BETA Healthcare Group (BETA) is focused on improving reliability and reducing risk in emergency medicine. As your partner in patient safety, BETA provides its members and insureds a tiered approach to receive premium renewal credit while enhancing safety. BETA organizations that provide emergency services are eligible to participate on an annual basis in our Quest for Zero: Excellence in ED initiative, which introduces key concepts designed to enhance the quality of care in this high-risk clinical setting.

Menu Selection:

The Quest for Zero: Excellence in ED is comprised of two Tiers. The basis of Tier One is to enhance knowledge and judgment in diagnosis. BETA fully sponsors the Relias Personalized Learning Modules and Courses for our members. The personal learning module, which measures a clinician's knowledge and judgment in diagnostic treatment and care delivery. The personalized learning path (red and yellow zones) must be completed by all providers and nurses practicing in the ED to qualify. Each year, individuals will be reassessed with a measure of improvement of 1.5% applied. Improvement must be demonstrated to meet Tier One.

If Tier One is met, members and insureds receive additional benefits for implementing optional Tier Two strategies customized to meet the individual member's risk profile needs. A description of each strategy, subcomponents, and the associated metrics are contained within this ED Guideline applicable to the 2024-2025 contract year.

Value of Participation:

Tier One offers an incentive credit of 2% of your emergency department premium. There is a further opportunity to gain additional credits by choosing up to two additional options per year in Tier Two, each worth an additional 2% if all criteria are met. This represents a potential annual renewal credit of up to 6%. Members or insureds who meet the requirements each year are recognized at our annual symposium for their achievement.

Get Started:

Please carefully review the Quest for Zero: ED Guideline. BETA offers tools and resources to assist with implementation. Our ED Toolkit contains best practice models for your use.

We value our members and insureds and appreciate your continued interest in BETA's Quest for Zero, as we strive to maintain excellence in emergency services. Don't delay opting in, as the clock starts ticking at the start of the new policy year, and validation surveys must be completed 60 days prior to policy renewal. Should you have questions, please contact BETA's risk management staff who will assist you in designing a plan for success.

For additional information about the Quest please contact Nicole Amidon, Manager, Risk Management and Patient Safety at Nicole.Amidon@betahg.com or at 858-379-0595.

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TIER 1
Annual Personal Proficiency Module
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
The Relias Platform Personal Learning Module is completed by all Physicians, Residents, Physician Assistants, Nurse Practitioners covered by BETA within 3 months of credentialing and/or after July 1 and before May 1 of the policy year * This includes all new employees of the medical staff and independent practitioners. *HealthPro insureds must meet the requirement within their annual policy period	☐ **Met** ☐ **Not Met**	☐ Staff roster is due to BETA on date of validation survey. ☐ Produce Relias report to demonstrate completion of assessment.
All nursing staff, including travelers and registry must complete the Relias Platform Personal Learning assessment within 3 months of hire, or assignment and/or after July 1 and before May 1 of the policy year.* *HealthPro insureds must meet the requirement within their annual policy period	☐ **Met** ☐ **Not Met**	☐ Nursing staff roster is due to BETA on date of validation survey. ☐ Produce Relias report to demonstrate completion of assessment.
Based on the Relias Platform Personal Learning module, the participant must complete all designated "Red & Yellow Zones" of their Learning Path *no later than 60 days before policy/contract renewal.* *HealthPro insureds must meet the requirement within their annual policy period	☐ **Met** ☐ **Not Met**	☐ Evidence of Personalized Learning module and confirmation of completion(s).

ED Units performing a reassessment of Relias Platform Personal Learning module must show a combined average score improvement of 1.5% in the knowledge domain. A provider and nurse unit average in the upper 25th percentile need only to maintain that upper quartile.	☐ **Met** ☐ **Not Met**	☐ Produce Relias analytics report demonstrating an overall increase in knowledge domain scores of 1.5% (or scores in upper quartile).

TIER 2

Quest For Zero: ED Sepsis Collaborative

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Management of sepsis is a complicated clinical challenge requiring early recognition and management of infection, hemodynamic state, and organ dysfunction. The Sepsis Collaborative is a two-year process designed to develop, implement, and improve your department's response to patients exhibiting signs or symptoms of the sepsis syndrome.

Requirement	Findings	**Validation Checklist** *The following items will be reviewed during validation:*
Implement the Severe Sepsis Bundle recommended in the 2021 International Guidelines for Management of Severe Sepsis and Septic Shock. Implementation to include quality oversight and must be in effect for a minimum of one year prior to qualifying for this option. Develop a protocol for treating patients with sepsis-induced tissue hypoperfusion, defined as hypotension persisting after an initial fluid challenge or blood lactate concentration ≥4. The protocol must include: • A screening tool to be used by nursing for prompt identification of patients likely to require the implementation of the Sepsis Protocol. • Measurement of lactate level promptly upon patient's arrival. • When possible, obtain blood cultures as well as cultures from other likely sources of infection (urine, cerebrospinal fluid, wounds, respiratory secretions) prior to administration of antibiotics. If > than 45 minutes to obtain cultures, do not delay antibiotic therapy. • Administer broad-spectrum	☐ **Met** ☐ **Not Met**	☐ Copy of sepsis protocol *submitted to BETA 60 days prior to policy/contract renewal* for review to ensure it meets the evidence-based recommendations.

antibiotics within one hour of presentation. • Administer 30ml/kg isotonic fluid bolus. • If the patient is hypotensive or has lactate ≥4, administer a bolus of crystalloid at 30ml/kg within the first hour. And, if indicated, within the first hour: • Administer vasopressors if hypotension is not responsive to initial fluid resuscitation to maintain mean arterial pressure ≥ 65mm Hg (Norepinephrine is identified as the drug of choice in septic shock). • Reassess lactate level if initially elevated (>2.0).		
Develop screening tool for early identification of patients presenting with sepsis and provide training. The screening tool shall include: • A clear definition of when the use of a screening tool is indicated • A trigger to capture the need for the use of the screening tool if using EMR • Training 100% of ED staff on the use of the tool.	☐ **Met** ☐ **Not Met**	☐ Provide a copy of the screening tool, ED nursing roster, and sign-in sheet as evidence that training was completed. ☐ Medical record review of five patient records with diagnosis of sepsis.
Compliance with the sepsis protocol and proper use will be introduced through the quality review process and include: • Quality review to be performed at minimum, monthly. • Individual coaching of ED staff to include both positive feedback on compliance as well as any identified opportunities for	☐ **Met** ☐ **Not Met**	☐ Provide a copy of the monthly quality improvement report addressing compliance with the Sepsis Protocol and evidence of individual feedback provided to staff and physicians. ☐ Access to Emergency Department and Medical Staff Quality Committee meeting minutes addressing the following:

improvement. • The findings of physicians, PA's and NP's are delivered to the Medical Director. The results are shared (positive feedback and opportunities for improvement) with the individual providers. • Reports of compliance with the Sepsis Protocol are presented at the Emergency Department Committee and Medical Staff Quality Committee meetings. The report(s) is evidenced by and reflected in the meeting minutes. • When barriers are identified, action plans are developed and implemented to address the issues.		• Reporting of sepsis bundle compliance that reflects at a minimum 60% compliance with the use of the screening tool. • Evidence of timely tests and treatment which is defined as completion within the recommended time frames.
All registered nurses practicing in the Emergency Department must complete the Relias Platform Personal Learning module on Sepsis.	☐ **Met** ☐ **Not Met**	☐ The facility will provide the required documents to BETA 60 days before policy renewal. ☐ Review current staff roster.
Based on the individualized Relias Platform Personal Learning module, participants must complete all designated "red and yellow zones," no later than 60 days before policy/contract renewal. Physicians and midlevel providers must complete one hour of sepsis specific education.	☐ **Met** ☐ **Not Met**	☐ Review Certificates of Completion for 100% of registered nurses. ☐ Review roster of provider education. ☐ Review education syllabus/outline.

Year 2:
 	
• Achieve 90% compliance with the bundle one-hour goal.
 	
• Illustrate process improvement.
 	
• There is evidence of cross-departmental collaboration where sepsis patients may be transferred to assure continuity of
	☐ **Met**
	☐ **Not Met**
		☐ Review each of the following:
		
		  1. Performance Improvement Plan
		  2. Formalized handoff tool or process
		  3. Medical record review
		  4. Review Performance Improvement Plan
		  5. Review Handoff tool usage

Care.
 	
Areas of focus may include:
 	
    - Formalized handoff
 	
    - Evidence of ongoing progress toward completion of the sepsis bundle elements
 	
• Registered nurses and providers complete the required Relias GNOSIS Personal Proficiency Module on Sepsis*
 	
Physicians and midlevel providers must complete one hour of sepsis specific education.
 	
Based on the individualized GNOSIS Learning Path, participants must complete all designated "Red, and Yellow," no later than 60 days before policy/contract renewal.
		compliance
		
		☐ Review Certificates of Completion for 100% of registered nurses and providers.
		
		The facility shall provide the required documents to BETA 60 days before policy renewal.

TIER 2
Participation in the Emergency Medicine Collaborative (EMC)
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
Identify two emergency department leaders to represent your facility on the EMC. • Team to include a physician leader and a nurse leader, and Risk Manager/ Director, or Quality representative. • These individuals do not need to be the department directors but should possess leadership authority in some capacity in the department. Identify which of the team members will serve as the primary contact.	☐ **Met** ☐ **Not Met**	☐ Name submission by the deadline set by EMC.
Attend a minimum of two full-day in-person EMC meetings as outlined in the EMC Timeline. • Team must participate in all scheduled meetings and calls. • At least one member of the facility designated team will attend.	☐ **Met** ☐ **Not Met**	☐ Sign-in rosters will be used to determine attendance at in-person meetings. Rollcall will be taken during all scheduled phone meetings and webinars.
Lead or co-lead a subgroup as assigned by the EMC. • Complete all assignments by the agreed-upon deadline. • Participate in initial research, craft recommended practices, establish outcome measures, pilot recommendations and provide feedback as outlined by the EMC Memo of Understanding.	☐ **Met** ☐ **Not Met**	☐ Although participation is subjective, a fair and objective assessment of participation will be done, and BETA will make the final determination regarding participation.

TIER 2

Organization-Wide Management of ED Patient Surge Capacity

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*

Emergency medical groups and members must review and implement the strategies as outlined in the BETA Toolkit, *"Organization- wide Management of Emergency Department Patient Surge Capacity"*
 	
The policy/procedure or plan reflects the following elements:
 	
• Cross-references the Patient Surge Capacity Plan if a separate document.
 	
• Glossary of key terms defined by the organization. To include:
 	
    ▪ Against Medical Advice
    ▪ Boarding
    ▪ Capacity
    ▪ Early Warning System
    ▪ Left without Being Seen
    ▪ Time "Seen by Provider"
    ▪ Patient Surge
    ▪ Throughput
 	
• Identifies which validated, objective overcrowding Tools and Techniques the Emergency Department uses. Examples include National Emergency Department Overcrowding Scale (NEDOCS) or Community Emergency Department Overcrowding Scale (CEDOCS).
 	
• Outlines the process for triggering the Organization-wide Plan when ED activity reaches "Extremely busy but not yet overcrowded" through "Severely overcrowded."
	☐ **Met**
	
	☐ **Not Met**
		☐ The process must be in place a minimum of 6 months before qualifying for consideration to meet Tier Two.
		
		☐ Review Organization-wide Management of Emergency Department Patient Surge Capacity policy(s).
		
		☐ Review: ED Central Log for the previous six months.
		
		☐ Review of log used to document ED activity levels and actions taken for the previous six months.
		
		☐ Documentation must support evidence of ongoing compliance with the Plan.

• Identifies for each of the tiered levels, the response to be taken by all units and departments to help prevent overcrowding from escalating.		
The Plan specifies a position responsible each shift to monitor ED activity at regular intervals to assess necessity for plan activation including: • Once per shift • After any rapid influx or surges of patients presenting to the ED. • One to two hours before routine reduction of treatment area beds in the ED. • Specifies the process used to document shift activity when assessed and actions taken. • Requires orientation and competency verification of float and registry staff.	☐ **Met** ☐ **Not Met**	☐ The facility will provide the required documents to BETA 60 days before policy renewal.
If the organization currently has an active organization-wide plan for management of patient surge capacity in the ED, conduct a Gap Analysis utilizing the Tools and Techniques provided in the BETA Healthcare Group Toolkit. If no plan currently exists or if current plan is not implemented organization-wide; utilize the *"Building an Organization-wide Management of ED Patient Surge Capacity Plan Development Guide & Worksheet"* provided in BETA's Toolkit here Emergency-Medicine-Toolkit.pdf (betahgprod.wpenginepowered.com)	☐ **Met** ☐ **Not Met**	☐ Review completed Gap Analysis Tools and Techniques with assigned action items, target dates to bridge any gaps. ☐ Review the Plan Development Guide and Worksheet.
Conduct a formal plan for launch to include: • Dissemination of Plan strategies • Role of each department • Review of Job Action Sheets (or	☐ **Met** ☐ **Not Met**	☐ Review materials used to disseminate Plan expectations. ☐ Review roster of names of individuals with assigned roles and corresponding sign-

similar tool) for each position • Verify that all staff in every department/unit throughout the organization are aware of the Plan and their expected response		off sheet of receipt of training for Plan implementation.
Verify staff competency with Plan implementation. • Conduct simulation and drills on each shift and on various days of the week to include weekends	☐ **Met** ☐ **Not Met**	☐ Provide evidence of scenario used for simulation (may be activation level) and documentation reflecting that those with assigned roles are provided timely feedback and acted upon according to the level of the activation.
• Provide float and registry staff with unit orientation and verify competencies prior to making patient assignments during patient surges. *(Note: best practice is to cross-train and orient float staff to the ED during quiet periods when staff can better respond to questions and provide guidance.)*	☐ **Met** ☐ **Not Met**	☐ Review of tools/checklists used for unit orientation of float and registry staff. ☐ Review tool used to verify competency. ☐ Review roster of individuals floating to the ED in the previous six-months. ☐ Review the personnel files of ten random float and registry nurses to verify presence of completed competency checklist and unit orientation checklist.
Measuring Plan effectiveness. Post-Surge debriefs will be conducted to determine opportunities for improvement in communication and with Plan compliance. The debriefs will be documented according to a formal process and will include action items, assigned individuals and target dates for completion as indicated. Develop a performance improvement metric using the number of times a code activation was indicated each day as the denominator with the number of actual activations as the numerator. These numbers should be reported through the quality committees of the organization and include any barriers that are identified and addressed.	☐ **Met** ☐ **Not Met**	☐ Review copy of the completed tool used for debriefing after a patient surge capacity activation. ☐ Review performance Improvement data by month for the previous six- months.

TIER 2

Management of Mental Health Patients in the ED

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*

Emergency medical groups must review and implement the strategies as outlined in the BETA Toolkit, "Management of Mental Health Patients in the ED" located here ED Toolkit - BETA Healthcare Group (betahg.com).
 	
Implementation is formalized in policy. The policy and/or procedure reflects the following elements:
 	
• Determination of primary and secondary locations best suited to keep agitated patients and those at risk of harming self or others safe.
 	
• Requires use of a formal tool or checklist to ensure treatment area is properly vetted for safety prior to patient placement.
   ▪ Use of secondary review when treatment space is not commonly used for this patient population.
 	
• Contains or cross-references a policy and procedure for conducting patient searches.
   ▪ Includes criteria for when searches are warranted
   ▪ Guidance of what to look for
   ▪ Management of weapons & contraband, including marijuana
   ▪ Securing patient belongings
	☐ Met
	
	☐ Not Met
		☐ The process must be in place a minimum of 6 months before qualifying for consideration to meet Tier Two.
		
		☐ Review Management of Mental Health Patient policy(s).
		
		☐ Review tool or checklist utilized for environmental safety check.
		
		☐ Review ten medical records, randomly selected, for evidence that tool or checklist is utilized for all agitated patients and those who are at risk of harm to self or others.
		
		☐ Review Patient Search policy.
		
		☐ Review ten medical records, randomly selected, for evidence of documentation of rational for patient searches, findings, and shows evidence of how belongings were secured. [May require review of Care of Patient Belongings & Valuables policy]
		
		☐ Review roster of staff providing Sitter Services in the ED over the past twelve months.
		
		☐ Review Use of Sitters policy if a separate policy.
		
		☐ Review a copy of the educational materials used for sitter training.
		
		☐ Review of Competency Checklist and Sitter Observation Records.
		
		☐ Examine five trained sitter's personnel

▪ Documentation
 	
• Use of trained sitters or cross-references a separate policy and procedure addressing the use of sitters.
 	
    ▪ Defines levels of observation and when 1:1 observation is indicated
 	
    ▪ Scope of duties
 	
    ▪ Oversight
 	
    ▪ Training and Competency
 	
    ▪ Use of trained mental health peer supporters or cross- trained ED/psych techs
 	
    ▪ Requires use of formal tool to evidence ongoing observations
 	
• Recognizes that different mental health issues require varied approaches in management.
 	
    ▪ Importance of determining patient's decision-making capacity
 	
    ▪ Determining patient's risk of suicide and elopement
 	
    ▪ Meeting the patient's needs for reassurance and control
 	
• Details objective criteria for patient detainment, transfer and discharge.
    ▪ Provides guidance for use of 5150 CA Health & Safety Code Section 1799.111
 	
    ▪ Utilizes objective criteria for when patient should be stopped from leaving the department vs. allowing to elope and
		files for evidence of completion of formal training and demonstrated competency.
		
		☐ Review ten medical records, randomly selected, of patients requiring 1:1 observation for appropriate use of observation documentation form according to policy.
		
		☐ Observation record confirming compliance with huddle requirement.
		
		☐ The facility will provide the required documents to BETA 60 days before policy renewal.

- notifying law enforcement - Patient's willingness for voluntary in-patient treatment if indicated - Provides a list of local outpatient mental health clinics and resources specific to common presentations. - Requires review of information and updating on an annual basis - Requires ED staff huddle when high- risk patient is placed in the ED treatment area so that all are aware of the risks.		
All ED providers and staff (including techs and registration personnel) will receive training on the management of *agitated individuals*. Education will include: - Importance of mindfulness and early intervention - Verbal de-escalation techniques - Identifying and attempting to meet perceived needs - Pre and post test - Nurses will additionally receive education on Assessment of Agitation using an evidence-based tool such as: The Behavioral Activity Rating Scale (BARS) *(Note: Provider education may be delivered through the provision of a Verbal De- escalation Fact Sheet with a sign-off sheet indicating the provider's review and understanding of the information).* Nursing staff will receive additional education to include: - Triage of patients with mental	☐ **Met** ☐ **Not Met**	☐ Review copy of educational materials used for "Management of Agitated Individuals", "Triage and Placement of Individuals Presenting with Mental Health Conditions", and "Assessment and Treatment of Patients Presenting with Mental Health Conditions"; along with pre and post-tests. ☐ Review of documented evidence of education includes medical providers and staff signatures reflecting receipt of the education. For example sign-in sheets, logs, etc. ☐ <u>BETA Hospitals</u>: provide a copy of the ED nursing roster to BETA, including dates of hire. ☐ <u>Medical Groups</u>: Return an updated roster, reflective of current providers to BETA *within 60 days of receipt of the roster from BETA.*

health complaints
 	
• Proper placement of patients with acute exacerbations of mental health conditions
 	
• Management of specific mental health conditions commonly presenting to the ED:
 	
    ▪ Bipolar disorder
 	
    ▪ Major depression
 	
    ▪ Schizophrenia
 	
    ▪ Anxiety
 	
    ▪ Borderline personality disorder
 	
    ▪ Delirium
 	
    ▪ Psychosis
 	
    ▪ Malingering behaviors
 	
• Pre and Post tests will be provided to measure knowledge acquisition		

The organization has a formal Workplace Violence Prevention Plan compliant with current Cal/OSHA Standards. The Plan is reviewed and updated as necessary on an annual basis. Resources: • BETA WPV Toolkit Employee Safety and Wellness Initiative (request copy from BETA) • WPV Toolkit Joint Commission/AONE/ENA • CHA Publications-WPV (calhospital.org) • Oregon WPV Safety Initiative 2020 • ASHRM-Workplace-Violence-Toolkit-2023	☐ **Met** ☐ **Not Met**	☐ Review copy of the organization's Workplace Violence Prevention Plan.

Measuring Quality and Performance Improvement. Focused chart review of patients presenting to the ED with Mental Health complaints is conducted monthly. The review should include at minimum: • Timeliness of triage • Patient placement • Complete and accurate suicidal risk assessment with appropriate interventions • Presence of complete Sitter • Observation documentation when sitter was used • Use of objective terms when describing patient behaviors • Measures taken to identify and meet the patient's perceived needs • Timeliness of verbal de-escalation • Timeliness of initiating stabilizing treatment • Timeliness of psychiatric consultation • Method of detainment used: 5150 vs. 1799.111 • Engagement of patient's family in treatment plan • Chart review should consist of 30% of the patient volume if greater than 30 patients, or 100% if less than 30 patients ☐ Review copy of the completed tool used for conducting quality and	☐ **Met** ☐ **Not Met**	☐ Review copy of the completed tool used for conducting quality and performance improvement checks. ☐ Review to include the number of patients presenting with mental health issues and those arriving with agitation each month for previous six- month period.

performance improvement checks.

☐ Review to include the number of patients presenting with mental health issues and those arriving with agitation each month for previous six- month period.

Resources:

- BETA WPV Toolkit Employee Safety and Wellness Initiative (request toolkit from BETA).

- BETA Healthcare Group's "Management of Mental Health Patients in the ED" Toolkit is available at: ED Toolkit - BETA Healthcare Group (betahg.com).

- Joint Commission, AONE, ENA toolkit for mitigating violence in the ED available at: WPV Toolkit Joint Commission/AONE/ENA.

- American Academy of Pediatrics: Pediatric Mental Health Visits on the rise in the ED Ready or Not, Here I Come: Emergency Department Readiness for Pediatric Mental Health Visits (silverchair.com)

Additional tools are available through the California Hospital Association at:

CHA Publications-WPV (calhospital.org).

TIER 2
High-Risk Patient Callback Program
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
Develop a policy for the emergency department that at a minimum addresses the following: • Callback purpose 　▪ This should include the goals, outcomes, and expectations of the callback program • Define which patients should be included in the callback process 　▪ Minimum callback criteria should include high-risk presentations, patients that have identified follow-up challenges, complicated discharge instructions, and identified concerns of the caregiver team. • Define the procedures for the callbacks to include: 　▪ An individual responsible for direct oversight 　▪ The individual responsible to conduct the call-back 　▪ The steps to take should the patient be unreachable 　▪ Escalation triggers (i.e., not improving, inability to secure a follow-up appointment, medication reactions) 　▪ A defined process to manage escalation	☐ **Met** ☐ **Not Met**	☐ Review ED callback policy. ☐ Review Call Log for completion in accordance with organization's procedure.

triggers

- ▪ Established method to document and record contact

- ▪ Log for communication and actions taken

- PI process

  - ▪ A list of criteria to identify quality review actions, i.e.:

    - o Tracking and trending
    - o Patient not improving
    - o Patient hospitalization after discharge
    - o Patient complaints received during the callback
    - o Adverse events identified during the callback

- Any event identified in the policy that would trigger quality review are presented in the Medical Staff Quality Committee and sent through the appropriate PI paths, including risk management.

TIER 2
Pediatric Readiness

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
There is a designated physician/nurse team who serve in the role of pediatric care coordinator. Their role includes: • Serve as the resource for pediatric Care for the respective disciplines and work together to develop education, formulate policy recommendation, and provide recommendations for general hospital emergency care. • Serve as liaison to coordinate care recommendations with the respective hospital-wide committees to ensure continuity of Care through the spectrum.	☐ Met ☐ Not Met	☐ Discussion with the designated pediatric care coordinators. ☐ Review appropriate committee minutes verifying participation. ☐ Review appropriate committee meeting minutes reflecting coordination of Care.
Ensure that the hospital meets the minimum equipment recommendations set out in the AAP/ACEP/ENA Joint Position Statement located here [Pediatric Readiness in the Emergency Department (silverchair.com)]().	☐ Met ☐ Not Met	☐ A copy of the policy, procedure, and protocol submitted to BETA. ☐ Walkthrough and observation within ED reveal availability of minimum equipment recommendations.
Emergency department staff receive continuing education in pediatric emergency care. All physicians shall complete and maintain current recognition in one of the following courses: • AHA-AAP Pediatric Advanced Life Support (PALS) course or • ACEP-AAP Advanced Pediatric Life Support (APLS) or	☐ Met ☐ Not Met	☐ Review staffing roster and education files for evidence of completion.

equivalent.

All full- or part-time emergency physicians shall have evidence of completion of a minimum of two hours of continuing medical education (AMA Category I or II) in pediatric emergency topics within a two-year period.

All Advanced Practice Providers (APPs) shall complete and maintain current recognition in one of the following courses:

- AHA-AAP Pediatric Advanced Life Support (PALS) course https://cpr.heart.org/en/cpr-courses-and-kits/healthcare-professional/pediatric or

  ACEP-AAP Advanced Pediatric Life Support (APLS) course https://www.aap.org/en-us/continuing- medical-education/life-support/APLS-The-Pediatric-Emergency-Medicine-Resource/Pages/APLS-The-Pediatric-Emergency-Medicine-Resource.aspx or

- ENA Emergency Nursing Pediatric Course (ENPC) https://www.ena.org/education/enpc

All full or part-time advanced practice providers (nurse practitioners and physician assistants) shall have evidence of completion of a minimum of two hours of approved continuing education units (AMA category I) in pediatric emergency topics within a 2-year period.

Credit for CME shall be approved by:

- Accreditation Council on Continuing Medical Education (ACCME) or
- American Osteopathic

Association Council on Continuing Medical Education (AOCCME) or • American Academy of Family Physicians (AAFP) or • American Academy of Physicians Assistants (AAPA).		

Registered Nurses
 	
All emergency department nurses shall maintain current certification in AHA-AAP Pediatric Advanced Life Support (PALS) course. These requirements must be met within 12 months of employment.
 	
Continuing Education
 	
All nurses assigned to the emergency department shall have evidence of completion of a minimum of two hours of pediatric emergency/critical Care continuing education hours within a two-year period.
 	
Continuing education may include, but is not limited to:
 	
• PALS
• APLS
• ENPC
• CEU offerings;
   ▪ Case presentations
   ▪ Competency testing
   ▪ Teaching courses related to pediatrics or
   ▪ Contributing author to a publication
 	
The continuing education hours can be integrated with other existing continuing education requirements, provided the content is pediatric specific.
 	
All staff caring for children in the emergency department take part in at least two pediatric mock scenarios
	☐ **Met**
	
	☐ **Not Met**
		☐ Review of documentation of mock pediatric scenarios including list of participants.

annually. Simulation Scenarios are available in the ED Quest Toolkit.		
Ensure the emergency department policies evidence the following ACEP/ AAP/ ENA Joint position statement standards on pediatric Care. Policies include: • Kilogram based weights • Triage of pediatric patients • Transfers of pediatric patients • Admission of pediatric patients • Pediatric medication formulary	☐ **Met** ☐ **Not Met**	☐ A copy of the policy, procedure, and protocol submitted to and reviewed by BETA.
The following activities are undertaken by a multidisciplinary Quality Committee: • Pediatric emergency medical care shall be included in the emergency department "Dashboard" or Performance Improvement (PI) program and reported to the hospital Quality committee • The Pediatric Dashboard shall consist of, but is not limited to, the review and tracking of all pediatric emergency department deaths, resuscitations, child abuse, and neglect cases and interfacility (outbound or incoming) transfers • The Quality Committee includes EMS representation • Multidisciplinary PI activities are established and include measures of effectiveness that address pediatric Care within the emergency department. Monitoring includes identified clinical indicators and outcomes of Care for children from birth to 18 years of age	☐ **Met** ☐ **Not Met**	☐ Review Emergency Department Committee meeting minutes.

• There is evidence of criteria-based review and follow-up of sample pediatric emergency department visits • There is evidence of pre-hospital provider transported pediatric cases that includes a feedback mechanism to the EMS System Coordinator		
The organization must participate in the Pediatric Readiness Project https://www.pedsready.org/	☐ **Met** ☐ **Not Met**	☐ Review documentation of participation.

TIER 2
Care for the Caregiver (Peer Support)
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
Care for the ED Caregiver Executive Champion, and Team lead(s) are identified for an active role in program development which includes nursing and physician leaders.	☐ Met ☐ Not Met	☐ Executive leadership champion has been designated and this is reflected in committee meeting minutes. ☐ There is department leadership represented on the committee.
The department has assessed its current infrastructure and human resources to support the development of a Care for the Caregiver program. The use of the CANDOR or BETA HEART toolkit may be helpful in identifying the elements needed for a successful program.	☐ Met ☐ Not Met	☐ Review of Emergency Department needs assessment. ☐ ED needs assessment can be accomplished through a review of culture survey data, incident reporting data and evaluating available resources, local needs and assets.
Care for the ED Caregiver Committee is created to drive the program development forward. Recommended members include: • Department Directors • Physician champion(s) • Nursing champion(s) • Ancillary champions(s) • Resident(s) • Advanced Practice Providers • Social Work • Employee Health • Pastoral Care	☐ Met ☐ Not Met	☐ Review the roster for Care for the Caregiver Committee members.
A policy is in place that specifies: The expectations for the peer supporter response (time of event through investigation and possible litigation) that includes: ▪ 24/7	☐ Met ☐ Not Met	☐ Review of department policies as they pertain to adverse events, staff support program, and any other supporting material. ☐ Interviews with staff.

- Intervention - Follow-up - Determines the criteria for activation of the response. At a minimum, this should include any event or series of events that result in an increase of emotional stress in the department, for example: - Family or co-worker dies in the department - Pediatric death - Failure to rescue - First death experience - Unanticipated change in patient condition - Patient harm (whether an error was made or not) - Multiple patient traumatic events or deaths within a short period - Policy includes criteria to determine the need for team debrief (makeup of the team is determined by event). - Staff is aware that peer support is available.		
A process is in place for the identification and training of Peer Supporters. The requirements include: - Peer Supporters sign a formal agreement defining their role and indicating their commitment to complete required training, be available to staff and maintain the confidentiality of discussions - The organization provides formalized training regarding resilience, burnout, fatigue and stress debriefing, crisis intervention, active listening, situational awareness, and recognition of signs and	☐ **Met** ☐ **Not Met**	☐ Review signed peer supporter agreements. ☐ Review training materials and peer supporter sign-in sheets.

symptoms that a colleague may benefit from peer support. • All unit supervisors, charge nurses, and other departmental leaders will attend the full training. Formalized training is ongoing		
Care for the ED Caregiver policy requires trained Peer Supporters to be embedded within the department and available on all shifts and days of the week. The policy contains a mechanism for a Peer Supporter to be available to emotionally traumatized staff within the department immediately after the event. • A department Peer Supporter is available for each shift and day of the week • The policy allows for a Peer Supporter's routine responsibilities to be managed when assistance is needed for staff support	☐ **Met** ☐ **Not Met**	☐ Review Care for the ED Caregiver policy (this requirement may be substituted for the organization-wide Care for the Caregiver policy). ☐ Review Peer Supporter Agreement Forms.
A process is in place for evaluating the C4C program. The C4C committee meets on a regular basis and reviews feedback provided by peer supporters (through encounter logs or other means) to evaluate the effectiveness of the C4C program.	☐ **Met** ☐ **Not Met**	☐ Review committee meeting minutes.

A process for referring clinicians needing a higher level of support is in place and includes guideline criteria and mechanisms for obtaining expedited access.
 	
1. Referral Network includes resources available both locally as well as separate from the organization such as:
    a. Chaplain Services
    b. Social Workers
	☐ **Met**
	☐ **Not Met**
		☐ Review process and user feedback surveys.

c. Clinical Psychologist and d. Employee Assistance Program, etc.		
A process is in place to evaluate the effectiveness and staff satisfaction with the Care for the ED Caregiver program. 1. User survey	☐ **Met** ☐ **Not Met**	☐ Review user surveys and evaluation tool.
A measurement strategy is identified, implemented, and captured on the Department Dashboard. Sample measures include: 1. # of Care for the Caregiver calls activated (peer to peer interactions) per month 2. # of Care for the Caregiver interactions 3. Types of referrals made (clinician self- referral/supervisor/RM/other) 4. Effectiveness and timeliness of response (User survey) 5. Timely access to a higher level of support (User survey) 6. Staff retention rates Resources: Care for the Caregiver Toolkit (request toolkit from BETA)	☐ **Met** ☐ **Not Met**	☐ Review Department Dashboard metrics for measures of effectiveness of the program.

TIER 2

Emergency Department Risk Assessment

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
Emergency Department Risk Assessment is scheduled with a BETA Risk Director no later than six months before the end of the policy period.	☐ **Met** ☐ **Not Met**	☐ Emergency Department Risk Assessment scheduled
Requested policies and forms must be submitted to BETA at least two weeks before the assessment date: 1. See Emergency Department Risk Assessment for requested policies and forms	☐ **Met** ☐ **Not Met**	☐ Submit policies and forms to BETA Risk Director.
Requested interviews will be scheduled at least two weeks before the assessment.	☐ **Met** ☐ **Not Met**	☐ Interview schedule sent to BETA Risk Director.
At least three performance improvement plans with measurable outcomes will be developed based on the findings of the risk assessment, in collaboration with your BETA Risk Director: 1. Establish measurable goals or matrix for use in determining the effectiveness of process improvement 2. Goals must be objective, clearly defined and measurable 3. Review plan and modify as indicated to achieve the goal 4. Plans should be developed no later than 90 days before the policy renewal period. The performance improvement (PI) plans must be submitted to appropriate medical staff and quality committees for review.	☐ **Met** ☐ **Not Met**	☐ Review the Performance Improvement Plan(s) with all required components and ensure that the plans were submitted to appropriate medical staff and quality committees for review.
One plan must be completed by May 1 with evidence of measurable outcomes. Results should be submitted to medical staff and quality committees for review.	☐ **Met** ☐ **Not Met**	☐ Review Performance Improvement Plan with evidence of data collection by May 1st or within 60 days of policy renewal.

TIER 2

Fracture Management and Follow-Up Care

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*

Develop a Radiology policy for the emergency department that at a minimum addresses the following:
 	
1. Radiology overread process
2. Criteria outlining which films should be read immediately vs. those that can be reviewed later (time to be defined).
3. What constitutes a critical result
4. Communication process for overread to include:
   a. Responsible person to contact the patient
   b. Follow-up plan with the patient
   c. Communication of anticipated plan for the patient
5. Mechanism for documenting communication and action(s) taken (i.e. logs, medical record tracking)
6. Quality review process for misreads
	☐ **Met**
	☐ **Not Met**
		☐ Radiology policy review.

Overread Communication Log:
 	
1. Tracking log is developed and maintained for review.
2. Log should track all overreads, and include:
   a. Date/Time
   b. Findings
   c. Individual involved in the
	☐ **Met**
	☐ **Not Met**
		☐ Review redacted copy of the current Overread Communication Log will be provided to BETA for review 60 days before policy renewal.
		
		Note: *Names and patient identifiers should be redacted. All email communications should be sent by secure email with encryption.*

communication
 	
    d. Method of communication
 	
    e. Resolution
 	
3. The log should be electronic allowing access to both ED provider, radiologist, and quality coordinator.		

A mechanism for quality oversight Includes: 1. Misreads are presented in Medical Staff Quality Committee and sent through the appropriate quality improvement and/ or risk management pathways. 2. Misreads are tracked by the provider and become a part of Ongoing Physician Performance Evaluation (OPPE)	☐ **Met** ☐ **Not Met**	☐ Review OPPE. ☐ Review Quality Committee meeting minutes.
Patient follow-up: Develop a formalized process for patient follow-up for both inpatient and outpatient reads.	☐ **Met** ☐ **Not Met**	☐ Site Visit Review a. Review follow-up process log

TIER 2

Emergency Department Medication Safety
#1: Quiet Zone
Must complete ALL (#1, #2, #3, #4, #5) Emergency Department Medication Safety Measure

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
A medication safety "quiet zone" designed to provide a designated area for medication retrieval without distraction is implemented. *ISMP, 2016; IHI 2014*	☐ **Met** ☐ **Not Met**	☐ Observation
The safety zone requires staff to identify themselves through some distinguishing feature.	☐ **Met** ☐ **Not Met**	☐ Observation
Compliance with this safety strategy is monitored monthly via observation of practice.	☐ **Met** ☐ **Not Met**	☐ Performance improvement statistics

Various structure standards for safe use of four common medications administered in the emergency department are in place, and 100% compliance is evident with these structure standards for the following:
   1. Propofol
   2. Narcotics
   3. Heparin/ Low Molecular Weight Heparin
   4. Electrolytes
	☐ **Met**
	☐ **Not Met**
		☐ Compliance with all structure standards contained in #1-5

TIER 2
Emergency Department Medication Safety
#2: Use of Propofol
Must complete ALL (#1, #2, #3, #4, #5) Emergency Department Medication Safety Measure
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
Pharmacy prepares or purchases standardized premixed concentration.	☐ **Met** ☐ **Not Met**	☐ Observation. ☐ Pharmacy procedure.
Dose concentrations are separated in the Automated Dispensing Machine (ADM) in separate bins/cabinets etc. Each bin/cabinet containing a high-risk medication is labeled as a High-Risk Medication.	☐ **Met** ☐ **Not Met**	☐ Observation.
The High-alert and Hazardous Medication policy designates Propofol as a high-alert medication and requires a double-check. TJC-MM.01.01.03	☐ **Met** ☐ **Not Met**	☐ Review High-alert and Hazardous Medication policy.
Procedural Sedation policy addresses the use of Propofol and reflects: 1. ACEP sedation guidelines 2. ASA Sedation guidelines 3. Staffing necessary for the administration 4. Credentialing of those privileged to administer Propofol for procedural sedation 5. 100% of procedural sedation cases occurring in the emergency department undergo quality review for compliance with policy requirements	☐ **Met** ☐ **Not Met**	☐ Review Procedural Sedation policy. ☐ Performance measures are recorded and submitted through the Quality Committee. ☐ Action plan(s) are developed for those in non-compliance.

TIER 2
Emergency Department Medication Safety
#3: Safe Use of Narcotics
Must complete ALL (#1, #2, #3, #4, #5) Emergency Department Medication Safety Measure
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist The following items will be reviewed during validation:
A well-defined Opioid Management policy is in place that, at a minimum, includes the following items: 1. Frequency of monitoring and vital signs 2. Protocols for the use of reversal agents 3. Expectation for the usage of smart pumps 4. Establish acceptable high and low limits for each medication administered via a smart pump 5. Avoid the use of overrides in the emergency department 6. Standardized concentrations available in the emergency department	☐ **Met** ☐ **Not Met**	☐ Review Opioid Management policy Observation.
Work with the pharmacy to develop standardized concentrations that meet the needs of the patient population. Develop a re-evaluation schedule to adjust the formulary and concentrations needed in the emergency department.	☐ **Met** ☐ **Not Met**	☐ Review committee meeting minutes.
Develop a fall prevention protocol for patients receiving narcotics/opioids in the emergency department to include: 1. Staff education 2. Patient education 3. Monitoring	☐ **Met** ☐ **Not Met**	☐ Review Opioid Management, Narcotics Management policy or other policy that reflects fall prevention strategies for patients receiving these high-risk medications. ☐ Observation.

4. Observation and assistance in ambulation/ toileting 5. Environmental safety measures		

TIER 2
Emergency Department Medication Safety
#4: Safe Use of Low Molecular Weight Heparin (Enoxaparin)
Must complete ALL (#1, #2, #3, #4, #5) Emergency Department Medication Safety Measure
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist The following items will be reviewed during validation:
Heparin ten thousand (10,000) units/mL will be stored in a separate bin/cabinet and labeled as a high-risk medication on the outside of bin as well as on the medication container.	☐ **Met** ☐ **Not Met**	☐ Observation.
Heparin one thousand (1,000) units/mL will be stored in a separate bin/cabinet and labeled as a high-risk medication on the outside of bin as well as on the medication container.	☐ **Met** ☐ **Not Met**	☐ Observation.
Heparin one hundred (100) units/mL doses will be stored in a separate bin/cabinet and labeled as a high-risk medication on the outside of bin as well as on the medication container.	☐ **Met** ☐ **Not Met**	☐ Observation.
A double-check process by Pharmacist/Pharmacy Technician is in place during refill of the Automated Dispensing Machine (ADM). The Tech Check system is written as a formal pharmacy procedure.	☐ **Met** ☐ **Not Met**	☐ A copy of the pharmacy procedure that addresses the requirement of double-check by pharmacy personnel (Tech-check-Tech) when re-stocking high-risk medications will be provided to BETA no later than 60 days before the policy renewal period.
The ADM drawer is labeled with a high-risk sticker.	☐ **Met** ☐ **Not Met**	☐ Observation.
Heparin/Low molecular weight heparin is designated as a high-alert medication and requires independent double-check before administration. This process is defined in the policy.	☐ **Met** ☐ **Not Met**	☐ Review High-alert and Hazardous Medication policy

Smart pumps with built-in high and low dose limits are used when infusing high-risk medications. Smart pumps have the ability to be programmed for the administration of bolus doses without the need to draw from a vial.	☐ **Met** ☐ **Not Met**	☐ Observation.
When heparin solution is necessary to flush IV lines, the premixed solution is supplied by the pharmacy and not mixed by nurses on the unit.	☐ **Met** ☐ **Not Met**	☐ Review Anticoagulation policy, pharmacy procedure.
Low molecular weight heparin is obtained from the pharmacy.	☐ **Met** ☐ **Not Met**	☐ Review Anticoagulation policy Review pharmacy procedure.
Lab values (APTT) are double-checked by two nurses before adjusting IV dose heparin per the formalized protocol. Acceptable values are specified in the protocol and defined in Policy.	☐ **Met** ☐ **Not Met**	☐ Review Anticoagulation policy.
Implement standardized weight-based dosing following evidence-based standards using preprinted orders or computerized order sets.	☐ **Met** ☐ **Not Met**	☐ Review anticoagulation policy Observation.

TIER 2
Emergency Department Medication Safety
#5: Safe Use of Electrolytes
Must complete ALL (#1, #2, #3, #4, #5) Emergency Department Medication Safety Measure
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
Develop a policy on administration of electrolyte solutions to include: 1. Potassium Chloride 2. Magnesium Sulfate 3. Hypertonic Sodium Chloride 4. Calcium Chloride/Calcium Carbonate	☐ **Met** ☐ **Not Met**	☐ Review Electrolyte Management policy.
The pharmacy provides standardized premixed concentration for a loading dose of electrolytes in 50 mL or 100 mL volume solution. Policy & practice restrict drawing bolus doses of electrolytes from the main IV infusion.	☐ **Met** ☐ **Not Met**	☐ Review Electrolyte Management policy. ☐ Observation of practice.
The pharmacy provides standardized premixed concentration for a maintenance dose of electrolytes in 250 mL or 500 mL volume solution.	☐ **Met** ☐ **Not Met**	☐ Review Electrolyte Management policy. ☐ Observation.
Electrolytes are designated as high-alert medication requiring an independent double- check prior to administration. This process is formally defined in the policy.	☐ **Met** ☐ **Not Met**	☐ Review High-Alert and hazardous Medication policy.
Nurse to patient ratio is 1:1 during the loading phase of electrolytes.	☐ **Met** ☐ **Not Met**	☐ Review Electrolyte Management policy.

TIER 2
Fall Prevention Program In the ED
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist The following items will be reviewed during validation:
A baseline evaluation of the current state of fall prevention strategies must be administered by month six of the policy year. Goals for improvement are based on findings.	☐ **Met** ☐ **Not Met**	☐ Performance Improvement Committee minutes reflect review of current state of fall prevention strategies.
Unit-specific information regarding staff perceptions of fall safety across the emergency department is gathered utilizing a survey instrument.	☐ **Met** ☐ **Not Met**	☐ Completion of Fall Perception knowledge test by 100% of ED staff.

A policy is in place on Fall Management. To include at a minimum:
  1. Universal fall precautions
  2. Fall Scale(s) utilized
  3. Criteria for utilization of Fall Scale
  4. Prevention/interventions
  5. Post fall management
  6. Communication/documentation
  7. Ongoing Fall Program Evaluation
	☐ **Met**
	☐ **Not Met**
		☐ Review Fall Management policy.

A clinical pathway is developed using a validated fall assessment tool and the policy indicates the level(s) of intervention required based on scoring criteria. Flarity, K., Pate, T., & Finch, H. (2013). Development and Implementation of the Memorial Emergency Department Fall Risk Assessment Tool. Advanced Emergency Nursing Journal January/March, 35(1), 57- 66. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS &C SC=Y&NEWS=N&PAGE=fulltext&D=ovft n&A N=01261775-201301000-00008	☐ **Met** ☐ **Not Met**	☐ Observation. ☐ Review clinical pathway.

McErlean, D. R., & Hughes, J. A. (2017). Who falls in an adult emergency department and why - A retrospective review. Australasian Emergency Nursing Journal, 20(1), 1216. doi:https://doi.org/10.1016/j.aenj.2016.11.001 Terrell, K. M., Weaver, C. S., Giles, B. K., & Ross, M. J. (2009). ED Patient Falls and Resulting Injuries. Journal of Emergency Nursing, 35(2), 89-92. doi: https://doi.org/10.1016/j.jen.2008.01.004 BETA Healthcare Group ESWI Workplace Violence toolkit (request toolkit from BETA).		
Department-specific event trends (incident reports/QRR's/ Chart Audits) are shared and discussed quarterly (at a minimum) at medical staff quality committee and nursing staff meetings to identify trends; the trends are addressed as evidenced by the development of solutions. Fall measures are adopted as a formal quality improvement metric, are monitored through quality, and compliance is reported to the appropriate medical staff committee.	☐ **Met** ☐ **Not Met**	☐ Review committee meeting minutes. ☐ Review staff meeting minutes. ☐ Review Dashboard where falls are tracked and trended.

TIER 2
Team Training and Communication (Year 1)
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
Executive leadership and unit-based agreement to deploy TeamSTEPPS principles and a baseline readiness assessment is conducted and reviewed by BETA prior to implementation. *Senior leadership supports the pursuit of team training in the emergency department as evidenced by attestation of the Opt In Agreement and completion of the readiness assessment.*	☐ **Met** ☐ **Not Met**	☐ Evidence of baseline readiness assessment findings and signed attestation of senior leadership's support of the principles.
Develop in-house staff (a minimum of 2) as certified trainers utilizing the "train the trainer" methodology to deploy TeamSTEPPS training. *BETA has certified Master Trainers who are available to you free of charge.* *For more information about this training please contact Nicole Amidon at* nicole.amidon@betahg.com.	☐ **Met** ☐ **Not Met**	☐ Evidence of certificates of completion of training for two master trainers (at a minimum).
All staff that practice in the emergency department setting are trained in TeamSTEPPS principles utilizing an interdisciplinary model of training. This includes all medical and nursing staff to include physicians, nurse practitioners and physician assistants.	☐ **Met** ☐ **Not Met**	☐ Evidence of education and training material. ☐ Evidence of participation by all staff is reflected in dated sign-in sheets.
Emergency department leadership meets monthly with BETA Manager during policy year for project mentorship and support.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation in monthly meetings (provided by BETA).

TIER 2

Team Training and Communication (Year 2)

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
Completion of readiness assessment within 6 months of department training.	☐ **Met** ☐ **Not Met**	☐ Readiness assessment completed, and findings reviewed prior.
Two or more of the following communication tools and strategies are selected and implemented, all staff, nursing staff and physicians are educated in the process. **Communication** • SBAR • Call Out • Closed Loop Communication • Teachback, • IPASS **Leading Teams** • Brief • Huddle • Debrief **Mutual Support** • Task Assistance • Formative Feedback • Advocacy and Assertion • Two Challenge Rule • CUS • DESC Script **Situation Monitoring** • I'M SAFE • Cross Monitoring • STAR • STEP	☐ **Met** ☐ **Not Met**	☐ Selected Tools and Strategies reviewed. ☐ Evidence of training and education material. ☐ Evidence of completed education by all staff is reflected in dated sign-in sheets.

Selected tools and strategies are incorporated into the annual department specific skills, simulations, and drills.	☐ **Met** ☐ **Not Met**	☐ Evidence of implemented tools and strategies incorporated into annual department skills, simulations, and drills.
A debrief is conducted upon completion of all simulations and drills.	☐ **Met** ☐ **Not Met**	☐ Review of debrief tool.
Track and Monitor effectiveness of the implemented tools and strategies as a monthly performance improvement measure(s) beginning no later than month 6 of the policy year.	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and performance.
ED leadership meets monthly with BETA for project mentorship and support during policy year.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation in monthly meetings (provided by BETA).
Implement annual TeamSTEPPS refresher and new hire education.	☐ **Met** ☐ **Not Met**	☐ Evidence of training and education material.

TIER 2
Simulation and Drills
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
Utilizing an interdisciplinary approach, implement simulation or drills on **two** low frequency, high-risk events, annually. High or low fidelity simulation may be used. Simulation is best conducted in-situ though a simulation center may be utilized.	☐ **Met** ☐ **Not Met**	☐ Evidence of active participation by <u>all required providers and staff</u> as reflected in the facility/group's roster to be provided to BETA.
Team members who respond to the specified emergency will be identified and included in the simulation/drill exercise. This may include anesthesia, obstetrics, neonatal team members, trauma, cardiology, lab or others.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation by all staff reflected in dated sign-in sheets.
Selection shall be based on events where there is potential for incidence, but rarely encountered to breed familiarity with clinical management. This may include: 1. Inadvertent deep sedation 2. STEMI 3. Stroke 4. Newborn delivery 5. Septic shock 6. Multiple critical patients requiring triage of resources	☐ **Met** ☐ **Not Met**	☐ The scenario utilized shall be produced on the day of validation.
A debriefing process is in place, and there is documented evidence of the debriefs preferably written by staff, identifying individual learning.	☐ **Met** ☐ **Not Met**	☐ Debrief summary of each simulation/drill scenario with an action plan as indicated with completion dates.
Documentation of one opportunity, the associated corrective action, and measure of success shall be provided.	☐ **Met** ☐ **Not Met**	☐ Documentation of corrective action and measure of success shall be produced on the day of validation.

TIER 2

Certified Emergency Nurse (CEN) Credential

Certified Pediatric Nurse (CPEN) Credential

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*

All eligible staff in the emergency department will sit for the CEN or CPEN exam no later than one month prior to policy renewal.
 	
Those eligible are defined as:
 	
  1. Those currently licensed in the U.S.
 	
  2. Two years of experience in the emergency department.
 	
Eligibility details can be found at the following links:
 	
  CEN:
 	
  https://bcen.org/cen/eligibility/
 	
  CPEN:
 	
  https://bcen.org/cpen/eligibility/
 	
RMRF's may be utilized to offset the costs of the exam
 	
Evidence of current certification; enrollment and participation in the exam is required to meet this goal. Evidence of pass/fail is not required.
	☐ **Met**
	
	☐ **Not Met**
		☐ Nursing staff roster provided on day of validation to include evidence of staff having greater than 2 years' experience in clinical specialty, and if indicated 1000 hours of practice time in a pediatric emergency department.
		
		☐ Review of certificates of completion

TIER 2
Culture of Safety
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
Unit-specific information regarding staff perceptions of patient safety are gathered utilizing a psychometrically sound, scientifically valid survey instrument. A 60% response rate is required to ensure statistical significance. The following instruments meet this requirement: • SCORE Survey by Safe & Reliable Healthcare • Pascal HealthBench Safety Attitudes Questionnaire (SAQ) • Agency for Healthcare Research & Quality (AHRQ) *RMRF's may be used to offset the cost of the survey.*	☐ Met ☐ Not Met	☐ The facility will provide the required documents to BETA 60 days before policy renewal. ☐ Review of the evidence-based culture of safety assessment tool used to conduct the assessment and results.
A baseline survey must be administered by month six of the policy year. Goals for improvement are based on findings. There is evidence that an annual survey is conducted to measure performance.	☐ Met ☐ Not Met	☐ As above.
The culture survey results have been debriefed with nursing and medical staff to understand common themes in response to the results. BETA Heathcare Group HEART Toolkit contains resources for developing interventions and debriefing culture survey results (request toolkit from BETA).	☐ Met ☐ Not Met	☐ Evidence of participation by a minimum of 80% of staff as evidenced by number of staff totaled from each debriefing.
Evidence that the culture survey results and PI actions developed as a result of unit level debriefings are shared and	☐ Met ☐ Not Met	☐ ED Committee meeting minutes.

discussed at the ED Committee and medical staff committee meetings. Evidence of discussion is contained in meeting minutes.		
To raise staff awareness of safety concerns, at a minimum, four case study presentations or M&M rounds are conducted, to discuss error and near-miss activity	☐ **Met** ☐ **Not Met**	☐ Evidence of participation by all staff reflected in dated sign-in sheets.
Department-specific event trends (incident reports) are shared and discussed quarterly (at a minimum), at medical staff committee and nursing staff meetings to identify trends and develop potential solutions.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation by all staff reflected in dated sign-in sheets, staff education documentation or other method to ensure staff receive the information. ☐ Review of committee minutes.
Leadership Walk Rounds are implemented by month six of the policy year and are conducted at least monthly. Specific information is obtained, recorded, and there is a feedback mechanism in place to address the patient safety issues that providers and staff voice as a concern. These issues are tracked and trended through a point of resolution. Resources and Tools: The Psychological Safety Scale of the SCORE Survey (dukehealth.org) Safety Culture and Workforce Well-Being Associations with Positive Leadership WalkRounds (sciencedirectassets.com) Providing feedback following Leadership WalkRounds is associated with better patient safety culture, higher employee	☐ **Met** ☐ **Not Met**	☐ Activity sheets are collected and signed by the CEO, CNE, CMO or other leaders conducting that specific WalkRound.

| engagement and lower burnout (bmj.com)

PatientSafetyLeadershipWalkRoundsTool.pdf		

TIER 2

Triage Education

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist The following items will be reviewed during validation:
All registered nurses and advanced practice providers who triage and who hold ED privileges and professional liability coverage through BETA Healthcare Group or HealthPro must complete the required Relias Platform Personal Learning module on Triage. Based on the Relias Platform Personal Learning module, participants must complete all designated "Red, Yellow," no later than 60 days before policy/contract renewal.	☐ **Met** ☐ **Not Met**	☐ The facility will provide the required documents to BETA 60 days before policy renewal. ☐ Review current staff roster. ☐ Review Certificates of Completion for 100% of registered nurses. ☐ Review Certificates of Completion for advanced practice providers conducting triage and who are covered by BETA Healthcare Group or HealthPro to confirm evidence of successful completion.
New hires and newly credentialed practitioners may use certificates of completion for the required Relias Platform Personal Learning module taken elsewhere if completed within the previous two years of the policy renewal.	☐ **Met** ☐ **Not Met**	☐ Verified by documents above.
Audit documentation of triage process of five charts per nurse/PA/NP who are covered by BETA Healthcare Group or HealthPro and perform triage. Audit will be conducted twice a year to verify the accuracy of severity index and compliance with Triage Policy and protocols. Providers will receive feedback on audit findings and can review the record for educational purposes. This process will be documented.	☐ **Met** ☐ **Not Met**	☐ Review Triage policy Review of audit results. ☐ Review meeting minutes or other data documenting the feedback mechanism taken.

Safer Sign-Out

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*

Emergency medical groups must complete the sections of the Emergency Medicine Patient Safety Sign out (EMPSF) initiative required of all providers (physicians, nurse practitioners, physician assistants)
 	
The process must be in place a minimum of 6 months before qualifying for consideration to meet Tier Two.
 	
The policy and/or procedure reflects Safer Sign-Out concepts as the authorized hand-off process for use by physicians, PA's, and NP's in the emergency department and require the following elements:
 	
1. Use of a recordable form containing all elements on the official Safer Sign-Out tool (at a minimum).
 	
2. Pre-rounding with patients by the off-going provider to update Sign-Out report.
   a. Identify patient
   b. Critical details
   c. Follow-up items
 	
3. Require joint focus on the available data (labs, imaging).
 	
4. Sign out occurs at the computer terminal between the oncoming and off-going physicians/providers.
 	
5. Require joint rounding at the bedside.
   a. Introduce on-coming provider
	☐ **Met**
	
	☐ **Not Met**
		☐ Review Handoff policy(s).
		
		☐ Review tool or instrument utilized for Safer Sign-Out.
		
		☐ Observation of handoffs.
		
		☐ The facility will provide the required documents to BETA 60 days before policy renewal.

b. Update the patient on his/her status c. Ask if the patient has any questions 6. Require the oncoming physician to update the nursing staff assigned to the patient of the patient's current status and provide the opportunity for the nurse to ask questions and provide input. 7. Require nursing staff to conduct their handoff using IPASS, SBAR or similar formalized hand-off process between the off-going and on-coming nurse. 8. Form used during the nursing hand- off must contain a place for both nurses to sign attesting that the hand-off occurred at the patient's bedside and that the on-coming nurse was allowed the opportunity to ask questions.		
Evidence of education pertaining to the process of Safer Sign-Out provided to all clinicians practicing in the ED. References: Handoffs and Patient Safety: Grasping the Story and Painting a Full Picture - PubMed (nih.gov) Handoffs and Signouts | PSNet (ahrq.gov) Patient Transfers and Handoffs Position Statement (ena.org)	☐ **Met** ☐ **Not Met**	☐ Review documentation of medical providers and staff signatures reflecting education of policy's expectations. ☐ BETA Hospitals: provide a copy of the ED nursing roster to BETA, including dates of hire. ☐ Medical Groups: Return an updated roster, reflective of current providers to BETA *within 60 days of receipt of the roster from BETA.*

TIER 2
Patient and Family Centered Care
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist *The following items will be reviewed during validation:*
A readiness assessment is completed by a multidisciplinary team including senior leadership, a physician lead, nurse lead, and one frontline staff member in preparation for deployment of a PFCC structure.	☐ **Met** ☐ **Not Met**	☐ Evidence of executed Readiness Assessment.
A policy is in place in the emergency department that includes patients on improvement teams. This may be accomplished through the formation of a Patient & Family Advisory Council, which includes emergency services.	☐ **Met** ☐ **Not Met**	☐ Patient & Family Advisory Council policy and/or procedure.
In partnership with a patient partner, identify three areas of improvement to enhance the patient experience in your emergency department. 1. Develop an action plan with reasonable target dates for completion 2. Monitor changes for sustained implementation Provide update to the Emergency Medicine Committee and medical staff committee as evidenced in the meeting minutes.	☐ **Met** ☐ **Not Met**	☐ Staff meeting minutes and medical staff committee meeting minutes. ☐ Evidence of implementation of the changes and sustained gains.
The facility measures the patient's experience and satisfaction. A performance measure is outlined in the department. Emergency Department satisfaction scores reflect performance in the 90th percentile at minimum or marked improvement toward that goal.	☐ **Met** ☐ **Not Met**	☐ HCAHPS, Press Ganey scores.

TIER 2
Data Visibility and Transparency
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Findings	Validation Checklist The following items will be reviewed during validation:
The organization participates in one formal or informal performance improvement projects on an annual basis (at minimum) to include: IHI, Regional Projects, ED Collaborative, etc.	☐ Met ☐ Not Met	☐ Evidence of participation & performance.
The organization studies outcomes utilizing evidence-based Trigger Tool screening mechanisms.	☐ Met ☐ Not Met	☐ Trigger Tool metrics.
The organization provides incident report trends to the medical staff committee and nursing staff. A minimum of two trends are analyzed, and performance improvement activities are implemented to address these trends and reported to the hospital's Quality Committee.	☐ Met ☐ Not Met	☐ Medical staff committee minutes. ☐ Nursing staff meeting minutes. ☐ Quality committee meeting minutes and medical staff meeting minutes.
The unit has adopted a one-page *unit-specific* scorecard designed to provide feedback on performance over time. This scorecard is shared on a quarterly basis (at a minimum) with staff and may include metrics such as: 1. Incident report trends 2. Trigger tool trends 3. Claims frequency data 4. Patient satisfaction metrics 5. Culture survey data 6. Nurse turnover rates 7. Leadership Walk Round performance (open/completed items)	☐ Met ☐ Not Met	☐ Most recent scorecard.

A "White Board" designed to address current progress toward the goal is visible in the unit with the purpose of providing ongoing feedback on performance to staff and providers. References Data Visibility: Sustainability Planning Worksheet | Institute for Healthcare Improvement (ihi.org) Visual Management Board | Institute for Healthcare Improvement (ihi.org) IHITool_Visual_Management_Board.pdf Shining_a_Light_Transparency_LLIReport.pdf Trigger Tools/References: The Emergency Department Trigger Tool: A Novel Approach To Screening for Quality And Safety Events (nih.gov) IHI Global Trigger Tool for Measuring Adverse Events | Institute for Healthcare Improvement IHIGlobalTriggerToolWhitePaper2009.pdf IHITriggerToolforMeasuringAdverseDrugEvents.pdf	☐ **Met** ☐ **Not Met**	☐ Observation.

The (name of hospital) _____

Intends to accomplish: (This usually contains an overarching statement describing what you intend to do i.e.: Reduction in Falls to zero)

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By: Time frame, i.e., month/year by which you intend to accomplish improvement- recommend July 1, 2024, to May 1, 2025.

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Our goals: These are goals for your measures. Your measures for this project should, of course, align with your Quest for Zero components. See Quest for Zero current Guideline.

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Our Stakeholders: (These are the people involved with and affected by your process and improvement initiative. The success of your improvement initiative often depends on the inclusion and involvement of multiple stakeholders).

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For questions or consultation regarding the Quest for Zero: Excellence in ED contact:
Nicole Amidon, M.S.N., RN
Manager, Risk Management and Patient Safety
Nicole.Amidon@betahg.com | (858) 379-0595