ulcers.

The home created new patient-encounter forms to reflect the guideline; modified its dietary-reporting forms; and designed new activity forms to indicate the times for repositioning each patient. In addition, it has conducted more nutritional lab-tests related to pressure ulcers.

To track progress in the care of pressure ulcers, the home developed a new reporting system. An incident report is completed whenever a pressure ulcer is identified. This report triggers the computer to order an assessment of the pressure ulcer. Within five days of the incident report, the shift supervisor must conduct a Norton assessment of risk factors for pressure ulcers, review any plan that was in place for care of the pressure ulcer, and determine if that plan was appropriate and if it was followed. The supervisor must correct any deficiencies in the plan or its implementation. One week later, the supervisor must review the revised plan to assure that it is appropriate and is being implemented.

OBSTACLES TO USE

Despite education for the home's residents about the new procedures, some have refused to adhere to the interventions. In particular, some younger residents (35-45 years old) have viewed the repositioning plan (which entails moving the patients in their chairs every fifteen minutes and moving them in their beds every two hours, even when sleeping) as an encroachment on their personal freedom. For these residents, the staff have developed care plans that address the residents' noncompliance, and they have tried to educate the patients about the importance of the repositioning. In addition, the staff are required to document the provision of information to the patient about the need for the intervention and the consequences of nonintervention, and the patients' refusal of the intervention.

COMPLIANCE AND EVALUATION

The home's assessments have focused on patient outcomes more than nursing practices. The home has produced a pressure ulcer report that lists residents' names, status, and trends in health status. Initially, these reports were prepared weekly; they are now produced on a monthly basis.

After the first year of guideline use, the incidence of, and the time required to treat, pressure ulcers decreased: the initial incidence included 27 areas (of which 17 were stage-one areas); after 1 year, the home reported an incidence of 14 pressure ulcers, 2 of which were not acquired in the home. Anecdotal reports have indicated that stage-1 ulcers now require very little treatment and that all treatments now require less care time than before.

In addition to outcome measures, the home has conducted annual evaluations of nurses' performance during an episode of patient care. Other observations and assessments of nursing practice take place throughout the year.

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CASE 10: A SKILLED-NURSING HOME'S USE OF THE PRESSURE ULCER PREVENTION AND INCONTINENCE GUIDELINES

ORGANIZATION PROFILE

This non-profit facility is affiliated with a denominational social-service organization and is located in a medium-sized urban area. The home has 140 beds, including a 58-bed Alzheimers unit. The home is staffed by nearly 100 nurses and nursing aides, and 2 medical directors. Eight physicians visit patients at the facility. In recent months, the home has had a significant staff turnover.

MOTIVATION FOR USING THE GUIDELINES

State law stipulates that patients entering nursing homes should not develop pressure ulcers in the homes. In the home's recent State survey, ten patients were found to have pressure ulcers; six of them had developed the ulcers after entering the facility. As a result, the facility received a citation.

State law also requires that the homes maintain patients' continence. In the State survey, the home also received a citation for failure to properly monitor incontinence and for failure to fully implement a bowel and bladder program. In response to both citations, the home was required to develop corrective action plans.

The director of nursing had used the pressure ulcer and incontinence guidelines at the nursing facility where he was previously employed. He regarded the guidelines as useful tools for quality assurance and thought that they would provide a sound foundation for revising this facility's policies and procedures in these two areas. He has found that adhering to the incontinence guideline has resulted in reduced use of incontinence products and reduced laundry costs, and that treatments for pressure ulcers have been far more expensive than prevention.

WAYS OF USING THE GUIDELINES

Revised policy and procedures. The nursing director worked with two staff members to develop new policies and procedures that reflect the guidelines. This rewrite took two months and drew on information from sales representatives and professional journals, in addition to the AHCPR guidelines. The nursing director indicated that, while the new policy and procedures are in place, the home's implementation of the guidelines is at an early stage.

Use with clinicians. The nursing director distributed copies of the guidelines to each nurse manager, charge nurse, unit manager, and support-staff nurse. Copies were made available to all others. He discussed the guidelines with his staff "almost page for page," and talked about how best to adapt the guidelines for use in the facility. The staff decided that some aspects of the guidelines were impractical for use in either the Alzheimers unit or the entire facility.

Use with patients. The nursing director felt that the patients "wouldn't understand or care about the guidelines." Nonetheless, he maintains an "open-door" policy for residents and their families. In addition, the staff explain the care of pressure ulcers and incontinence to all residents and the families of the residents that express interest.

The home already conducted annual pressure ulcer in-service training (one session is required by the State). In addition, two nurse managers were trained in guideline-recommended care for pressure ulcers and incontinence. These two nurse managers then taught the other nurses.

The facility has instituted the use of a new skin-care form that reflects the pressure ulcer guideline; this is used on a weekly basis to assess the status of patients' pressure ulcers.

OBSTACLES TO USE

The nursing director had anticipated some resistance to the guideline by clinical staff. The home's internal review process had indicated that physicians were in the habit of ordering antibiotics for their patients without examining the wounds and without consulting with the nurses. The nursing director wrote to the physicians about the guideline and asked that they not be upset if nursing staff questioned the use of antibiotics or other specific treatments when these were inconsistent with the new policy and procedures. The physicians have realized that they have had to depend on the nursing staff to provide the bulk of patient care and have accepted the wound care protocol, which is now part of the routine standing orders.

Nurses initially were resistant to the new policy and procedures because they thought too much work was involved. Some nurses still refuse to comply, but most have come to appreciate that the new rules can mean less work and better patient outcomes.

COMPLIANCE AND EVALUATION

The unit managers have assessed the appropriateness of care plans and the extent to which clinicians have implemented care plans. As a result of the recent State citations for pressure ulcers and incontinence, the unit managers have focussed their reviews on these two topics. In addition, the home has had nurse consultants review records on pressure ulcer and incontinence care on a monthly basis.

The home is planning to have a nurse consultant perform a formal review of the home's progress in using the new policy and procedures. Weekly record reviews have already demonstrated a decrease in the incidence of pressure ulcers among the residents.

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CASE 11: A SMALL-TOWN, PROPRIETARY NURSING HOME'S USE OF THE INCONTINENCE GUIDELINE

ORGANIZATION PROFILE

This facility has about 100 Medicaid-certified beds. Recently, it was purchased by a firm that owns other nursing homes in the State and in a neighboring State.

It has a staff of about 90 and has 8 physicians treating residents at the facility.

MOTIVATION FOR USING THE GUIDELINE

The facility has been using the AHCPR guidelines on acute pain management, urinary incontinence, depression, and cataracts, but has the most experience with the urinary incontinence guideline.

State law requires quarterly and annual reports on the residents' bowel and bladder conditions and on the home's ability to address bowel and bladder problems among the residents.

A pharmacy that provides training for the home provided a copy of the incontinence guideline and suggested that the home implement it. A speaker at one of the training sessions warned that State surveyors would look for the guideline as part of their annual survey. In fact, the surveyors did make a written note documenting the presence of the guideline materials.

The parent firm, which provided the home with its quality-assurance system, also recommended use of the guideline.

WAYS OF USING THE GUIDELINE

Use with clinicians. The nursing director discussed the guideline with the nursing staff during a regularly scheduled staff meeting. The guidelines and the patient guides have been kept in a central office and have been available for the staff to review. Handouts were made available to the staff. There has been no in-service training on urinary incontinence, although there has been in-service training on pain management.

The home has been modifying its policy and procedures to reflect the urinary incontinence guideline recommendations. The home has incorporated the AHCPR guideline's ten-point pain scale into its policy and procedures. The director of nursing is not yet completely satisfied, however, that all the necessary changes have been incorporated.

The home has been changing its incontinence treatments to reflect guideline recommendations. It has instituted measures to increase awareness of patients' fluid intake and of the patients' activity schedules. It has also tried to make its incontinence programs better suited to individual needs. The nursing director reported, however, that it is difficult

to get staff to follow-up on care with measurements and documentation of the residents' conditions.

The home has started using a new incontinence assessment form for new patients and, on a quarterly basis, for those patients who stay at the home.

Use with patients. The facility does not distribute guides to the patients. It conducts all patient teaching when patients are discharged from the facility.

OBSTACLES TO USE

The nursing director noted that the physicians have tended to be highly suspicious of mandates coming from State government. They have responded more favorably to the guidelines when the association with State mandates is not made.

Another obstacle noted by the director was insufficient time for her staff to read and implement all of the guideline recommendations. She suggested that a pocket guideline would be more even useful than the quick reference guide.

COMPLIANCE AND EVALUATION

Quality assurance reviews have been conducted on a monthly basis. Nurses are provided with feedback on their care of incontinence at least quarterly, during care plan conferences for incontinent patients.

The nursing home requested that its name not be released in this report.

CASE 12: A LARGE HEALTH MAINTENANCE ORGANIZATION'S USE OF THE CATARACT GUIDELINE

ORGANIZATION PROFILE

This health maintenance organization (HMO) is part of a national, proprietary chain with a presence in many States. It serves 8 counties in a large metropolitan area. It has more than 150,000 members belonging to its HMO and preferred provider organization (PPO) programs. About 40 percent of its members are Medicare beneficiaries. Its staff model HMO component has 2 physicians and serves about 2,000 members. The rest of the organization's physicians are under contract; they practice either solo, in small groups, or in physician organizations.

MOTIVATION FOR USING THE GUIDELINE

Because of its large Medicare membership, the HMO has had a lot of interaction with the Medicare Peer Review Organization (PRO). In one recent instance, a patient complained to the PRO that he was unfairly denied cataract surgery. The PRO found some merit in the patient's complaint and recommended that the HMO adhere to the AHCPR guideline on cataracts as a means of settling the dispute. The HMO had its own committee review the guideline. Ultimately, this committee also recommended adherence to the guideline, and the company has adopted it as a new policy. The guideline represents a slight change in the protocol previously used by the HMO.

WAYS OF USING THE GUIDELINE

Use with clinicians. The HMO sent notification of its change in policy and the new criteria for determining the need for cataract surgery to all of the primary care physicians and ophthalmologists contracted and credentialed with the company. The organization did not distribute the AHCPR guideline per se because it uses a standardized format for communicating standards of care to its providers.

Clinicians received no education or skills training on the guideline. A physician with the HMO explained that, because the change in policy was slight--and not a matter of new diagnosis or treatment techniques--no education or skills training was necessary. He feels that the HMO's physicians have accepted the new standard.

Use with patients. As part of the HMO's agreement with the PRO, the HMO plans to publish an article for patients about cataract treatment and its use of the AHCPR guideline. The article will also invite patients to call the HMO for additional information.

COMPLIANCE AND EVALUATION. The HMO is planning a follow-up audit of clinician compliance with the guideline's standards of care. The population for this study will be all patients aged 65 or older who underwent cataract surgery during a 6-month period. In

addition, the HMO is considering a cooperative project with the PRO in which records would be chosen at random for a detailed review of compliance with the new cataract surgery standard. This proposed project would use encounter or claims data as a basis for the assessment of clinician performance.

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