Sleeping-Hazardous to your Health? Recognizing the Dangers of OSA
Fredrick Memorial Hospital

Program/Project Description
Problem to be solved: A mechanism to screen patients on admission for Obstructive Sleep Apnea (OSA) did not exist and current processes did not support adequate treatment of patients with known OSA.

How was it identified: A series of three adverse events in the spring of 2010 were analyzed using the root cause analysis (RCA) process. Two of the three patients were known to have obstructive sleep apnea on admission and the third exhibited symptoms consistent with OSA. At that time, the prevailing perception of the staff was that treatment for sleep apnea was a night time only intervention and therefore, neither of the known OSA patients were using CPAP or Bi-PAP during daytime hours even in the presence of sedation. The remaining patient initially presented to the Emergency Department with what appeared to be an acute psychiatric problem and unfortunately, the sleep apnea symptoms were not fully assessed.

Process.
A multiple disciplinary team was formed to review current literature on obstructive sleep apnea incidence and screening initiatives that have been implemented at other institutions. The team made recommendations for FMH and developed an action plan for implementation based on information revealed through the RCA and evidence based practice.

Solution.
Two flow charts were developed to outline the workflow. The first tool was for patients admitted to FMH who are known to have OSA and details the interventions necessary to provide safe care during their stay. The second was an OSA risk assessment tool which standardizes the care of patients who are identified as being at risk. A facility wide education plan is being implemented to insure that all staff recognizes the potential hazards and symptoms associated with OSA for improved patient outcomes. Monitoring was incorporated to reduce negative outcomes. At the time of discharge, standardized education materials were incorporated that enhanced knowledge about the patient's OSA condition.

Measurable Outcomes.
All patients admitted to FMH have an OSA risk assessment completed by the admitting nurse. The attending physician is notified when a patient is at risk or is known to have OSA and the appropriate workflow is initiated. Data is currently being collected and analyzed to measure the effects of this improvement.

Sustainability.
The process improvement team is continuing to meet at regularly scheduled intervals to review data, evaluate the new processes and make recommendations for further improvements within the facility.

Role of Collaboration and Leadership.
This initiative was fully supported by leadership at FMH. During the process of conducting the RCA’s, the senior leadership team was briefed by the Vice President of Medical Affairs and the Performance Improvement Department. With the support of leadership, the process improvement team was formed with representation from nursing, cardiopulmonary services, the medical staff and performance improvement. The progress of the team was shared throughout the organization through newsletters and presentations to all levels of staff.

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