

Hospital Inpatient Waste Identification Tool

This Tool was produced by the Institute for Healthcare Improvement
and commissioned by the Health Foundation (Registered Charity Number: 286967)

Version 7
5 May 2010

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1. Background

Hospital waste can be defined as hospital resources that are used, consumed, spent or expended where, from the perspective of the patient, the hospital or the community, patient care is not enhanced as a result of such expenditures. Extensive literature review suggests that the extent and types of inpatient hospital waste are varied and debatable. The Institute for Healthcare Improvement (IHI), commissioned by the Health Foundation, developed the Hospital Inpatient Waste Identification Tool (the Tool) to identify meaningful waste as assessed by front-line health care providers that can be connected to system-level improvement strategies.

Efforts to reduce waste in the inpatient hospital setting have not progressed in some areas due to inherent conflicts either with hospital revenue or failure to recognize the activity as waste. For example, infections that develop during hospitalization have the potential to add revenue under some payment schemes, although from a population health and resource perspective this represents a waste of resources because these infections are potentially preventable. Due to these complexities, the design of the Tool defines waste *without reference to revenue*. Obviously some waste adds to cost, some waste adds to revenue, and some waste adds both to cost and detracts from revenue. However, whether waste contributes to revenue or cost is not easily determined at this time.

2. Design

The primary purpose of the Tool is to identify and categorize actual or potential waste from the perspective of front-line hospital staff in order to identify strategies for waste reduction and create the engagement necessary for successful implementation of such strategies. Identifying and categorizing waste is accomplished through an assessment in a geographic area or based on functional concepts for which potential waste is documented as either present or not. There is no attempt to quantify the degree or cause of waste.

Geographic areas (such as wards or inpatient units) and functional concepts (such as diagnosis or treatment) are organized into modules with clear definitions of potential waste to identify. There are five defined modules in this Tool: Ward Module, Patient Care Module, Diagnosis Module, Treatment Module, and Patient Module. Each module contains multiple types of potential waste and in some modules these are defined as a “waste stream” — a collection of waste with homogeneity, significant volume, and measurability. Each waste stream is designed to be unique with minimal overlap.

Each module is designed around a one-page worksheet for data collection to be used by a front-line provider in real time. A companion instruction page has been provided for each module and should be used by reviewers for data collection. The worksheets and instructions are designed as one-page documents for simplicity of use and printing as one two-sided document for each module.

3. Methodology

Data collection using the Hospital Inpatient Waste Identification Tool occurs similar to the process of a conducting a point prevalence study. Measurement is based on a simple

analysis as to whether each type of potential or actual waste is assessed as either “yes” (present) or “no” (not present). It is not the goal at this stage to explore for mitigating factors or to determine the degree or severity of any type of waste — the sole purpose of the Tool is to determine the presence of potential waste at the time of evaluation. This allows insight into the likely impact of a given waste stream, and subsequent studies are required to measure the financial impact of the identified waste.

Waste is measured with a simple calculation of percent of waste present (i.e., percent of beds or patients with one or more types of waste identified). The denominator varies for each module depending on the unit of measure.

It is best to start by conducting a small test of the Tool using only one module. Identify one or more individuals to conduct the test on one inpatient ward or unit. Some organizations have used multidisciplinary teams in this review. Reviewers should complete the test in collaboration with the nurses or physicians caring for the patients in the beds being evaluated. The module reviews are easiest and most informative if the reviewers communicate directly with the hospital staff who are most familiar with the patients in those beds.

The following process can be used for testing any module:

- a) Identify an inpatient ward (unit) to review — i.e., any ward that currently has inpatients in designated beds who are receiving care.
- b) Identify a reviewer. The review is best conducted by a mid-level (not senior management or executive) or front-line staff person who is familiar with daily ward care and has a good understanding of medicine. Examples include a nurse, physician, case manager, or knowledgeable mid-level manager or matron.
- c) Select the appropriate worksheet and instructions for the module you are testing (see section 7. Tools: Worksheets and Instructions). The reviewer should visit the ward or unit to assess each item. This should be done in person — not via phone, or by electronic or other remote communication.
- d) For every unit of measure (e.g., patient or bed), place a mark in the appropriate column to indicate that the type of waste listed is present. (Refer to section 4. Module Description and Definitions.)
 - i. The answer as to whether a waste stream applies is based on the review occurring at that moment in time. Past events are only applicable if they affect the current status of bed use (e.g., readmission for heart failure would be considered a “yes” in the Unnecessary Hospitalization waste stream of the Ward Module for any day of the patient’s stay).
 - ii. Direct communication is the best method for obtaining some information in some modules — the reviewer should ask those staff caring for the patient directly. Bedside nurses will likely be able to answer many items in the worksheet. The worksheet questions may also be asked of physicians and other clinical staff if they are present at the time of review. Direct communication has enormous value and engages front-line staff in the process.

- iii. Review of the case notes or patient record is necessary for obtaining information in some modules or for situations when the bedside nurse is not available. Refer to the instructions for each module for recommendations on sources of information.
- iv. In a few cases, it may be necessary to contact physicians or other clinical staff to answer items in the worksheet. This should be rare and it is recommended that limited time be spent on contacting others as this could significantly lengthen the review time and ultimately is not likely to provide value-added information.
- e) Note the number of beds or patients (depending on the module) with any waste identified in the appropriate space on the worksheet. The percentage is calculated as the number of beds or patients, divided by the total number reviewed.
- f) Space is provided in the worksheet to sum the number of each individual type of waste or waste stream (e.g., healthcare-associated infections). This information will be helpful for assessing the impact of a specific waste stream for improvement going forward.
- g) When reviews progress to multiple wards or units, use one worksheet per ward or unit.

4. Module Descriptions and Definitions

A. Ward Module

Waste in this module is assessed in geographic areas in which patients are placed into beds for care. This includes the traditional inpatient care areas of medicine and surgery and other locations such as Accident & Emergency (A&E, or the emergency department), admission wards, intensive care, or any holding areas. The primary focus in this module is waste related to bed utilization, thus in some streams, only certain events are included. For example, not all healthcare-associated infections, adverse drug events, and procedure complications result in hospital admission or increase length of stay. This module only includes those that do. Because it is not always clearly documented when hospital stay is lengthened from one of these events, reviewers shall need to rely on the judgment of those caring for the patient.

Bed Occupied or Used Inappropriately

Empty beds represent a waste of hospital resources. Empty beds may be necessary to maximize bed flow, but they are still considered waste in this analysis. Every bed contributes to the fixed costs of the hospital, via construction of the space and maintenance. Patient rooms used as temporary storerooms or offices are another form of waste since they are not used for the intended purpose. Staffed beds not in use represent additional waste of human resources. Operational problems with flow contribute to empty beds as a form of waste such as no current demand for beds, patient rooms not yet cleaned, unresolved maintenance issues, or beds blocked from use due to isolation of a patient.

Inappropriately occupied beds could include patients occupying an inpatient bed for outpatient services such as administration of chemotherapy or blood.

Healthcare-Associated Infection

Healthcare-associated infections are infections that are neither present nor incubating on admission to a hospital or other outpatient health care service. Infections are considered healthcare associated if signs and symptoms are first identified 48 hours or more after hospital admission or within 30 days after discharge.

If the patient has an infection that does not meet healthcare-associated criteria (e.g., admission for community-acquired pneumonia), there is no waste in this stream. The decision regarding the healthcare-associated infection should only reflect whether the infection is present, not whether appropriate treatment or appropriate preventive measures were used.

Adverse Drug Event

The intent in this waste stream is to include cases where an adverse drug event caused or extended hospitalization. Certainly adverse drug events can result in other forms of waste, such as mitigating or rescue therapies, but that type of waste is not counted in this module. Examples of adverse drug events that *are* considered waste in this stream because they could cause or extend hospital stays include (but are not limited to) renal failure secondary to diuretics, muscle inflammation from anticholesterol drugs, liver failure from antiviral agents, bleeding complications from anticoagulants, or bone marrow suppression secondary to antibiotics.

Procedure Complication

Complications from any surgical or nonsurgical procedure that result in admission or prolonging length of stay are waste, whether or not they were preventable. Examples include but are not limited to: post-procedure emboli, unplanned return to surgery, post-procedure myocardial infarction, or post-procedure stroke. Complications that do not appear to extend the hospital stay should *not* be included.

Unnecessary Hospitalization

There are commonly two types of cases that one may find in this waste stream and both represent waste due to failure of some aspect of care (e.g., during a prior admission, during transition to the next care setting, or in an outpatient setting).

The first type is readmissions to the hospital, particularly shortly after discharge. It is probably best to start by including those patients readmitted within 30 days of prior hospitalization — at *any* hospital. The second type is admissions due to failures in settings other than hospitals. Some of these may be more difficult to determine and best judgment should be used.

Pay particular attention to patients who have chronic diseases or had recent procedures in any setting for both types of waste. Do not evaluate quality of clinical care when determining waste, or the appropriateness of the admission. The admission may have been appropriate at the time based on presenting symptoms and signs but still unnecessary if other failures had not occurred prior to patient presentation.

Flow Delay

Issues related to flow and movement of patients through the hospital can contribute greatly to wasted utilization of beds. Any time a patient occupies a bed while waiting for transfer to the next care setting, or a bed is being held for a patient who has not arrived, the bed utilization should be considered waste. Examples include:

- Patient in a bed with a completed discharge waiting to leave
- Bed being held for any type of patient — medical, surgical, admission, or transfer
- Expired patient in the bed awaiting transfer to morgue (*this may prevent or delay a subsequent admission*)
- Room not cleaned (*this may delay patients who are waiting for bed assignments*)

It may be advisable to set some time criteria for these examples to ensure consistency within an organization. Use expected turnaround times when available; for example, if expected turnaround time to clean a room after patient discharge is one hour, then count rooms not cleaned for more than one hour.

Clinical Care Delay

In this waste stream, include situations where delays extend the patient's stay in the hospital while waiting for some action to occur, such as:

- Imaging procedures not able to be done or delayed
- Surgery delays due to tests or consults that are not completed
- Consultation delays resulting in prolonged stay

B. Patient Care Module

In this module, the form of waste captured is unnecessary patient care, particularly treatment that is no longer needed based on changes in patient condition.

Monitoring: Any forms of monitoring that are no longer necessary or are being used or completed more frequently than necessary should be considered waste. Examples are telemetry, pulse oximetry, capnography, neuro checks, capillary glucose checks, etc. This does *not* include standard vital sign measurements.

Invasive Devices: Consider whether any invasive device is unneeded such as central lines, peripheral IV lines, chest tubes, drains, arterial lines, urinary catheters, etc.

Medications: Consider whether medications are still needed by the same route and at the same frequency (e.g., antibiotics, pain medications, etc.). Any medications that are no longer needed or are still being administered via invasive route when an alternative route is now possible should be considered waste.

Tests: Consider whether repeated daily laboratory tests are still helpful (e.g., electrolytes, glucose, etc.). Determination of this type of waste will take some judgment and might be helpful to do in consultation with a physician.

Therapies: Similar to invasive tools and medications, consider whether any form of therapy (e.g., physical, speech, occupational, or respiratory) that may have been appropriate when initiated is still necessary, or still necessary at the same frequency.

C. Diagnosis Module

At the time of hospital admission, or prior to a surgical procedure, diagnostic tests and procedures may be required to complement a comprehensive history and a complete physical examination. However, the literature suggests that many such tests and procedures are either overused or misused. The Diagnosis Module looks at these types of waste by starting with tests and procedures that are requested as a matter of “routine” on admission or done pre-operatively rather than based on the patient’s signs, symptoms, and predicted diagnosis.

This module only measures whether common diagnostic tests or procedures were requested or not (yes or no). Some may have been necessary and appropriate for particular patients so at this level they are considered as “possible” waste. Further analysis will be needed to determine the amount of actual waste.

This module has two waste streams:

- Hospital Admissions
- Pre-operative Evaluations

The review should be conducted on a selected ward or inpatient unit.

The following tests should be considered as possible waste when requested on admission (i.e., in physician orders at time of admission and within first 12 hours) or prior to surgery. Reviewers only determine whether or not the test was requested.

- Urinalysis
- Thyroid function studies
- Electrocardiogram (ECG)
- Chest x-ray (CXR)
- Metabolic panel (typically includes glucose, electrolytes, proteins, kidney function tests, and liver enzymes)

D. Treatment Module

The Treatment Module assesses whether treatments supported by scientific evidence are provided, based on the assumption that such treatments will minimize waste resulting from use of other potentially medically unnecessary resources or from complications. Most hospitals apply science to treatment through protocols, guidelines, order sets, or other standardized approaches to care. There is no attempt in this module to validate whether the treatment is appropriate in individual cases.

The Treatment Module defines several waste streams based on several areas of care supported by much published science, and leading to consensus on treatment recommendations by expert organizations and use of standardized approaches in many hospitals.

- Anticoagulation
- Glucose management
- Post-operative care for high-volume procedures
- Pain control

This is certainly not a comprehensive list as there are other clinical topics with accepted treatment guidelines backed by science that may be included in future modules or versions. A first assessment using these four areas may provide important insight as to the application and use of standards in a hospital.

E. Patient Module

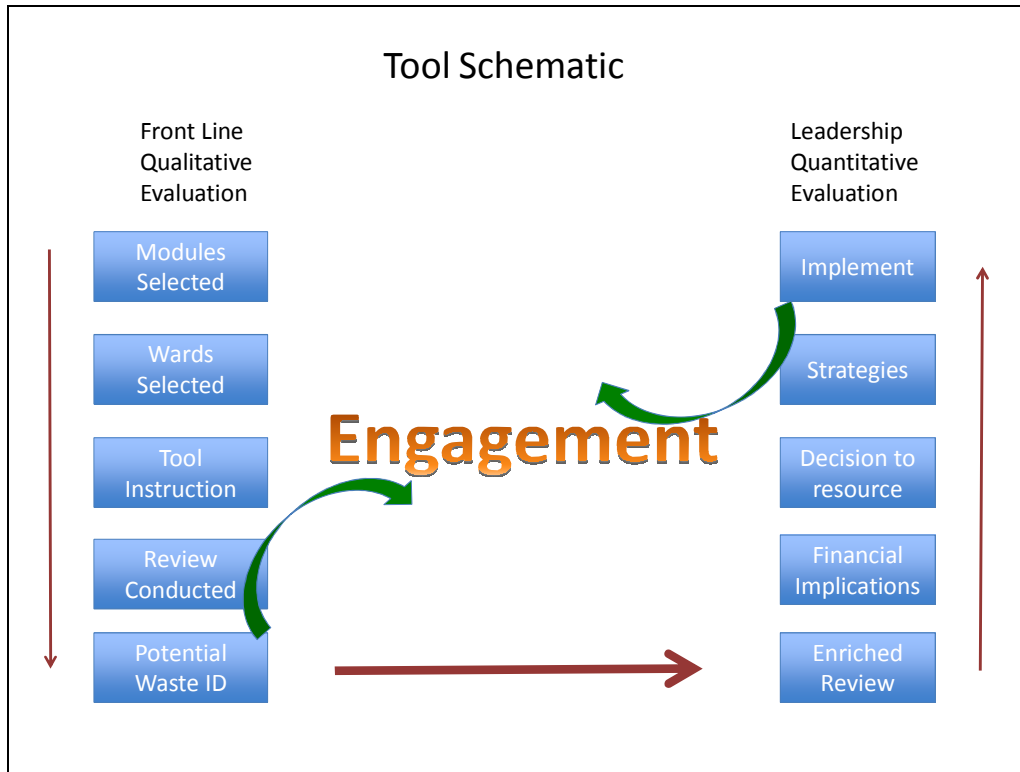
The Patient Module is meant to function as a reality check regarding what patients perceive as helpful and valuable in their inpatient care. Although most patients do not have the benefit of a background in health sciences, it would be erroneous to assume that patients have no insight into possible waste that has occurred during their hospitalizations.

This module differs from the measurement methodology used in other modules. The Patient Module uses an interview technique to gather *qualitative* information about possible waste from the patient's perspective, rather than a *quantitative* measure that calculates the percent of possible waste using patients or beds in a ward or unit as the denominator.

5. Analysis

The modules and various waste streams described in this Tool represent the starting point in a journey to reduce significant waste in an acute care hospital. While identification of potential waste is necessary, it alone is not sufficient to reduce waste.

Figure 1 represents a schematic of the process by which an initial cycle of waste reduction should occur.



The front-line qualitative evaluation is designed to identify potential waste from the perspective of front-line staff and clinicians. This first-level evaluation must be followed by a quantitative evaluation to determine actual waste and estimate financial impact. The following steps should be taken to analyze, interpret, and utilize the results to inform improvement efforts.

Step #1: The Enriched Review

This step is a focused and deliberate effort to determine the amount of actual waste identified during the front-line evaluations (using the module worksheets and process described in section 4). The simple “yes/no” assessment used in most modules only determines whether something was present, so by design there will be cases of both actual waste (where the item being present is truly waste) and cases of no waste (where the item was appropriate for the patient situation). For example, in the Diagnosis Module the front-line reviewer assesses whether common diagnostic tests were ordered on admission. In this next analysis, it should be determined in which cases these diagnostic tests were appropriate given the patient’s signs and symptoms and those cases that should be excluded as waste.

Assemble a team to review the cases, ideally as a group. Team members should include those who have the training and experience to make the determinations of what is actual wastes versus what is not. Physician representation is essential and others to include on the review team are front-line staff (from the area of review), quality improvement personnel, and leadership. Financial representatives will be essential in the next step and it is recommended to include them here so they can gain perspective on the issues.

Review documentation (patient records or case notes) for those patient cases that were positively identified as having some potential waste. It is not necessary to review those cases for which no waste was identified (i.e., do not review every patient case from the ward (unit) or group of patients reviewed).

The review team should determine whether potential waste identified by front-line staff involves instances of misuse and overuse and whether care was appropriate or inappropriate. If waste is confirmed in this small sample then it is likely that similar waste is occurring in many areas of the hospital, and the team should progress to step #2 to analyze the potential business case for improvement.

Step #2: Define the Business Case for Improvement

After determining the amount of actual waste identified, the next step is to assess the estimated financial impact of the waste and potential savings for the hospital from reducing or removing such waste. This should also be completed by the review team assembled for step #1, which provides an opportunity for front-line and medical personnel to learn more about the financial impact of the various waste streams.

If a compelling business case can be made for reducing the waste in a particular waste stream, then efforts should be made to allocate resources to the improvement work in particular waste stream(s). In some cases a waste stream may lack a strong business case for improvement and thus action shall not be taken.

It is important to provide feedback to the front-line staff who completed the initial reviews as to what was learned during the enriched review and any decisions made to implement waste reduction strategies.

6. Frequently Asked Questions

Q: *Most recent reports list misuse and overuse as key areas of waste. Why are these types of waste not represented in the Tool?*

A: Misuse and overuse are commonly identified by experts during retrospective review of specific resource utilization (such as MRIs) or with specific types of diseases and patients. The Hospital Inpatient Waste Identification Tool was designed specifically to *not* place front-line staff in the position of having to judge the validity of another clinician's decision and leaves this determination to the experts performing the enriched review that occurs later.

Q: *Can we add waste streams to the Tool?*

A: Yes. The waste streams identified and defined in the Tool are based on commonly observed waste streams in most hospitals, but will not be observed equally in all hospitals. We encourage the addition of waste streams that reflect the unique nature of your ward or hospital. The best way to add waste streams is to clearly define the type of

waste you wish to identify and then do a simple objective review as to whether it is present or not.

Q: We had several different people survey the same ward (unit) and they came up with different percentages of waste. Should we be worried about the lack of reproducibility of the waste data?

A: No. The first step in using the Tool is to obtain the perspective of the front line — the person completing the worksheet for the selected module. Each reviewer will interpret waste based on his/her experience and knowledge. Since the purpose of the initial evaluation using this Tool is to start the dialogue about whether waste streams warrant improvement efforts, this type of variation is expected. Use this as an opportunity for learning — meet with the reviewers and discuss the differences and how they reached their conclusions. This may help identify opportunities to clarify the instructions or add criteria that may be helpful during future reviews.

Q: How does the Tool differ from the current way leadership looks at waste in the hospital?

A: Most efforts at waste reduction often focus on budget reductions because volume, staffing, and finances are easy to measure. This Tool instead uses the perspective of front-line staff to identify opportunities to change the way work occurs rather than just eliminate services. By engaging the front line in the identification of waste, the prediction is that there will be greater staff support for changes to reduce waste and ultimately these changes will lead to better care for patients and improved finances for the hospital.

Q: As a hospital leader it seems unlikely that the front-line staff really have insight as to which types of waste will have an economic impact on hospital cost. How can the front-line reviews actually lead to money saved?

A: Generally, the best people to identify waste are those actually doing the work. Given the correct tools and permission to label work or outcomes as “waste,” the front-line staff who tested this Tool demonstrated that this works quite well. However, they are not in a position to quantify the actual cost savings that might be realized from waste reduction efforts — that is the reason that finance personnel and leadership must be involved in these efforts. The front-line reviews alone using this Tool will not lead to money saved. The dialogue between front-line staff, leadership, and finance can lead to changes that will.

7. Tools: Worksheets and Instructions

The Hospital Inpatient Waste Identification Tool includes five modules, and the worksheets and instructions for the five modules follow in this section.

- Ward Module: Worksheet and Instructions
- Patient Care Module: Worksheet and Instructions
- Diagnosis Module: Worksheet and Instructions
- Treatment Module: Worksheet and Instructions
- Patient Module: Worksheet and Instructions

The worksheet for each module is intended to be used by a front-line provider for data collection in real time. The worksheets and instructions are designed as one-page documents for simplicity of use and printing as one two-sided document for each module.

Ward Module Instructions

INSTRUCTIONS

Determine the number of beds for the ward or unit. This should be the total number of all beds, including those in use and not in use. Each bed should be noted on the worksheet in the "Patient Bed ID" column, noting each bed with an identification that will be understood locally (for example, room numbers, ward bed numbers, or other identifications typically used on the ward). Use a second worksheet if you need additional space to review all beds on the ward or unit. Note the number of total beds reviewed in the space for "Total Beds Reviewed."

Direct communication with bedside caregivers is recommended for this module. Use review of case notes or patient records only for information that cannot be obtained or if bedside caregivers are not available.

EXAMPLES OF WASTE or POTENTIAL WASTE to INCLUDE

Bed Occupied or Used Inappropriately: Beds used for other than inpatient care

- Temporary storage
- Temporary offices
- Outpatient use

Healthcare-Associated Infection: Patient admitted or treated for a infection caused by medical care

- VAP
- MRSA
- C. diff
- Bloodstream infection
- UTI
- Wound infection
- Other

Adverse Drug Event: Drug caused admission or extension of stay

- Anticoagulant bleeding
- Dialysis secondary to drug toxicity
- Bone marrow depression
- Dehydration
- Arrhythmia
- Other

Procedure Complication: Any procedure complication causing admission or extension of stay

- Intra-operative complication
- Pneumothorax
- Hematoma
- Post-operative shock, MI, renal failure
- Other

Unnecessary Hospitalization: Any hospitalization where a defect in care caused the readmission or admission

- Diabetes
- Heart failure
- Hypertension
- Chronic obstructive pulmonary disease
- Adult asthma
- Pneumonia
- Urinary tract infection
- Unplanned readmission
- Other

Flow Delay: Delays causing beds to be occupied that should not be

- Patient in a bed with a completed discharge waiting to leave
- Bed being held for any type of patient – medical, surgical, admission or transfer
- Expired patient in the bed awaiting transfer to morgue (*this prevents other admissions*)
- Room not cleaned or in the process of being cleaned (*this may delay patients who are waiting for bed assignments*)

Clinical Care Delay: Delays in the delivery of clinical care that result in the patient remaining in a bed

- Imaging procedures not able to be done or delayed
- Surgery delays due to tests or consults not completed
- Consultation delays resulting in prolonged stay

Patient Care Module Instructions

INSTRUCTIONS

Review each patient. Use the “Patient Bed ID” column to note an identification that will be understood locally (e.g., room numbers, ward bed numbers, or other identifications typically used on the ward or unit). Use a second worksheet if you need additional space. Note the number of total patients reviewed in the space at bottom of worksheet. Unoccupied beds are not used in this module.

Direct communication with bedside caregivers is recommended for this module. Use review of case notes or patient records only for information that cannot be obtained or if bedside caregivers are not available.

EXAMPLES OF WASTE or POTENTIAL WASTE to INCLUDE

Monitoring: Any forms of monitoring that are no longer necessary or are being used or completed more frequently than necessary, such as unneeded monitoring or use of monitoring device (this does not include standard vital sign measurements)

- Telemetry
- Pulse oximetry
- Capnography
- Neuro checks
- Capillary glucose checks
- Other

Invasive Tools: Consider whether any invasive device is unneeded

- Central lines
- Peripheral IV lines
- Chest tubes
- Drains
- Arterial lines
- Urinary catheter
- Other

Medications: Consider whether all medications are still needed and at same route and frequency, particularly those that were initiated during hospitalization

- Antibiotics
- Pain medications
- Other

Tests: Consider whether laboratory tests are still helpful

- Orders for daily laboratory tests (e.g., glucose)
- Tests being repeated because results were invalid, or specimen was lost or unusable

Therapies: Any form of therapy that may have been appropriate when initiated but is no longer necessary or not necessary at the same frequency

- Physical
- Speech
- Occupational
- Respiratory

Diagnosis Module Instructions

INSTRUCTIONS

Review each patient. Use the “Patient Bed ID” column to note an identification that will be understood locally (e.g., room numbers, ward bed numbers, or other identifications typically used on the ward or unit). Use a second worksheet if more space is needed. Note the number of total patients reviewed in the space at bottom of worksheet. Unoccupied beds are not used in this module.

Case note or patient record review will be necessary for this module.

1. Hospital Medical Admissions: On any medical ward or inpatient unit, review the case notes or patient record for each patient and evaluate only the initial admission orders — those initiated in A&E (ED), admission unit, or within the first 12 hours since decision to admit.

2. Pre-operative Evaluation: On a surgical ward or inpatient unit, review the case notes or patient record for surgical patients (pre-op or post-op) and determine if these five tests were completed during pre-operative evaluation, either in an outpatient setting or as part of inpatient pre-operative testing.

3. Determine whether any of the five tests were requested. Do not attempt to validate why the tests were ordered.

EXAMPLES OF WASTE or POTENTIAL WASTE to INCLUDE

The following tests should be considered as possible waste when requested on admission (in physician orders at time of admission and within first 12 hours) or prior to surgery. Reviewers only determine whether or not the test was requested.

- Urinalysis
- Thyroid function studies
- Electrocardiogram (ECG)
- Chest x-ray (CXR)
- Metabolic panel (typically includes glucose, electrolytes, proteins, kidney function tests, and liver enzymes)

Treatment Module Instructions

INSTRUCTIONS	DEFINITIONS
<p>Select a ward or unit and identify the following types of patients for review:</p> <ol style="list-style-type: none"> 1. Receiving anticoagulants 2. Receiving insulin 3. Post-operative for: <ol style="list-style-type: none"> a) Elective hip or knee replacement b) Coronary artery bypass graft c) Cardiac valve replacement d) Femoral-popliteal bypass graft 4. Receiving pain control (for any reason – oncology, post-op, chronic pain, etc.) <p>Do not review patients who are not in these categories.</p> <p>Determine if a standard protocol or pathway is being used.</p> <p>Do not attempt to determine if the use or non-use of a protocol is appropriate.</p> <p>To be considered a “standard” there must be one standard designed for most patients, regardless of the physician caring for the patient.</p> <p>If treatment plans vary by clinician, such as each surgeon or group of surgeons with a protocol or order set for their patients, this does not represent a standard. In such cases select “no standard exists.”</p>	<p><i>On standard</i> – Patient is receiving care from the standard</p> <p><i>Not on standard</i> – A hospital standard exists, but documentation indicates that it is not being used for the patient’s care</p> <p><i>No standard exists</i> – There is no standard *Select this answer if there is a standard for this treatment but not for this type of patient. For example, if an anticoagulation standard exists that is used only for medical patients but you are reviewing a surgical patient, select “no standard exists.”</p>

Hospital Inpatient Waste Identification Tool Worksheet: Patient Module

Date & Time of Interview: _____ Interviewer(s): _____

Ward/Unit: _____ Patient reference*: _____

**Optional – Note a reference number to patient if notes or record may be reviewed later. Ensure compliance with privacy and confidentiality policies.*

QUESTIONS:

1. Do you feel you could have been discharged home sooner? _____NO _____YES If yes, why?

2. Was there anything during your hospital stay (such as treatments, tests, or professional visits) that you received or occurred that was not helpful to your recovery, or hindered your recovery? _____NO _____YES If yes, what?

3. Did you wait longer than expected for anything during your stay (such as a test, procedure, consultation, or results)? _____NO _____YES If yes, what?

4. Did you have any test or procedure that caused you harm? _____NO _____YES If yes, what?

Patient Module Instructions

Identify five adult patients scheduled for discharge to the home setting and who are capable of participating in a brief interview.

First explain the purpose of the interview and obtain permission.

Be sure to inform patients as to what information will be noted and how it will be used.

Only interview patients who are willing to participate.

Record some brief notes with the patient's comments and perspectives in the worksheet.

