TRACER METHODOLOGY 101

Using Mock Tracers to Evaluate Care of Patients with Intellectual Disabilities, Part 1

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This is the first part of a two-part series describing a mock tracer performed in a major academic medical center in Chicago by hospital staff. The second part of this series, detailing how the hospital made improvements in pain assessment and management, the environment of care, transitions of care, and other key areas, will appear in the January 2016 issue of this newsletter. The second part will also include a tool used by the organization during its mock tracer.

Providing quality care, treatment, and services to each patient in the acute care setting is a goal of health care organizations. A 2010 Joint Commission white paper, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*, notes that hospital quality of care and outcomes differ by race, ethnicity, language, disability, and sexual orientation.[1] Health care organizations are responsible not only for addressing the clinical aspects of the patient's needs, but also their unique needs based on the patient's personal and demographic characteristics.[1,2]

One way hospitals can evaluate their performance in meeting the specific needs of various patient populations is to conduct mock tracers that follow the patient's experience through the health care process. When Joint Commission surveyors visit hospitals, they often trace patients from high-risk, vulnerable populations in order to evaluate the effectiveness of an organization's policies and procedures and processes of care.[3] Often the tracer follows a patient who has used multiple complex services and uses the evaluation of actual patients as the framework for assessing compliance to standards along with coordination and communication among disciplines and departments.[2,4]

Joint Commission–style mock tracers conducted independently by hospitals are useful tools for ongoing evaluation of patient care and the associated services, processes, and procedures. Hospitals find it useful to conduct mock tracers with patients who are members of a high-risk patient population, who are fragile, unstable, and/or vulnerable. Tracing the care of these patients may indicate

Using a multidisciplinary team is the most effective way to conduct a mock tracer.

gaps in processes and procedures that can be addressed and reduce inequities in care. Mock tracers also provide nurses and other health care professionals with meaningful examples of how their actions affect patient safety and the quality of care, and help to identify areas of noncompliance with standards, policies, and procedures.[5]

Patients who have intellectual disabilities (ID) are a vulnerable population, and hospitals should evaluate the care provided to these individuals. Despite 20 years of research and government initiatives, many patients with ID continue to have poor hospital experiences.[6] Persons with ID have higher rates of hospitalization for ambulatory sensitive conditions, higher rates of days in intensive care for some conditions, and higher rates of hospital complications than the rest of the population.[6,7] Issues that affect the experience of these patients include the following[6,8]:

• Staff inattention to basic needs

- Poor communication
- Patient fear and anxiety
- Poor discharge preparation

Many patients with ID and their caregivers report dissatisfaction with their care at hospitals.[9] Some health care professionals report negative attitudes toward treating patients with ID, and when caring for individuals with ID, some physicians and nurses were noted to exhibit common characteristics of ignorance, indifference, and lack of education.[10]

The Scenario

Mock tracers for patients with ID were developed and conducted in a large academic medical center in Chicago. Prior to the tracers, the medical center had several interventions in place that are specific to the care of patients with ID. These include, but are not limited to, the following:

- A specialized care plan in the electronic medical record (EMR)
- A module to educate staff on the use of this care plan
- A committee specific to advocating for the care of patients with ID

With the mock tracer, student, staff, and faculty surveyors examined information regarding patients with ID hospital care along with their interactions with different hospital services.

The tracers were conducted on acute inpatient units, perioperative units, the emergency department, and pediatric and neuroscience intensive care units during the course of a year, and the original units were revisited at the end of the year. Upon arrival to each of the units, a nurse was interviewed about the care that individuals with ID receive and a specific patient was chosen to assess the care being provided. The mock tracers included the following[3]:

- Direct observation
- Asking staff a series of questions regarding their care and experiences with particular patients
- Chart reviews for particular patients
- Interviews with patient family members to discuss the care provided (in some cases)

Staff interviewed included unit directors, nurses, physicians, patient care technicians, physical and occupational therapists, and social workers. From conducting the tracers, internal surveyors were able to identify both strengths and gaps in care.

The surveyors observed that staff could explain how they tailored communication to patients with ID, and they

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were able to describe how they altered observations when assessing for pain. Surveyors also noted that more than 300 health care staff participated in the education module. The mock tracer identified gaps in some areas, including the following:

- Lack of communication both before planned admissions and during patient handoffs
- Managing the environment for care
- Adjusting care so that it is specific to the patient
- Difficulty in finding ID diagnosis and information on guardianship in the EMR
- Limited availability of specialized equipment
- Additional time was necessary to access specific nursing standards of patient care (care plans).
- Lack of a standardized place in the EMR or formal process to document to whom and how staff delivered patient education and discharge instructions

Identified strengths and gaps with care are detailed as follows (additional information will appear in Part 2 of this article in January 2016).

Communication

With specific patients on hospital units, the majority of staff could identify how they adjusted and tailored communication to meet the needs of patients. It was also easy to navigate the EMR to chart tailored communication. Staff reported breakdowns in communication due to insufficient information before planned admission. For example, a nurse discussed difficulties with an admission in which the staff were informed before admission that the patient had ID but not that the patient had sensory difficulties with lights and noise. The communication gap in conveying the information led to a difficult experience for not only the patient but the health care staff as well. Staff reported that had they known, they would not have had the

patient come to an area with bright lights but would have had the patient enter directly to a quiet area with dimmed lights.

Staff also noted communication breakdowns during transitions of care within the hospital. One nurse stated that she would prefer to get as many details about the patient as possible, such as a review of systems and all other pertinent information about the patient, including any specific needs related to managing the environment for sensory issues and issues whether ambulatory or not. **TS**

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