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INSIDE

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Patient Satisfaction vs. Quality Scores: What They Really Mean

Hospitals are in constant pursuit of both quality and patient satisfaction, and it is easy to assume that good marks in one will mean good marks in the other. That often is not the case, however, and hospital quality leaders must be careful not to assume correlation.

The importance of patient satisfaction has increased in recent years, particularly with the implementation of Hospital Value-Based Purchasing (HVBP), part of CMS' effort to link Medicare payment to a value-based system. Under the HVBP, hospitals are paid for inpatient acute care services based on the quality of care rather than just quantity of the services, with poorly performing hospitals receiving less reimbursement. Patient satisfaction is one of the metrics used to determine quality, via the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey, the first national, standardized, and publicly reported survey of patients' perspectives of hospital care,

There can be some overlap in the measures used to compute scores, such as Medicare's star ratings and HCAHPS, but the scores must be interpreted correctly, says **Emma Mandell Gray**, a senior manager at ECG Management Consultants, who specializes in care model transformation and performance improvement.

> THERE CAN BE SOME OVERLAP IN THE MEASURES USED TO COMPUTE SCORES, SUCH AS MEDICARE'S STAR RATINGS AND HCAHPS, BUT THE SCORES MUST BE INTERPRETED CORRECTLY.

Research has shown that there often is no correlation between patient satisfaction and hospital quality scores, but Mandell says that may be changing. *(See the story in this issue for more on the research.)* As the healthcare environment continues to transition toward value and patient satisfaction, and experience measures are being

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integrated into overall quality scores, additional emphasis is being placed on these areas, Mandell says. That will help to ensure a positive correlation between patient satisfaction and hospital quality scores, she says.

There are good reasons a hospital may have good quality scores and poor patient satisfaction scores, or vice versa, Mandell says.

"Hospitals are, oftentimes, a place where patients go as a last resort, admitted to the ED appropriately or not appropriately, and are a place where providers have to deliver difficult news to patients," she says. "Those participating in patient satisfaction surveys often only remember the outcomes of the situation, such as a death or a diagnosis of cancer, so the scores become skewed."

(See the story in this issue for more on the accuracy of patient satisfaction scores.)

Resource Use Can Affect Scores

Hospital quality scores, however, are often focused on improvements in health outcomes, readmissions, mortality, safety, and resource use. With regard to resource use, this may mean that providers are more mindful of prescribing unnecessary medications or conducting unnecessary testing, regardless of the patient's requestdemand to receive more medications or tests.

"If the provider does not comply because she or he may feel it is not necessary or quality care, then the patients may feel they are not being treated well and will report as such on their patient satisfaction survey," Mandell says. "Some providers, who may be doing well with patient satisfaction scores, may end up over-prescribing or over-treating, which then could result in negative quality scores."

In addition, hospitals are a fast-paced environment with staffing models that could be fairly lean, she says. The shift toward value-based care delivery is still fairly new and hospitals are now investing in the additional resources to ensure patients have the best experience while staying in the hospital. Mandell offers the examples of hospitals using care managers to help further explain treatment plans and get patients connected to resources once they are discharged, patient navigators to help patients through the system while in the hospital, and social workers or life coaches to assist with various community resources or social needs while in the hospital.

"The patient does not want to feel a rushed experience; rather, that they were attended to and their needs were met," Mandell says. "This is difficult in the historical, volume-based environment we have been part of for many years."

Mandell notes that hospital quality measures and patient satisfaction measures continue to be reassessed and evolve year after year, with the goal of identifying and prioritizing those measures that are most applicable and achievable. That analysis must take into consideration the value-based environment and patient population, she says.

"This conundrum of a negative correlation between the two should hopefully dissolve over the coming years as the healthcare environment continues to transform," Mandell says.

Subjective vs. Objective

For the time being, though, the two measures should be seen as completely separate tools, each useful in its own way but having no relation to each other, says **Shakil**

Haroon, CEO of MPIRICA Health Analytics in Bellevue, WA. The company analyzes hospital quality by focusing only on outcomes.

Patient reviews on public forums are particularly unreliable, he notes.

"We find absolutely no correlation between actual outcomes and patient satisfaction reviews, or other subjective reviews," Haroon says. "Using those subjective reviews to assess a hospital or surgeon's performance is extremely unreliable. We've seen numerous instances in which we've compared our scores to patient satisfaction scores like those on Yelp or HealthGrades, and the reviews have no correlation with reality."

Subjective reviews are generally easy to acquire and curate, Haroon says, so they have become useful tools for hospital marketing departments. The marketing campaigns often are misleading and intentionally imply a connection between patient satisfaction and quality that does not exist, he says. Haroon recalls one hospital system's marketing campaign boasting that 100% of its surgeons had at least a four-star rating, of a possible five, on satisfaction surveys.

"These corporations want to give the impression that their staff and facilities are uniformly excellent, but the facts don't support that assertion," he says. "Consumers need to know the difference between marketing and actual performance. If that information is kept from them, you create a situation that is extremely dangerous."

Quality Overstated by Marketing

Haroon and his colleagues have studied surgeons' publicly available qualifications, such as patient reviews and their educational background, alongside those surgeons' outcomes. The results can be surprising, he says.

"The marketing will talk about how the surgeon went to Harvard, is board certified, and has a 4.5-star rating on HealthGrades. You're presented with this information as if that's all you need to know about picking a surgeon," Haroon says. "When you look at the actual data, the number of procedures performed, and the outcomes, you might find that the Harvard guy has consistently delivered a low level of care over four years, whereas the surgeon with the more pedestrian background and a lower HealthGrades review has consistently delivered excellent outcomes."

Even when considering only

What Do Satisfaction Scores Really Mean?

Sometimes patient satisfaction scores are not even an accurate measure of how patients perceive the hospital, says **William Fletcher**, clinical outcomes analyst with Proliance Surgeons, a system of surgical practices based in Seattle. Unlike objective measures, a patient satisfaction score can be influenced easily, and usually in a negative way.

"We have found over and over again that the entire list of 25 questions on a patient satisfaction survey can be ruined if a patient has to wait 45 minutes in the waiting room," Fletcher says. "To that patient, everything was miserable. The doctor was awful, the front office was awful, the back office was awful. Everything was awful because they had to wait 45 minutes."

A long wait time is a valid complaint and has a place in measuring satisfaction, Fletcher says, but a problem like that can unreasonably affect the rest of the survey. The hospital needs to know that the patient was unhappy with the wait time, but it will be misled if the patient answered the other questions in a negative way out of anger.

"We have surgeons with the highest satisfaction scores I've ever seen, but their outcomes are not better than our other surgeons, at least not to any degree that the score would suggest," Fletcher says. "And we have other surgeons who, for whatever reason, just bottom out on patient satisfaction scores — they get horrible scores — and yet they're some of the best surgeons in the country."

Fletcher also notes that patient satisfaction is different from patient-reported outcomes, in which patients are asked how they fared after surgery. That is a valid measure of quality, though it can be influenced by subjective assessments to a lesser degree than satisfaction surveys, Fletcher says. Proliance uses patient-reported outcomes as a key measure of quality.

Proliance also relies on data on quality outcomes from sources such as MPIRICA and ProPublica, a non-profit news organization that publishes information on hospital quality, mostly derived from Medicare data.

"With those sources, we can get a much more accurate understanding of the quality of our physicians than we could ever get by asking patients if they were satisfied with their wait time and if the nurse explained the medication," Fletcher says. ■

SOURCE

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patient satisfaction and not overall quality, patient-derived scores usually represent a small fraction of a physician's patients, Haroon notes. That can be misleading if the score is based on as few as 10% of a physician's patient population, he says.

Haroon says hospitals should distance themselves from any metric that significantly underrepresents case volume and has no correlation with outcomes, he says. Many hospital leaders know from outcomes data and other objective measurements that their actual level of quality is not as high as patient reviews in their marketing campaigns suggest.

"I'd say they know exactly what they were doing. The use of patient surveys is self-serving and potentially dangerous," Haroon says. "There are hospitals that are paying fines and losing reimbursement because Medicare penalizes low quality, but they're still advertising that they have excellent-quality physicians and facilities across the board."

Scores Can Frustrate Clinicians

Putting too much emphasis on patient satisfaction reviews also can frustrate physicians and staff, says **Donald Fry**, MD, executive vice president for clinic outcomes management with MPA Healthcare Solutions in Chicago, and adjunct professor of surgery at Northwestern University Feinberg School of Medicine. Patient reviews are influenced by a range of factors, he notes, including many that have nothing to do with the actual medical care.

"Quality metrics actually are examining whether the measures of care and the outcomes of care were appropriate," Fry says. "Patient satisfaction and quality metrics are two independent variables in the overall scheme of what happens to patients in the hospital."

Patient satisfaction should not even be the purview of a hospital quality department, Fry says. The scores from patient surveys can be legitimate and useful, he says, but they have little-to-no bearing on the quality of medical care at the facility. They can be helpful in recruiting patients, so satisfaction scores should be the concern of marketing or another business-related department, Fry suggests.

That does not mean patient satisfaction ratings are unimportant, Fry says. Hospitals have a legitimate reason to measure patient satisfaction and act on any problems identified, he says.

"Treating people with respect and kindness, and having the conveniences in the hospital that they expect, will give them a favorable impression that they will pass on to friends and family, and remember when they need care," Fry says. "If I were a hospital CEO, I would have a great deal of interest in patient satisfaction. But patient satisfaction should not be a metric in measuring the hospital's quality of care." ■

SOURCES

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Research Shows Disparity with Quality, Satisfaction

The correlation between patient satisfaction scores, publicly available ratings, and clinical outcomes has been studied by many researchers, but they do not come to a consensus. Some say there is a positive correlation, while others say no.

Research from 2008 suggested that patient satisfaction is associated with improved treatment outcomes and correlated with higher quality hospital care "for all…conditions measured." The researchers used data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for the study reported in the *New England Journal of Medicine*.

"Patients' ratings of hospital care are of interest because they are, in many ways, 'the bottom line,'" the researchers said.

Hospitals received a rating of 9 or 10 from 63% of their patients and a rating or 7 or higher from 89%, the study report says. Only a small percentage of patients were seriously dissatisfied, the researchers wrote, but very few hospitals received the highest ratings from 90% or more of their patients.

There was a "moderate" relationship between the ratio of nurses-to-patient days and patients' experiences in the hospital, they found. The researchers reported a stronger relationship between patient satisfaction and quality.

"We found a positive relationship between patients' experiences and the quality of clinical care in U.S. hospitals. Although the differences in quality between hospitals that received high ratings on the HCAHPS survey and hospitals that received low ratings were not large, care was consistently better in the

hospitals that received high ratings across all conditions independently of other covariates measured," they reported. "Our findings suggest that there is no need for tradeoffs between these two areas of performance."

(The full study is available online at http://bit.ly/2d7hTOf.)

Website Ratings in Doubt

On the other hand, 2011 research from the University of Maryland's Robert H. Smith School of Business found no evidence associating online physician satisfaction ratings with clinical quality measures. The researchers used a sample of 1,299 physicians who completed an American Board of Internal Medicine Hypertension or Diabetes Practice Improvement Module between July 1, 2011, and November 30, 2012.

They used medical record abstractions and other data to determine overall and intermediate outcomes, and they obtained physician ratings from eight publicly available health-based websites. The researchers normalized the physician website ratings by dividing each rating by the website's maximum score.

The associations between physician website ratings and clinical quality measures (QMs) were small and statistically insignificant.

"We found no evidence that physician website ratings were associated with clinical QMs. We did find a statistically significant, but small, association between physician website ratings and 2 Practice Improvement Module measures of patient experience," the study says. "Overall, the weak associations we found could have resulted from the low number of website ratings per physician or because patients whose ratings are reported on websites are not typical of the overall population of patients treated by the physicians in our sample."

(The full study is available online at http://bit.ly/11U5zVO.)

In another study, researchers found that patient reports of clinical experience may differ significantly from what the surgeon reported. Surgeons and their patients individually reported surgical complications and their severity after spinal surgery.

"When patients reported complications, their surgeons also reported one only 29% of the time. Furthermore, 61% of the patients for whom surgeons reported a complication did not report a complication themselves. In other words, patients and their surgeons had very poor agreement on the fundamental question of whether the same surgery had resulted in a complication." *(The study is available online at http://bit.ly/2cCCTKW.)* ■

Include Patients, Family in Reporting Patient Safety Events

Hospital leaders are realizing that in the push to improve patient safety and quality of care, some valuable input is being overlooked. Patients and family members have not been involved in any formal way at most hospitals, and there is now reason to think that should change.

Patients and family have been absent from patient safety efforts mostly as an oversight rather than a deliberate effort to exclude them, says **Jeffrey Brady**, MD, MPH, rear admiral in the U.S. Public Health Service and director of the Agency for Healthcare Research and Quality's (AHRQ's) Center for Quality Improvement and Patient Safety. Healthcare leaders naturally focused on clinicians and other healthcare professionals because they are familiar with safety issues, and assumed laymen would not be able to contribute much.

"We've found that that really is not the case, that patients and family members have an insight that contributes significantly to improving patient safety," Brady says. "They are closer than anyone else to the care of the patient, so they have knowledge of symptoms, treatments, and oversights that may be different from what the clinician observes, or may add information to a known safety issue."

Patient and family input is an important component of patient safety efforts because some safety concerns would not be detected otherwise, Brady says. That is particularly true with outpatient services because there usually is less surveillance in that setting, he notes. Even when a patient safety issue already is known by the healthcare provider, patient input can add details that aid the analysis.

"It's not that we expect all the reports from patients and family members to be news to the healthcare provider, something that they were completely unaware of," Brady says. "Often, it's going to be information that supplements what you're already doing to address a safety issue. It may be a perspective you had not considered, or it could contribute to your understanding of how widespread the issue is."

AHRQ addressed the issue in its Health Care Safety Hotline project, designed to actively involve patients and their families in reporting patient safety issues. The hotline allows patients, family members, and caregivers to report patient safety problems, including errors and adverse events, on a secure website or by calling a toll-free phone number. A recent AHRQ report explains how they sought the patient perspective and what the experience means for hospitals with the same goal. *(The report is available online at: http://bit.ly/2dtVhqs.)*

The report notes the perspective of patients and families has been documented in the past.

"In an early study, Weingart and colleagues found that 8% of inpatients reported adverse events, and 4% experienced 'near misses.' Importantly, none of these events were documented in the hospital's adverse event reporting systems," the report says. "In the largest study of its kind, Weissman and colleagues compared patient reports with medical records and found that 23% of the study patients had at least one adverse event detected by interview, and 11% had at least one adverse event identified by medical record review. Two-thirds of the adverse events were detected by patient interview alone, demonstrating that patients could identify adverse events of which the hospital was unaware." *(See below for the studies referenced.)*

A hotline was theorized to be the best way to collect information from patients and family. Previous research was based on interviewing patients and noting whether they reported safety concerns as part of their healthcare experience, a method that yielded some valuable information but which was considered too cumbersome and time-consuming to employ on a large scale, Brady explains.

"Establishing a hotline and encouraging people to report their safety concerns is a more proactive and patient-centered method for getting to this information," Brady says. "Rather than having a small subset of patients interviewed, this approach opens the reporting system to any patient or family member with a concern. The hotline, and the information promoting it at the hospitals, sent the message that we respect your input and we want to hear your concerns."

Hospitals Promoted Hotline Availability

When the pilot project launched in February 2014, the researchers and participating hospitals promoted the availability of the hotline with posters throughout the facilities and brochures available in lobbies and at registration desks. In addition, 4-by-9-inch cards placed throughout the hospital and provided to individuals on admission. folded business cards,

AHRQ researchers recognized several challenges from the start, Brady says. One concern was that patients and family would respond too much and burden the staff with reports that were not significant or valid patient safety issues. Closely related was the concern that patients and family members would not have the clinical or patient safety background to understand safety issues, which could result in both underreporting and overreporting.

AHRQ tested the system in two hospitals for 15 months with mixed results. Patients and family members did not report as many issues as expected on 37 reports during the pilot project. Projects on a smaller scale also have yielded low participation rates. *(See the story in this issue about a hospital's attempt to get more patient and family input.)*

Nevertheless, Brady says the researchers found those reports did provide information that might otherwise have been overlooked.

About 25% of the reports cited involved communication issues, consistent with how clinicians know that is a primary cause of patient safety failures. Other reports cited safety concerns with the healthcare environment, care coordination, process or documentation issues, and problems when being discharged. Twenty-three of the 37 reports affected the patient, as opposed to an observed condition that did not affect the patient. Examples of the reported issues included mistakes involving a prescription drug or a test, errors in diagnosis or advice from a clinician, and poor cleanliness or hygiene.

Nearly half of the issues cited in the reports resulted in harm, with the harm categorized as mild according to the scale for grading harm that is a component of the AHRQ Common Formats, used to standardize reporting of patient safety events.

During the two-year run of the pilot program, the AHRQ researchers modified some details of the hotline website to clarify and standardize some terms and also improve the overall appearance. The researchers also added a request for permission to share the reporter's name with the relevant healthcare organization, and they increased the number of words that could be used in the narrative text box. *(See the story in this issue for lessons learned during the project.)*

The pilot project supported the idea of including patients and family in safety efforts, Brady says.

"Some of the concerns from the beginning of the project were shown to be not as significant as feared, particularly the idea that including patients and family in this proactive way would result in a number of

reports that overburdened staff but produced no valuable information," Brady says. "We found that patients and family members actually reported less than expected, and what they did report was legitimate and useful for improving patient safety." ■

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Lessons Learned from Patient Safety Hotline

The Health Care Safety Hotline project yielded lessons about how the details of a website can influence participation and the quality of information submitted, says **Jeffrey Brady**, MD, MPH, rear admiral in the U.S. Public Health Service, and director of AHRQ's Center for Quality Improvement and Patient Safety.

"This was a work in progress, and the researchers were always on the lookout for ways to improve the hotline and make it more user friendly," he says. "The website and the marketing materials were changed as they identified issues, often very small things, that could be changed to make the hotline more effective and more efficient."

These were some of the lessons learned and improvements made:

- Minimize the use of words like "safety" and "error" because they can suggest that you are only interested in serious adverse events. Using words like "concern" will encourage users to submit a wider range of issues.
- The hospitals moved from providing the brochure at admission to day two of the hospitalization because patients often are too stressed to read everything in the packet when admitted. For the same reason, the hospitals started including promotional material in discharge packets because patients may reflect on the experience after discharge and decide to report a concern.
- Remind patients about the hotline in follow-up calls a few days after discharge.
- Avoid the term "investigator," as in "an investigator will look into your concern," because users may think you mean a government investigator.
- Emphasize that people can report anonymously.
- Clarify that reporting a concern will not result in any sort of retaliation against the person reporting.
- Stress that the purpose of the hotline is to prevent future safety issues and the report will not get clinicians or other staff in trouble.
- Make it clear that family members and other caregivers can use the hotline. ■

Hospital Tries Reporting Project, but Few Takers

Efforts to include patients and family members in reporting safety issues don't always work, as the staff at Dana-Farber Cancer Institute in Boston recently discovered.

The hospital launched a webpage encouraging people to report concerns, but spokesperson **Ellen Berlin** says there were very few reports.

"It turns out we didn't have much success with the program," she says. "We are not really sure why, but patients didn't respond. We suspect that our patients have a lot going on and this wasn't top of mind for them, nor was it the best way to collect the information. We do hear from patients when they are here, but we learned this system wasn't the best way to reach them."

The form is still available on the hospital's website at *http://bit.ly/2dllHpj,* but Berlin says they do not expect any increase in participation.

The Patient Safety Reporting Form states, "Patient safety is a top priority at Dana-Farber. While your care team takes responsibility for ensuring your safe care, we've found that patients and their families can teach us things that we didn't know. This helps us create the safest possible care."

The form continues, "You may have ideas about things we can do to improve patient safety. If you have experienced something that seemed risky or caused you harm, or if you noticed something that you think is unsafe, we want to hear about it." It also notes that the reports are confidential and explains that, even if a staff member has already reported the concern, the patient or family member may have a different viewpoint, noticed other details, or have suggestions for improvement. ■

SOURCE

- Ellen Berlin, Director of Media Relations, Dana-Farber Cancer Institute, Boston. Telephone: (617) 632-5357. Email: ellen_berlin@dfci.harvard.edu.

Nurses' Project Improves Handoffs

A nursing initiative to improve patient handoffs began by addressing the root cause of poor transitions from the ED to the ICUs: The nurses didn't know each other very well, and weren't concerned with how their actions affected their counterparts on the other unit.

The ED at South Shore Hospital in South Weymouth, MA, has the second-highest volume of patients in the state of Massachusetts, with frequent ED-to-ICU handoffs. But they weren't going smoothly a few years ago, according to **Lisa Nolan**, RN, AD, a nurse in the surgical ICU (SICU), and ED nurse **Nicole Howley**, RN, BSN.

"Throughout the entire hospital, and any hospital I've ever been in, it's difficult to move a patient from the emergency room to anywhere else," Howley says. "It's kind of a push-pull because we want them to pull the patient up if they have a room, and they're busy with their patients."

Over the years, an animosity built up between the ED and ICU nurses, with rumors and accusations about how one department or the other was at fault, Howley says. Poor handoffs were common as both groups grew frustrated and less cooperative.

"We were a little overwhelmed when we starting looking into handoffs because a lot of the culture of the institution plays into the problem," Howley says. "There was a lot of history behind what we were trying to change. The expectations on both sides had become a little unrealistic."

Poor handoffs and patient safety incidents traced to them were common. As part of a quality improvement program offered by the American Association of Critical-Care Nurses (AACN), Nolan and Howley developed a program to improve handoffs. They first had to identify the causes of the process failure, and the most obvious factor was the lack of a formal structure for reporting and handing off patients. They also determined that poor handoffs were caused by each group of nurses not understanding the others' workload, workflow, and priorities, which resulted in a strained relationship.

They also observed that nurses trying to transfer or receive patients were often interrupted when exchanging information. Nurses also reported that the heavy volume of patients left them feeling always rushed and forced to sacrifice some handoff concerns.

Nolan and Howley developed a quality improvement program and set the primary goal as standardizing handoff communication by using the Situation-Background-Assessment-Recommendation (SBAR) format. *(More information on SBAR is available online at http://bit.ly/2daqZpm.)* Another important task was improving the relationship between the nursing groups.

The project began with a survey of ED and ICU nurses, which helped pinpoint the problem. *(See the survey in this issue.)* They realized that much of the antagonism was the result of nurses not knowing or understanding their counterparts, Howley says. If they could get the groups to know each other and understand each other's situations, they thought that alone would improve the handoff process. Nolan and Howley began by switching jobs for a day so they could see the demands and workflow of each other's departments.

That opened their eyes to how both sides of the handoff process had misconceptions or false impressions of what was going on in the other department. They saw that when everyone was rushed and pressured, it was easy to attribute problems to the other side's bad motives, Howley says. Nurses working EDs and ICUs tend to have strong personalities, Nolan says, which made confrontation and criticism the frequent response to a transfer problem.

"When everyone is stressed, everybody thinks they're working harder than the next person because they don't understand the demands the other person is facing," Nolan says. "It's easy to be self-absorbed and think of only your own work. We're so busy that we're always Code Red and people in the ED get focused on moving those people out, without understanding why they can't sometimes. Likewise, the ICU nurses didn't understand why the ED nurses were pushing so hard."

No Criticizing Others

Both nurses reported back to their colleagues about what they learned, and encouraged them to do the same. After some nurses had made the switch for a day, the effects were immediate.

"Putting a face to a person changes everything," Howley says. "It's a lot harder to get angry with someone when you know them as a person, someone who is doing the best they can, rather than just a voice on the other end of the phone."

Howley and Nolan both made a conscious effort to tamp down criticism of the other departments, reminding their colleagues that the nurses on the other floor were nice people doing their best. They were all trying to do good for the patients, they said, so everyone had

to find a way to work together.

"I would say, 'Don't talk bad about the ICU' and she would say, 'Don't talk bad about the ED,' Howley says. "We just kept saying that we had to try to be nice and figure out why your situation is not going well. A lot of the time, we could get the nurse to see the other person's point of view."

They also encouraged nurses to take their patients to the other unit themselves rather than having someone else do it. While not always possible because of the workload, the face-to-face interaction goes a long way toward maintaining mutual respect, Howley says.

Orientation Includes Shadowing

The hospital also began requiring nurses at orientation take the time to walk in each other's shoes, Nolan says. During the orientation process, each nurse spends one day shadowing a nurse in the ED or ICU, whichever one is not the one in which they'll be working. Nolan suggests this is perhaps the best move a hospital can make to build relationships and understanding of each other's workflow.

To encourage more interaction between the groups of nurses, Nolan and Howley hosted a mixer and chose a football theme because it was during football season. Their chief nursing officer was supportive and approved a budget for an off-site get-together. They named the project: "Tacking Communication: Don't Fumble the Handoff!"

They invited the ED and ICU nurses and got a good turnout. To keep the groups from huddling together with their own co-workers, Howley and Nolan made sure each table had a mix of nurses from the departments. Each nurse got two drink tickets and there were appetizers and desserts available, because "nurses always respond pretty well to free food," Nolan says. The event started with ice-breaker games, and then a video demonstrating a good handoff and a bad handoff. The video parodied the animosity that an ED nurse and ICU nurse both might experience in a handoff.

SBAR and Checklist Used

After almost a year of team-building, Howley and Nolan turned their focus to improving the use of SBAR at South Shore. The hospital had implemented the system already, but it was not being used consistently. Howley and Nolan, along with nursing management, encouraged the consistent use of SBAR in every handoff and the nurses cooperated better because they knew each other, Nolan says. Both groups were using SBAR every time, so there was no frustration with one party not cooperating, she says.

The hospital also began using a transfer checklist to ensure procedures were followed and the departments cooperated with each other. *(See the checklist in this issue.)*

Though the formal project has ended, Howley and Nolan are continuing to encourage good relationships between ED and ICU nurses and the consistent use of SBAR.

Measuring success for the project was challenging because there were few statistics, so Howley and Nolan relied mostly on incident reports that involved handoffs. In the month the project first started, South Shore had 10 incident reports involving handoffs. In the same month two years later, there were zero. With the Association of periOperative Registered Nurses reporting that medical errors cost an average of $8,750 per patient, Howley and Nolan calculated that the project was saving $87,500 per month and $1,050,00 per year.

"We've presented the project results at an AACN nursing conference and got a very good response," Nolan says. "It seems this is problem that is familiar to a lot of hospitals." ■

SOURCES

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- Nicole Howley, RN, BSN, Emergency Department, South Shore Hospital, Chicago. Email: nicole_howley@sshosp.org.

Survey and Checklist Help Improve Handoffs

To kick off their project to improve handoffs at South Shore Hospital in South Weymouth, MA, **Lisa Nolan**, RN, AD, a nurse in the surgical ICU, and ED nurse **Nicole Howley**, RN, BSN, began with a survey to help them find the root causes of poor handoffs.

They sent a survey to the ICU and ED nurses, and 30% responded — a rate higher than expected. The survey used these questions:

- Which unit you do you work on? (ICU or ED)
- Do you typically review online documentation prior to giving/receiving reports (i.e., labs, VS, meds, history, etc.)? (Yes/No)
- Is the SBAR report format typically used when giving/receiving report? (Yes/No)

- Which system barriers have you experienced that impede giving/receiving report? Select all that apply. (Background noise, frequent interruptions, insufficient staffing, insufficient time to devote to handoff, nurse giving/receiving report is not prepared.)
- Thinking of your most recent handoff, was there mutual respect and courtesy demonstrated over the phone? (Yes/No)
- Please feel free to add any additional comments or concerns below. All information will be kept confidential.

The South Shore team also developed an ED/ICU Transfer Checklist to ensure proper procedures are followed and to identify any lack of cooperation between departments. The following is the checklist nurses complete after report and patient transfer to ICU:

ED:

1. When you called the ICU to give report, were you connected to the nurse the first time?
2. Did you follow the SBAR format when giving report?
3. Were you interrupted at any point giving report by the receiving RN?
4. Were you able to answer all questions asked by the receiving RN?
5. Did you as the primary RN accompany/transfer patient to the unit?
6. Were you met in the room by the primary RN receiving the patient?

ICU:

1. Did you have to call the ED nurse back to receive report?
2. Was report given in SBAR format?
3. Were there any questions you asked that were unanswered by the ED RN?
4. Did you review the "special panels" page or any other patient information online before or during report?
5. Did the nurse you received report from transfer the patient to the unit themselves?
6. Did the patient arrive to the ICU as you expected based on the report you were given?
7. Did you greet the patient in the room upon transfer from the ED? ■

Nearly All Wrong-Patient Errors Preventable

Most, and possibly all wrong-patient errors are preventable, according to a recent report from ECRI Institute PSO in Plymouth Meeting, PA.

Errors in patient identification mistakes are usually discovered before they can harm the patient, but can result in patient deaths when they do cause harm, ECRI reports in *The ECRI Institute PSO Deep Dive: Patient Identification*. ECRI estimates that 9% of the events led to temporary or permanent harm or even death.

The findings are based on thousands of patient error reports, according to a statement announcing the results. ECRI researchers studied more than 7,600 wrong-patient events occurring over a 32-month period. The events were voluntarily submitted by 181 healthcare organizations, and may represent only a small percentage of all wrong-patient events.

The following are some of the key findings:

- Patient identification errors can occur almost anywhere in the healthcare process, including patient registration, electronic data entry and transfer, medication administration, medical and surgical interventions, blood transfusions, diagnostic testing, patient monitoring, and emergency care.
- Errors occur in every healthcare setting, from hospitals and nursing homes to physician offices and pharmacies.
- Any healthcare professional or staff member can make a wrong-patient error.
- In many cases, the patient identification error affects two or more people. ECRI cites the example of a patient receiving a medication intended for another patient. In that case, both patients can be harmed.

A summary of the report is available at: www.ecri.org/patientid. ■

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log onto AHCMedia.com, go to "My Account" to view your available continuing education activities. *First-time users must register on the site.*
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4. After completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE QUESTIONS

1. According to Emma Mandell Gray, how can efforts to limit resource use lead to poor satisfaction ratings?

a. Patients may be unhappy if the doctor does not prescribe drugs they want.
b. Hospitals may cut back on how much and how often they survey patients.
c. Hospitals may reduce marketing.
d. Patients may worry that the hospital is in financial trouble.

2. What does Shakil Haroon, say about the correlation between patient satisfaction scores and quality scores?

a. There is a very strong correlation.
b. There is absolutely no correlation between actual outcomes and patient satisfaction reviews, or other subjective reviews.
c. There is a strong correlation, but only in certain healthcare fields.
d. There is a correlation only when patient satisfaction scores are high.

3. Which of the following is true of the AHRQ hotline project?

a. The response was higher than expected.
b. The response was lower than expected.
c. The information provided was of no use.
d. The information provided was old and the problems had been addressed.

4. At South Shore Hospital in South Weymouth, MA, what was a key reason for poor handoffs between the ED and ICU?

A. Outdated communication methods.
B. Delays related to patient privacy.
C. Poor relationship between nurses in the departments.
D. Time limits imposed by administration on the handoff process.

COMING IN FUTURE MONTHS

- Changes in Joint Commission surveys
- Home visits to reduce readmissions
- Most common survey problems
- Hospitals reduce hospital-acquired conditions 40%

CE 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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