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AHC Media

Info card for surgery waiting room improves satisfaction

Improving patient satisfaction can be challenging in any area of the hospital, but the surgery department can be especially difficult, with family members becoming increasingly anxious every minute without information. Baylor Jack and Jane Hamilton Heart and Vascular Hospital in Dallas has conquered that problem with a simple information card that is given to family members accompanying the patient to surgery.

The Family Care Card provides estimates on how long different procedures will take and how to get information about the patient's status. *(See p. 113 for an example of the card.)*

The idea for the cards was born several years ago when nurses realized that many patients and family members were complaining about a lack of information, says **Nancy Vish**, RN, PhD, NEA-BC, FACHE, president and chief nursing officer at Baylor Jack and Jane Hamilton Heart and Vascular Hospital. They expressed dissatisfaction after the procedures with how they had no idea how long the procedures would last or when they would be able to see the patient again.

> "THE FAMILY CARE CARD PROVIDES ESTIMATES ON HOW LONG DIFFERENT PROCEDURES WILL TAKE AND HOW TO GET INFORMATION ABOUT THE PATIENT'S STATUS."

A team of nurses worked to address the problem, and in 2011, determined that the best solution would be an information card that addressed the complaints most often heard in the waiting area and in the recovery room. The primary concern was with time and what family members should expect for a particular procedure, so the nursing team worked with physicians to determine reasonable estimates of how

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long different procedures last.

They ended up with estimates for 16 of the most commonly performed procedures at the hospital. A diagnostic angiogram will take 30 minutes to an hour, for instance, and a carotid endarterectomy will take about two hours. The Family Care Card emphasizes that these are only estimates.

Those times were not based simply on physician estimates of their procedures, **Brenda Keeton**, manager of service excellence at Baylor Jack and Jane Hamilton Heart and Vascular Hospital.

The team working on the card analyzed data on surgeries performed at Baylor, determining the average time for each procedure and for each physician performing that procedure. Combining those two figures, they determined the median time that the procedure takes, Keeton explains.

> "IN COMPILING THOSE ESTIMATED TIMES, THE NURSING TEAM ALSO ADDRESSED ANOTHER PROBLEM CITED BY PATIENTS: CONFLICTING INFORMATION."

In compiling those estimated times, the nursing team also addressed another problem cited by patients: conflicting information.

"We found that nursing staff and physicians didn't always give the same information on wait times, and sometimes they even conflicted," Vish says. "By putting together this list of estimated times, we eliminate that variability and everyone is providing consistent information."

A few of the times have been adjusted in the past few years, as a result of ongoing monitoring of procedure times. Baylor also tracks procedures in real time and responds when a procedure runs long. When an open abdominal aortic aneurysm repair goes beyond the estimated four hours, for example, a service alert automatically alerts staff members and one visits the family to explain that the procedure is taking longer than expected.

"We tell them that everything is OK but just taking a while longer, or if there is an issue to discuss we'll have a physician come talk to the family and explain what is going on," Keeton says.

Baylor also has volunteers in the waiting area to assist families with directions to the cafeteria and other food sources, and providing blankets for those waiting through a long procedure. The volunteers also watch for messages from the surgery staff and relay them to the family members.

The discussion about typical waiting times begins in the pre-operation area, and then the patient transport team takes the patient and family members to the OR. At the "kissing corner" where the family must say goodbye, the transport team gives them the Family Care Card from a supply on the wall at the procedure entrance. *(See p. 112 for more on the patient transport team.)*

Keeton notes that Baylor made this a specific expectation of the transport team, and they do more

EXECUTIVE SUMMARY

A hospital is reporting improved patient satisfaction from providing an information card in the surgery department. The card includes expected wait times.

- The card is provided by the patient transport team.
- Telephone numbers are included for more information.
- Staff update family members hourly during surgery.

than simply handing over the card. The transport team gives the family member the card and shows where it indicates the time for that procedure, and where the card has instructions for more information. The transport team then directs the family member to the nearby waiting area.

"We chose that location to provide the Family Care Card because when someone is accompanying a loved one to surgery, there is growing anxiety and it peaks at that moment when you have to kiss and say goodbye. That's when people can feel the most anxious and lost without information," Keeton explains. "Addressing that critical moment has been a factor in improving patient satisfaction."

When they arrive in the waiting room, volunteers greet them and gather information about the patient and procedure so they can help the family stay informed. Surgery staff make contact with the family at least once an hour to update them on the surgery's progress and answer any questions, Keeton notes.

The Family Care Card originally did not have phone numbers for family members to call during the procedure, but Baylor added two dedicated phone lines for patients who couldn't wait on the next progress report from staff.

"Even though our expectation was to touch base with the family once an hour, sometimes families are very close and have high anxiety, so we wanted to give them the opportunity to call back to us," Keeton says. "Even if that means they want an update every 15 minutes, we want to make sure they connect with us about their loved one as much as possible."

The phone lines empower the family, Vish says, helping avoid the feeling that they had no control and were just waiting for someone else to decide it was time for an update. The phone lines also act as a safety net in case something goes wrong and staff do not appear on time for the hourly update, she says.

To make the card accessible to most people, the Flesch-Kincaid grade level for the card is 8.5. To implement the Family Care Card throughout the hospital, the nurses who developed it conducted inservice programs to describe the process of using the card, its purpose, and the rationale behind it to staff members. In addition to the procedure room entrance, the cards are available at other key spots such as registration and guest services, and all staff members are encouraged to provide one to patients asking for information while waiting during surgery.

> "ADDRESSING THAT CRITICAL MOMENT HAS BEEN A FACTOR IN IMPROVING PATIENT SATISFACTION."

Staff members report that the cards have reduced the number of questions asked by family members, and Baylor published a survey report showing that patient satisfaction has improved. *(See the story on p. 112 for more on that report.)* The hospital's Press Ganey patient satisfaction scores also have increased steadily since the card was implemented.

The importance of keeping the patient's family informed and minimizing their anxiety must not be underestimated, Vish says.

"When a family member comes to see the patient after surgery, the first thing the patient does is look into the eyes of that family member, and they can tell if the family member has been cared for or not. They can see the anxiety in their face and their eyes," Vish says. "That correlates to their anxiety and satisfaction, and even their recovery. Our goal is to take care of the family while we're taking care of the patient."

SOURCES

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Transport team key to patient satisfaction

The patient transport team can be an overlooked link in the care process, but they can have a great influence on patient satisfaction. That is what Baylor Jack and Jane Hamilton Heart and Vascular Hospital in Dallas found out when it improved the patient experience with a Family Care Card.

In the project to develop the information card, the Baylor team found that the patient transport process affected patients and family more than might be expected, says **Brenda Keeton**, manager of service excellence at Baylor Jack and Jane Hamilton Heart and Vascular Hospital. That prompted Baylor to put more focus on the transport team, particularly in the hiring process. Customer service is now seen as a key component of the transport team's job, so Baylor hires people who are friendly and comfortable interacting with people at a stressful time.

"A lot of people consider them behinds the scenes, just transporting the patient, and they don't have a lot of influence on the patient experience," she says.

"The transport team spends only five to eight minutes with the patient and family, yet when we send patient satisfaction surveys to patients five days after discharge, our patient transport team members are mentioned by name. That's the kind of impact they can have."

SOURCE

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Waiting room card reduces family anxiety

The Family Care Card provided to family members waiting during surgery at Baylor Jack and Jane Hamilton Heart and Vascular Hospital in Dallas has significantly improved patient satisfaction, according to a study the Baylor team published.

The team noted in its report that anxiety can be exacerbated if staff members provide inadequate or inconsistent information about the patient's status, but educational interventions and other staff-intensive and time-intensive measures may not be practical in a high volume facility.

A survey of family members indicated that receiving Baylor's Family Care Card reduced anxiety in a significant proportion of the respondents.[1] Prior to the card's introduction, some family members believed that they were not being adequately informed about the patient's status during surgery, even though a volunteer or a guest services staff member was available in the waiting room to assist families with questions or concerns, the report notes.

An investigation identified the following targets for improvement: insufficient or delayed communication between staff members in the procedure areas and family members in the waiting room, time estimates by a nurse or staff member in the waiting room that contradicted information previously given by the physician, inability of family members to call the postanesthesia care unit (PACU) to determine whether the patient had been transported there, and lack of tangible reference material about the details of surgery to help staff members and family members communicate.

> "PRIOR TO THE CARD'S INTRODUCTION, SOME FAMILY MEMBERS BELIEVED THAT THEY WERE NOT BEING ADEQUATELY INFORMED ABOUT THE PATIENT'S STATUS DURING SURGERY."

The Baylor team surveyed family members and friends after procedures at the hospital and received 47 usable responses. Twenty-nine (61.7%) of the patients underwent diagnostic angiography or diagnostic angiography with angioplasty. At 8.5, the Flesch-Kincaid grade level for the card was slightly higher than the goal range of 5 to 8.

"Nevertheless, all 47 respondents (100%) felt that the card was easy to read, and 46 (97.9%) agreed that it also was easy to understand. Most respondents reported that the procedure times listed on the card were accurate; 33 (70.2%) thought

that the actual waiting time was equal to the time listed on the card, and the 14 remaining respondents were equally divided in reporting that the actual waiting time was greater than or less than the time listed on the card (7 [14.9%] for each category)," the report says.

More than half of the respondents either strongly agreed or agreed that the information on the Family Care Card decreased their anxiety during the waiting period.

"In summary, our project showed that a statistically significant proportion of survey respondents believed that the Family Care Card helped reduce their anxiety, regardless of the amount of time they spent in the waiting room or the type of procedure the patient underwent."

REFERENCE

1. Muldoon M, Cheng D, Vish N, et al. Implementation of an Informational Card to Reduce Family Members' Anxiety. *AORN J* 2011; 94: 246-253.

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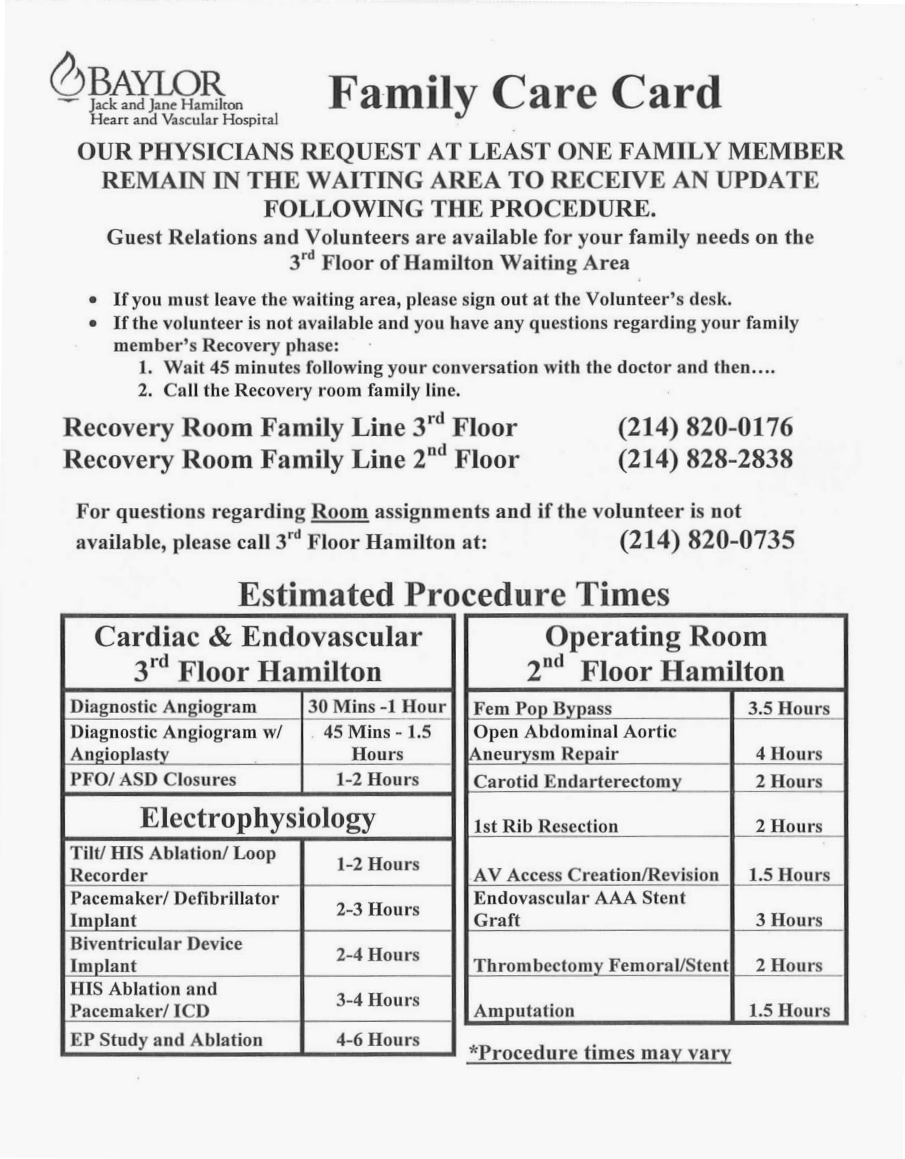

BAYLOR
Jack and Jane Hamilton Heart and Vascular Hospital

Family Care Card

OUR PHYSICIANS REQUEST AT LEAST ONE FAMILY MEMBER REMAIN IN THE WAITING AREA TO RECEIVE AN UPDATE FOLLOWING THE PROCEDURE.

Guest Relations and Volunteers are available for your family needs on the 3rd Floor of Hamilton Waiting Area

- If you must leave the waiting area, please sign out at the Volunteer's desk.
- If the volunteer is not available and you have any questions regarding your family member's Recovery phase:
  1. Wait 45 minutes following your conversation with the doctor and then….
  2. Call the Recovery room family line.

Recovery Room Family Line 3rd Floor (214) 820-0176
Recovery Room Family Line 2nd Floor (214) 828-2838

For questions regarding Room assignments and if the volunteer is not available, please call 3rd Floor Hamilton at: (214) 820-0735

Estimated Procedure Times

Cardiac & Endovascular 3rd Floor Hamilton	
Diagnostic Angiogram	30 Mins -1 Hour
Diagnostic Angiogram w/ Angioplasty	45 Mins - 1.5 Hours
PFO/ ASD Closures	1-2 Hours
Electrophysiology	
Tilt/ HIS Ablation/ Loop Recorder	1-2 Hours
Pacemaker/ Defibrillator Implant	2-3 Hours
Biventricular Device Implant	2-4 Hours
HIS Ablation and Pacemaker/ ICD	3-4 Hours
EP Study and Ablation	4-6 Hours

Operating Room 2nd Floor Hamilton	
Fem Pop Bypass	3.5 Hours
Open Abdominal Aortic Aneurysm Repair	4 Hours
Carotid Endarterectomy	2 Hours
1st Rib Resection	2 Hours
AV Access Creation/Revision	1.5 Hours
Endovascular AAA Stent Graft	3 Hours
Thrombectomy Femoral/Stent	2 Hours
Amputation	1.5 Hours

*Procedure times may vary

Compliance with standing orders, protocol rule can be difficult

Standing orders and protocols are key to the operation of any healthcare facility, but abiding by CMS' rules on these tools can be difficult, says **Sue Dill Calloway**, RN, AD, BA, BSN, MSN, JD, CPHRM, CCMSCP, president of Patient Safety and Healthcare Consulting and Education in Dublin, OH.

"Standing orders is the topic I am asked most often about lately," Calloway says. "Hospitals use these a lot and in some situations the answer to what CMS expects is not always in the COP."

Calloway recently worked with a hospital that does ambulatory surgery and wants to have extensive protocols for intravenous lines and other routine patient care, with the nurse implementing the protocol before having it signed by a physician. The COP does not clearly delineate that as a permitted use because standing orders are typically used in emergent conditions rather than for everyday care.

"It was not intended to take the place of having a physician or licensed independent practitioner review orders that are non-emergent, so there is a lot that the COP doesn't tell us about when this use is and is not permitted," she says.

Protocols are another frequent problem, Calloway says, with hospitals questioning what must be documented in the electronic record,

among other questions. Calloway recently has counseled two hospitals and discussed the issue with CMS officials, and she says some of CMS' expectations are becoming clearer.

"They don't want you to write something in the electronic chart like 'trauma protocol,'" she says. "It needs to state the elements of the protocol, like give this morphine dose, put a large bore needle in, just like in a paper chart would have had a page that says all the things you do rather than just saying 'trauma protocol."

Review of protocols also is causing some consternation. CMS requires that all protocols be reviewed regularly, but just how often you should do so is not clear. While an annual review is the minimum accepted by CMS, a hospital could opt to do more frequent reviews, Dill Calloway says.

A "periodic and regular review" is what CMS requires, but it is not clear exactly what that means. Under the minimum requirements section, the interpretive guidelines state "at a minimum, an annual review of each standing order would satisfy this requirement. However, the hospital's policies and procedures must also address a process for the identification and timely completion of any requisite updates, corrections, modifications, or revisions based on changes in nationally recognized, evidence-based guidelines."

Questions also have arisen lately about Patient Safety Initiative Surveys based on the three worksheets — Quality, Discharge Planning, and Infection Prevention — that were finalized last year. Some have wondered if CMS would be conducting focused surveys using these worksheets rather than incorporating them into existing survey processes. The answer apparently is yes.

Calloway recalls hearing from hospitals recently that CMS surveyors have shown up for surveys based on the worksheets.

"These were not complaint surveys, validation surveys, or certification surveys," Calloway says. "They just showed up for two days and said, 'We're going to do these worksheets.'"

CMS also is citing hospitals for not having a trained infection preventionist. She heard from one hospital that recently was cited and wanted to appeal. The hospital was small and when its infection control director left, a nurse with no special training was given the responsibility. CMS did not approve.

She advised the hospital not to appeal because it would lose.

"It's one of the first questions they ask. Do you have a trained hospital infection preventionist?" she notes. "Hospitals should make a priority of addressing this requirement."

Calloway notes that, though not strictly required, CMS highly recommends completion of the three worksheets in advance as a self-assessment tool. The worksheets are available online at http://tinyurl.com/pa5dju3.

SOURCE

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Diagnosis errors are a system problem, not just doctor's fault

Diagnostic errors should be addressed as systemic problems and not human errors made by individuals, according to a recent report from the Institute of Medicine.

IOM called on the healthcare community to address diagnosis errors with a collaborative approach. IOM's Report of the Committee on Diagnostic Error in Health Care outlines the steps necessary for reducing these errors. Committee Chair **John R. Ball**, MD, JD, said that although it has been estimated every American will suffer a consequential diagnosis error in his or her lifetime, no reliable figures exist for how many occur each year.

The key finding in the report is that reducing diagnosis errors will require a collaborative effort among not just healthcare team members, but also the patient and family, he said. *(The IOM report is available online at http://tinyurl.com/oogmdas.)*

"The stereotype of a single physician contemplating a patient's presentation and discerning the diagnosis is not always true," Ball said. "The diagnostic process often involves intra- and inter-professional teamwork. Nor is diagnostic error always due to human error. It often occurs because of errors in the healthcare system."

The committee defines diagnostic error as "the failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or (b) communicate that explanation to the patient." Despite the pervasiveness of diagnostic errors and the risk for serious patient harm, "diagnostic errors have been largely unappreciated within the quality and patient safety movements in healthcare," the report says.

It goes on to say that, "Without a dedicated focus on improving diagnoses, these errors will likely worsen as the delivery of healthcare

EXECUTIVE SUMMARY

The Institute of Medicine has issued a report calling on the medical community to more effectively address diagnostic errors. Reducing these errors will require a collaborative approach.

- Diagnostic errors are not typically caused by only a physician's error.
- Radiologists and pathologists should be more involved with diagnoses.
- Risk managers should treat diagnostic errors as a system problem.

and the diagnostic process continue to increase in complexity."

The IOM report stops short of calling for mandatory reporting of diagnosis errors but emphasizes that healthcare providers must improve the entire diagnostic process, not just reduce errors.

While acknowledging the pervasiveness of diagnostic errors, Ball warned against calls for mandatory public reporting.

"The committee believed that, given the lack of an agreement on what constitutes a diagnostic error, the paucity of hard data, and the lack of valid measurement approaches, the time was simply not ripe to call for mandatory reporting," Ball said. "Instead, it is appropriate at this time to leverage the intrinsic motivation of healthcare professionals to improve diagnostic performance and to treat diagnostic error as a key component of quality improvement efforts by healthcare organizations. Better identification, analysis, and implementation of approaches to improve diagnosis and reduce diagnostic error are needed throughout all settings of care."

Healthcare IT should be utilized more for diagnoses and not just billing or other administrative purposes, the report says. The IOM committee also calls for more involvement by radiologists and pathologists as members of the diagnosis team, and it praises the educational efforts of some medical malpractice insurers.

The report comes nearly 16 years after IOM's landmark study *To Err Is Human: Building a Safer Health System*, which prompted a campaign to reduce medical errors.

The report outlines eight goals for improving diagnoses. *(See the story on p.118 for more on those goals.)*

The Society to Improve Diagnosis in Medicine (SIDM) praised the report. **Mark Graber**, MD, founder and president of SIDM, a member of the report committee, says the report is a major milestone in the effort to improve diagnoses, quality of care and patient outcomes.

"Diagnosis is one of the most difficult and complex tasks in healthcare. There are more than 10,000 potential diagnoses, thousands of lab tests, and the problem that symptoms of each diagnosis vary from person to person," he says. "Moreover, our healthcare systems are highly complex, which contributes to problems coordinating care and completing the diagnostic process successfully."

SIDM recently spearheaded the launch of the Coalition to Improve Diagnosis, made up of leading healthcare organizations, to bring awareness, attention, and action to diagnostic error. **Paul Epner**, executive vice president of SIDM and chair of the Coalition, notes that diagnostic errors have no single root cause.

"This report addresses a significant gap in our knowledge, and SIDM intends to drive review and action on the recommendations across the entire healthcare system. It is the responsibility of everyone involved in the diagnostic process to consider the steps they can take to improve outcomes," Epner says. "This begins with healthcare providers and their organizations, which need to establish a culture of safety where these errors can be identified, studied, and addressed." ■

IOM says diagnosis errors underappreciated

This is an excerpt from the Institute of Medicine's Report of the Committee on Diagnostic Error in Health Care:

The delivery of healthcare has proceeded for decades with a blind spot: Diagnostic errors—inaccurate or delayed diagnoses—persist throughout all settings of care and continue to harm an unacceptable number of patients. For example:

• A conservative estimate found that 5% of U.S. adults who seek outpatient care each year experience a diagnostic error.

• Postmortem examination research spanning decades has shown that diagnostic errors contribute to approximately 10% of patient deaths.

• Medical record reviews suggest that diagnostic errors account for six to 17%

of hospital adverse events.

• Diagnostic errors are the leading type of paid medical malpractice claims, are almost twice as likely to have resulted in the patient's death compared to other claims, and represent the highest proportion of total payments.

In reviewing the evidence, the committee concluded that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences. Despite the pervasiveness of diagnostic errors and the risk for serious patient harm, diagnostic errors have been largely unappreciated within the quality and patient safety movements in healthcare. Without a dedicated focus on improving diagnosis, these errors will likely worsen as the delivery of healthcare and the diagnostic process continue to increase in complexity.

Getting the right diagnosis is a key aspect of healthcare — it provides an explanation of a patient's health problem and informs subsequent healthcare decisions. Diagnostic errors stem from a wide variety of causes, including: inadequate collaboration and communication among clinicians, patients, and their families;[1] a healthcare work system that is not well designed to support the diagnostic process; limited feedback to clinicians about diagnostic performance; and a culture that discourages transparency and disclosure of diagnostic errors — impeding attempts to learn from these events and improve diagnosis. Diagnostic errors may result in different outcomes, and as evidence accrues, these outcomes will be better characterized. For example, if there is a diagnostic error, a patient may or may not experience harm. Errors can be harmful because they can prevent or delay appropriate treatment, lead to unnecessary or harmful treatment, or result in psychological or financial repercussions. Harm may not result, for example, if a patient's symptoms resolve even with an incorrect diagnosis.

Improving the diagnostic process is not only possible, but it also represents a moral, professional, and public health imperative. Achieving that goal will require a significant re-envisioning of the diagnostic process and a widespread commitment to change among healthcare professionals, healthcare organizations, patients and their families, researchers, and policymakers.

See a chart on Where Failures in the Diagnostic Process Occur on the digital version of this article. ■

NLRB says nurses entitled to union representation at peer review

A recent decision by the National Labor Relations Board (NLRB) indicates that nurses must be allowed union representation during peer review.

The cases stemmed from two nurses who were requested to voluntarily appear before a hospital's nursing peer review committee and denied permission to have their union representatives.

The NLRB determined that their union representatives could attend the peer review meeting because the nurses could reasonably expect that the meeting might result in them being disciplined.

Menorah Medical Center in Overland Park, KS, argued otherwise, saying it did not discipline employees based on the outcome of peer review meetings.

The NLRB dismissed that argument as without merit, saying union representation was allowed even if the committee could not impose any disciplinary action because the nursing peer review committee could report the nurses' conduct to the Kansas Board of Nursing. That could lead to suspension or revocation of their licenses and subsequent loss of employment.

The hospital also claimed that all business "conducted in the committee is confidential between the Hospital and the State," but the NLRB said that wasn't good enough.

The NLRB decision explained that where requested information is "relevant to the Union's ability to (a) effectively monitor and enforce the terms of the collective-bargaining agreement, (b) enable the Union to compare incidents that cause nurses to become targets of investigations, and (c) determine whether to file a grievance on behalf of unit employees who might have unknowingly been the victims of discriminatory investigations and discipline," the party asserting confidentiality has the burden of establishing that the information is confidential and "that its confidentiality interest in the information sought outweighs its bargaining partner's need for the information."

The NLRB decision explained that the hospital has three options when an employee requests union

representation. It can grant the request, discontinue the interview, or offer the employee the choice between continuing the interview unaccompanied by a union representative or having no interview at all.

If the employee voluntarily agrees to remain unrepresented after having been presented by the employer with those choices, the hospital can proceed with the interview.

The NLRB decision is available online at http://tinyurl.com/q47b6mt. ■

Sentinel event report to The Joint Commission not privileged in Pennsylvania

Sentinel event reports to The Joint Commission (TJC) are not privileged in Pennsylvania, according to a recent decision by the Lackawanna County Court of Common Pleas.

The court ruled that a hospital's sentinel event report must be produced in litigation.

Hospitals typically have been confident that TJC sentinel event reports are confidential because of the Peer Review Protection Act and the Medical Care Availability and Reduction of Error (MCARE) Act.

In the interest of patient safety, those laws permit hospitals to investigate adverse patient events without having to disclose the data from that process.

In *Mallik v. Brink,* Marion Community Hospital in Ocala, FL, refused to turn over a sentinel event report concerning an event at the center of a malpractice lawsuit.

The hospital argued that the report was protected from disclosure by the Peer Review Protection Act and MCARE.

In deciding otherwise, the court explained that a hospital's voluntary reporting to a private organization does not constitute peer review.

As far as the law is concerned, peer review involves an internal analysis by a peer review committee, the court said, and is not related to compliance with any portion of the MCARE Act.

"It is laudable that Marian opted to transmit the sentinel event report to The Joint Commission [on Hospital Accreditation] so that the Joint Commission could conduct a root-cause analysis and communicate its findings and recommendations to Marian, but the fact remains that the sentinel event report was not prepared by The Joint Commission, nor was it authored by or presented to Marian's own peer review committee," the judge wrote.

"Accordingly, Marian has not met its burden of establishing that the sentinel event report is protected by the peer review privilege set forth in the PRPA." ■

Hospital accused of firing employee questioning credentialing

A former employee of San Juan Regional Medical Center in New Mexico is suing the hospital, claiming she was fired for speaking out against the credentialing of unqualified radiologists.

Rebecca Hahn filed the lawsuit Sept. 16 in Aztec District Court and seeks unspecified damages on claims that include retaliation, breach of implied contract, defamation and intentional infliction of emotional distress.

She claims in the lawsuit that her direct supervisor, John Buffington, then director of staff medical services, told her not to voice concerns in September 2006 over the credentialing of resident students as locum tenens radiologists.

Hahn claims in the lawsuit that the credentialing violated the hospital's by-laws, as well as its credentialing and privileging standards.

She also claims that an attorney for the hospital told her one of the resident student radiologists whose credentialing she challenged later misread an appendix scan, causing a woman's miscarriage.

Hahn claims she met with hospital Chief Executive Officer Rick Wallace to discuss her concerns but was subsequently fired.

The hospital issued a statement denying the claims. "At all times, San Juan Regional Medical Center has used medically qualified providers to read radiology scans, and it does not know of any situation where a scan was misread because the provider was not medical qualified," the statement said. ■

Sentinel Event Alert focuses on patient falls

Preventing patient falls and fall-related injuries is the focus of the new *Sentinel Event Alert: Issue 55* released recently by The Joint Commission. The new alert examines the contributing factors to patient falls and includes suggested solutions to be implemented by healthcare organizations to help reduce patient falls and falls with injury.

This topic was chosen for the Sentinel Event Alert because patient falls with serious injury are among the top 10 sentinel events reported to The Joint Commission Sentinel Event Database. The Joint Commission has received 465 reports of patient falls with injuries since 2009, and approximately 63% of those falls resulted in death.

The Joint Commission defines a sentinel event as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm or severe temporary harm where intervention is required to sustain life. Although the majority of falls reported to The Joint Commission occurred in hospitals, the ECRI Institute also reports a significant number of falls occurring in non-hospital settings such as long-term care facilities.

An analysis of falls with injury reported to The Joint Commission Sentinel Event Database from January 2009 through October 2014 showed the most common contributing factors include:

- Inadequate assessment,
- communication failures,
- lack of adherence to protocols and safety practices,
- inadequate staff orientation, supervision, staffing levels or skill mix,
- deficiencies in the physical environment, and
- lack of leadership.

"THE ECRI INSTITUTE ALSO REPORTS A SIGNIFICANT NUMBER OF FALLS OCCURRING IN NON-HOSPITAL SETTINGS SUCH AS LONG-TERM CARE FACILITIES."

The Sentinel Event Alert recommends the following six steps for reducing falls:

1. Lead an effort to raise awareness of the need to prevent falls resulting in injury.
2. Establish an interdisciplinary falls injury prevention team or evaluate the membership of the team in place to assure organizational infrastructure and capacity to reduce injury risk from falls.
3. Use a standardized, validated tool to identify risk factors for falls.
4. Develop an individualized plan of care based on identified fall and injury risks, and implement interventions specific to a patient, population or setting.
5. Standardize and apply practices and interventions demonstrated to be effective.
6. Conduct post-fall management, which includes: a post-fall huddle; a system of honest, transparent reporting; trending and analysis of falls which can inform improvement efforts; and reassess the patient.

The suggested actions in the Sentinel Event Alert address all of the identified contributing factors to patient falls. The *Sentinel Event Alert* is available online at http://www.jointcommission.org/assets/1/18/SEA_55.pdf. ■

CNE INSTRUCTIONS

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CNE QUESTIONS

1. How did the team developing the Family Care Card at Baylor Jack and Jane Hamilton Heart and Vascular Hospital in Dallas determine the estimated time for surgical procedures?

A. They used published data on surgery times nationwide.
B. They analyzed data on surgeries performed at Baylor, determining the average time for each procedure and for each physician performing that procedure.
C. They did an informal survey of physicians.
D. They had OR nurses time the procedures for one week.

2. At what point are family members provided the Family Care Card?

A. At the "kissing corner" where the family must say goodbye before the patient enters the procedure room.
B. At the front door of the main entrance to the hospital.
C. It is mailed to them before the surgery date.
D. It is made available for download online.

3. According to Sue Dill Calloway, RN, AD, BA, BSN, MSN, JD, CPHRM, CCMSCP, president of Patient Safety and Healthcare Consulting and Education in Dublin, OH, which of the following is true of protocols?

A. CMS considers a notation like "trauma protocol" to be sufficient.
B. CMS does not expect you to state the elements of the protocol in the electronic chart.
C. CMS provides no guidance on how to indicate protocols in a patient's chart.
D. CMS expects you to state the elements of the protocol in the chart, rather than just writing that used a certain protocol.

4. In IOM's Report of the Committee on Diagnostic Error in Health Care, a conservative estimate found that what portion of U.S. adults who seek outpatient care each year experience a diagnostic error?

A. 2%
B. 5%
C. 10%
D. 15%

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general.
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

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