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Restrict subspecialists to their own field or risk quality problems

New study raises serious concerns about patient safety

How many subspecialists do you have working outside their field, treating patients either just to stay busy or because you don't have enough physicians to handle the load?

Subspecialists caring for patients outside their specialties pose a significant risk to patients, according to worrisome new research, and experts are urging hospital quality professionals to take immediate steps to restrict the most dangerous types of care. Quality assurance leaders may have to take some difficult steps that physicians will resist, they say.

Scott R. Weingarten, MD, MPH, a researcher at Cedars-Sinai Medical Center in Los Angeles, was the lead author on a recent study that confirmed what many quality assurance leaders have suspected for years. Subspecialists may be an asset when they work in their own fields, but they are a risk to patients when they work outside their specialties.[1]

Previous studies have shown that subspecialists can provide better quality care than primary care physicians when working within their subspecialty for patients with some medical conditions, Weingarten says. However, many subspecialists care for patients outside of their chosen subspecialty.

These latest study results show that their patients are at risk, Weingarten tells *Hospital Peer Review*. "The results show that quality of care may vary between types of physicians in a meaningful and clinically important way," he says. "These results call attention to the importance of hospitals monitoring quality of care for different types of physicians."

That conclusion is endorsed by **Martin Merry**, MD, a health care quality consultant and associate professor of health management and policy at the University of New Hampshire in Exeter. He says quality professionals have long suspected there was a problem with subspecialists working outside their field, but this study shows the problem is worse than he had imagined. "I've seen other research suggesting this, but now we have to say it's true," Merry says. "More and more materials are revealing the

dirty little secret in health care, that to allow an MD or a DO to do anything he wants to do just because he has the credentials after his name is not good for the patient."

In their recent study, Weingarten and his colleagues used severity-adjusted mortality rate and severity-adjusted length of stay as indexes of quality of care. They collected data from 5,112 hospital admissions (301 different physicians) for community-acquired pneumonia, acute myocardial infarction, congestive heart failure, or upper gastrointestinal hemorrhage at six hospitals in the greater Cleveland area.

The data indicated that subspecialists working outside of their subspecialty cared for 25% of hospitalized patients. When the researchers compared patients cared for by subspecialists practicing outside of their subspecialty, the problems were readily apparent. Severity-adjusted lengths of stay were 23% longer for patients with congestive heart failure, 22% longer for upper gastrointestinal hemorrhage, and 14% longer for community-acquired pneumonia than for patients cared for by subspecialists practicing within their subspecialty.

The analysis also revealed that patients had a slightly higher hospital mortality rate when cared for by subspecialists practicing outside of their specialty than by those practicing within their subspecialty.

Even when compared to general internists, the subspecialists fared poorly outside of their specialty. Patients cared for by subspecialists practicing outside of their subspecialty had longer lengths of stay, and prolongation of stay was observed for patients with congestive heart failure (16% longer), upper gastrointestinal hemorrhage (15% longer), and community-acquired pneumonia (18% longer) than patients cared for by general internists.

Weingarten, et al, conclude, "subspecialists commonly care for patients outside of their subspecialty, despite the fact that their patients may have longer lengths of stay than those cared for by subspecialists practicing within their specialty or by general internists. In addition, such patients may have slightly higher mortality rates than those cared for by subspecialists practicing within their subspecialty."

Merry says he was surprised to see that subspecialists cared for 25% of the patients in the hospitals studied; he didn't know the practice was that common. He says quality professionals should take notice of the study results and the implications for credentialing and privileging in hospitals, even though he doesn't find the researchers' other conclusions surprising.

"This is not rocket science. When we look at patient care outcomes, we find that physicians do best at what they're trained to do," Merry says. "Anybody with common sense has known that a lot of physicians haven't been busy enough in their own specialties, and they get outside of it for economic reasons. And they don't serve their patients well there."

Restrict physicians to protect patients

Weingarten and Merry agree that hospitals should take steps to protect patients from subspecialists practicing outside of their fields.

The first step, Weingarten says, is to conduct in your own facility a quality of care study similar to the one he did. The results probably will confirm the study results and will provide specific information about subspecialists and treatment areas that need your attention, he says. "I think that hospitals should consider monitoring the quality of care of subspecialists who are practicing outside of their subspecialty," Weingarten says. "In cases when objective and clinically meaningful evidence of substandard care is demonstrated, hospital credentialing committees must decide upon the best course of action."

Hospitals must act on this information to protect patients, Merry adds. The necessary action is likely to upset some physicians, he says, but the "credential committee has to get serious about the notion of developing specialty-specific profiles and incorporate them more rigorously."

Merry advises *HPR* readers to check into the policies and procedures currently in place to determine what, if any, restrictions there are to keep subspecialists from practicing outside their fields. Don't be surprised if you find that

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there are few restrictions, he says.

Next, you should investigate how your overall scope of care compares to the number and type of physicians who are credentialed at your hospital, Merry says. How much gastroenterology are you doing, for instance, and how much cardiology? What does your specialist cadre look like?

"Ask yourself, 'What is our supply of cardiologists, and how does that compare to how many cardiology patients we get? Do we have a shortage so that other specialists are forced to practice outside their specialties? Or if we have plenty of cardiologists around and we still have a gastroenterologist practicing cardiology, then we have a real credentialing and quality issue here,'" Merry says.

Once you have assessed your own situation, possibly by analyzing outcomes data, credentials committees must enact strict rules that ensure subspecialists only practice outside their fields irregularly, when necessary because of physician shortages, Merry says. And even then, some restrictions should be carved in stone.

"It should be just like it is in surgery, with everyone knowing that just because you're a surgeon you can't do anything you want in the OR," he says. "You're not going to let a general surgeon schedule a craniotomy. The OR scheduler just wouldn't let it happen. You should have the same sort of procedures in medicine."

Preventing the problem may not be easy in the short run, Merry says. If you have subspecialists working outside their fields just because you don't have enough physicians on hand, remedying that situation could take time.

But Merry says you would be well advised to take whatever steps are necessary, and you must brace yourself for an inevitable flurry of complaints by subspecialists.

"We're learning more and more about how there is not a good match between the supply of physicians and the needs of patients," he says. "We might have to redesign systems, and that might include limiting the scope of what physicians are allowed to do. Maximum freedom for providers is not necessarily what is in the best interest of the patient."

Reference

1. Weingarten SR, Lloyd L, Chiou C, et al. Do subspecialists working outside of their specialty provide less efficient and lower-quality care to hospitalized patients than do primary care physicians? *Arch Intern Med* 2002; 162:527-532. ■

Reader Question

Emergency credentialing helps disaster response

But don't go overboard, expert advises

Question: Like many hospitals, we're trying to improve our emergency response plan in light of last year's terrorist attacks. We've heard suggestions that we should have an "emergency credentialing plan" for physicians who are not affiliated with our hospital but show up in an emergency and want to help. Is this necessary or beneficial? How would we set up something like that?

Answer: An emergency credentialing system can be a good addition to your emergency response plan, but don't go overboard with it, says **Fay Rozovsky**, JD, MPH, DFASHRM, a risk management and quality consultant. She is senior vice president of the March HealthCare Group in Richmond, VA.

The Sept. 11 attacks prompted many hospital leaders to question their preparations for a large-scale disaster, and emergency credentialing is an issue that falls squarely in the laps of quality and peer review professionals. In the New York attack, hospitals accepted help from hundreds of physicians who volunteered their services for expected victims. Many of those physicians went home without ever touching a patient because the flood of victims never materialized.

Nevertheless, the situation has led many to wonder whether the medical staff office should have a policy for credentialing physicians who are not members of the hospital's medical staff or privileged at the facility.

It is a good idea to have a simple system in place, Rozovsky says, but she cautions *Hospital Peer Review* readers against the notion that they could do true credentialing in the midst of a disaster. For practical reasons, it wouldn't work. "If we were ever in a situation like New York, with phones jammed and phone lines reserved for emergency use like ordering blood, how in the devil does one do emergency credentialing?" she asks. "You won't be able to call Albany. Relying on a book published months ago doesn't guarantee anything. When we're talking about a true catastrophe of such magnitude that it's overwhelming and lives are in the

balance, you have to look at the emergency exceptions to every rule that requires credentialing."

The law and most federal regulations allow for good Samaritans and emergency conditions, Rozovsky says. Even those that don't explicitly state an emergency exception can safely be interpreted to allow one under true disaster conditions in which a hospital needs every available physician. "That's what a disaster is all about," she says. "The normal rules don't apply because they just can't apply."

That does not mean, however, that you should just open the front door and let in anyone who claims to be a physician. How much credentialing you can do depends on how much time and manpower you have to spare. For a routine sort of mass-casualty incident, such as a bus accident, you should try to stick with your credentialing program and verify any physician's qualifications before allowing him or her to treat a patient. But on the other end of the spectrum, with a catastrophe, you may have to be satisfied with much less.

At a minimum, ask for identification from anyone volunteering his or her services as a physician. A good addition to a disaster plan, Rozovsky suggests, would be a system in which volunteer physicians are directed to a medical staff office where they can show identification and some type of physician verification. If more information is available, such as a certificate of malpractice insurance, record that information also. The medical staff office could photocopy their identification cards and provide a badge designating that they have checked in with the hospital. "Asking to see their identification and state licensure card is not really credentialing. It's more like granting temporary privileges," Rozovsky says. "But that may be the most you can do if there are lots of hurt people outside waiting for help."

At a minimum, gathering the physicians' identification allows for follow-up after the event. She also suggests that a hospital's disaster plan should include training staff on how to work with volunteer physicians. If possible, it is best to pair the volunteer physician with a physician or nurse from your own facility, she says. That way, the in-house staff member can help the volunteer with unfamiliar surroundings and procedures. Pairing a volunteer with a staff member also allows the volunteer physician to be watched. "The volunteer physician should be limited in the scope of care he provides. If he says he's a neurosurgeon, don't let him go in the operating room and start working on someone's brain," she says. "If a staff member sees the volunteer doing anything unusual or going beyond that basic care level, a stop sign should go up. You should encourage staff to speak up if they're not comfortable with what they see."

Liability is not a big concern in such a situation, Rozovsky explains, because you can show that you were acting in good faith and the situation was extraordinary. Nevertheless, she advises contacting your risk manager and possibly your insurer for their input on any emergency credentialing policy. "We're not talking about getting lax just because your emergency room is busy one night," she says. "But I have to believe that the people who survived those towers coming down in New York, as badly injured and burned as they were, just wanted a doctor. They didn't want someone keeping the doctors outside because they couldn't check their credentials. Sometimes, we just have to be practical." ■

ICU care improves with intensivists, initiatives

Use of restraints minimized

When quality improvement leaders at the M.D. Anderson Cancer Center at the University of Texas in Houston decided to improve patient safety in the intensive care unit (ICU), they found that some necessary changes could be done at little cost, while others needed a huge budget. But the overall quality improvement project yields lessons

for any hospital, they say.

M.D. Anderson is a well-known cancer center, with 518 beds, including an ICU with 42 beds and a staff of 160. In 2001, the ICU experienced 1,467 admissions, 9,183 patient days, and an average daily census of 28 patients. In 2000, the hospital's office of performance improvement decided to target the ICU for a study of process improvement. The office is made up of the departments of quality improvement and the academy for performance improvement, both focused on promoting continuous quality improvement in patient care, research, clinical education, and cancer prevention.

The ICU was a natural target for the office's process improvement efforts, says **Sherry Martin**, MD, associate vice president for process improvement in the department of quality improvement. She tells *Hospital Peer Review* that patient care in an ICU is inherently costly and unsafe, noting that the Washington, DC-based Leapfrog Group reported in November 2000 that approximately 500,000 patients die in ICUs each year. "A new critical care unit was built at M.D. Anderson in 1999, so that provided the opportunity to create a new environment in the ICU that would ensure safer practices at lower costs," she says. "With the Leapfrog report drawing attention to the issue, we saw an opportunity to improve our ICU care."

Intensivists added, restraints minimized

The quality improvement staff teamed up with representatives from the ICU to conduct an extensive analysis of the ICU's operations and patient outcomes. The team was led by **Thomas Feeley,** MD, division head of anesthesia and critical care, and **Lee Parmley**, MD, ad-interim chair of critical care at the hospital. The team devised a multipronged approach to improving operations in the unit. The first step was to rename the ICU. It is now known as the critical care unit (CCU). These are the other changes implemented recently:

• **Use of intensivists.** The hospital changed the CCU's physician model so that medical care is provided by or in conjunction with intensivists, physicians devoted exclusively to management of critically ill patients. The six intensivists are physicians who are board-certified in anesthesiology, surgery, or internal medicine and have subspecialty training and board certification in critical care medicine. "This system replaced a prior staffing model in which CCU patients were managed by the primary admitting service with assistance from consultants when requested," Martin says.

The new physician group provides two intensivists each week, Parmley says. One group covers medical patients, and the other covers surgical patients. Each attending conducts rounds on his or her respective patients with a multidisciplinary team composed of critical care fellows, anesthesiology residents, medical students, and one or more critical care nurse practitioners or physician assistants, a dietitian, pharmacist, social worker, respiratory therapist, and charge nurse. The team participates in a presentation of each patient and, together with the intensivist, develops the day's treatment plan.

"A physician representative remains present in the CCU 24 hours a day, and the intensivist is available to the CCU nursing staff and in-house physician 24 hours a day and can be at the bedside in less than 30 minutes if called," Parmley says.

• **Nurse management.** To provide nursing leadership 24 hours a day, the hospital established three additional nurse management positions in the CCU. In addition, two clinical nurse specialists were added to provide sophisticated clinical management support to the nursing staff. Continuous quality management was a key goal for the team, so they reconfigured positions to provide data management and financial functions and improve communication.

"Minimizing cost was also a goal of the team," Martin says. "Therefore, after studying the personnel cost data, [team members] determined that elimination of agency nurses and float pool would not only improve the quality of care but would save money. The team implemented aggressive hiring techniques to maintain the core staff levels."

• **Team building.** The hospital hired a consultant to help the CCU team create a mission statement and conduct team-building sessions. The sessions were directed by the nurse leadership and focused on establishing consistent policies and procedures.

• **Pain management.** The team paid special attention to pain management in the CCU because it is such a priority for critically ill patients. The team audited charts for documentation of pain scale scores and found only 76% compliance with policies requiring pain assessment on every admission and every two hours thereafter. When the team investigated, it found that nurses often attempted to assess pain but found the standard pain scales useless when patients were unable to verbalize their pain levels. Further investigation of pain management literature revealed that a

nurse's estimation can correlate closely with a patient's reported pain level.

"So the team modified the procedure to allow nurses to use criteria-based estimation when the patient is unable to respond," Martin says.

• **Patient satisfaction.** The quality improvement team considered patient satisfaction an important indicator of quality in the CCU, so it developed an assessment tool. The survey tool contains questions about the adequacy of information given by the physicians and staff, pain management, courteousness of the physicians and nurses, visiting hours, and cleanliness of the waiting area. A volunteer gives the survey to a family member once a week, and a quality team member in the CCU tallies the results.

With the survey results, staff are able to intervene with problems while the patient is still in the CCU, Martin says.

• **Restraints.** Restraint use is common in any CCU to prevent patients from extubating themselves or interfering with monitoring devices, but the quality improvement team wanted to ensure that restraints were used judiciously and as little as possible. The team collected data for three months examining the duration of restraint, type of restraint, reason for restraint, and correlation to self-extubations. The analysis helped the CCU develop new standards for restraints that minimized their use, and after the implementation of the new system, all restrained CCU patients were audited for three months.

• **Nosocomial infections.** The incidence of ventilator-related pneumonia from December 1999 to July 2000 was 5.8 per 1,000 vent days in the CCU, which was on the high end of the national averages, Martin says. The quality improvement team saw an opportunity for improvement and found that, within 48 hours of hospital admission, the oropharynx of the CCU patient changed from mostly gram-positive organisms (normal mouth flora) to predominately gram-negative organisms, many of which are pathogens. Therefore, the team focused on better oral care. They added a dental oncologist and respiratory therapist to the team, with the goal of developing a standard procedure for oral care with respect to technique, products, and frequency. The team developed a comprehensive policy on oral care and taught the nursing staff and respiratory therapists.

• **Antibiotic-impregnated catheters.** Central venous catheters are integral to the treatment of critically ill patients, but they are the leading cause of primary bloodstream infection. To reduce the rate of infections, the quality improvement team introduced the use of central venous catheters impregnated with minocycline and rifampin.

• **Medication errors.** Medications for critically ill patients typically are numerous and complicated, increasing the risk of error. Most patients are seen by several physician specialists, resulting in a multitude of medication orders. Quite often, Martin says, the CCU staff was not sure if certain medication orders needed to be continued, discontinued, altered, or whether there was any conflict among the multiple orders.

"The team established a new procedure in which physician order forms are pre-printed each Monday with the patient's medications," she says. "The intensivists and the primary team jointly review the medications and reorder only those that are required, thereby discontinuing some medications more rapidly. In addition, the team identified the most high-risk medications and developed protocols for their administration."

Positive outcomes, but at a cost

Martin says the quality improvement team's work yielded substantial improvements in the CCU. Mortality in the CCU decreased from 22% in 1998 to 15.5% in 2001. The average length of stay decreased 18%, from 5.5 days to 4.5 days. She also says the improvements, especially the new staffing models, led to more content employees and decreased personnel turnover rates. The average turnover per month was 3% in 2000, but it decreased by 63% to 1.12% in 2001.

Pain-assessment documentation increased 49% over a three-month audit period. The patients' family satisfaction surveys yielded mostly high scores for the CCU, but they also highlighted problems such as dissatisfaction with the waiting areas. The quality improvement team initiated the purchase of new furniture for the waiting areas and worked with the housekeeping staff to increase cleaning rounds, especially on weekends.

Restraint usage decreased 46% over a six-month period without increasing self-extubations. The introduction of antibiotic-impregnated catheters decreased catheter-related infections 96.6% for medical patients and 69.9% for surgical patients. The Monday review of medication orders results in an average reduction of about 9% of the drug orders, which staff say results in fewer side effects, errors, and drug interactions.

There were some significant cost savings as a result of the quality improvements, mostly related

to the elimination of agency nurses, but the overall project was quite expensive, Martin says.

The addition of intensivists to the CCU costs the hospital in the neighborhood of $1 million a year, she says.

"A lot of people will look at this and say, 'Oh sure, M.D. Anderson can do it because they have the money,'" Martin says. "And that is true for some of these improvements. But when you look at the changes that led to some real improvements, most of what we've done could be done on a shoestring budget." ■

How to evaluate your staffing decisions

Staffing effectiveness standards take effect July 1

By **Patrice Spath**, RHIT
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Is patient safety threatened when there are fewer registered nurses at the bedside? When the workload of the respiratory therapy staff goes up, are more treatments missed? Is there an increased incidence of pulmonary complications in critical care patients when staff work more overtime hours? It is these types of questions that hospitals are expected to address after implementing the new staffing effectiveness standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The standards, scheduled for implementation on July 1, 2002, are designed to improve an organization's understanding of the relationship between staffing and outcomes. The goal is to ensure that staffing is adequate to protect patients from unintended harm and maintain high satisfaction levels.

The staffing effectiveness standards do not replace current human resource management requirements. It still is necessary for the hospital to have a plan for providing adequate and capable staff and a method for assessing staff competencies. What's being added is a requirement that the organization's leaders use information to evaluate the effectiveness of staffing decisions in terms of outcomes. Quality patient care is dependent on adequate numbers of capable staff who can meet the complex needs of patients. To evaluate how well the hospital is meeting this goal, the Joint Commission expects the organization to use several indicators to identify potential staffing problems. Data should be gathered that enable both the staff and the senior leaders to collaboratively monitor the relationship between quality patient outcomes and staffing and make changes when staffing decisions are negatively impacting expectations.

The new staffing effectiveness standards have no phase-in period. If your hospital is scheduled for a Joint Commission survey in September 2002, surveyors will expect to see a 2-month track record of data collection and analysis. Hospitals surveyed in January 2003 will be expected to have a 6-month track record. A 12-month track record is expected for hospitals not scheduled for survey until July 2003 or beyond.

Hospitals must select indicators or measures that can be used to evaluate staffing effectiveness. The organization as a whole must identify two human resource variables and two clinical outcome or service variables that will help the organization evaluate the impact of staffing decisions. The standards require that at least one of the human resource indicators and one of the clinical or service indicators be chosen from the list provided in the standards manual.

It may be best to start with your "hunches" about possible cause-and-effect relationships rather than merely picking all four indicators from the list provided by the Joint Commission. Examples: "I wonder if the number of overtime hours affects the number of medication errors? Is there a relationship between the supervisor-to-staff ratio and the number of postoperative complications? Is there a relationship between test turnaround times in the emergency department and patients who left without being seen?" Ask staff to provide their input. They very likely have some good hunches worth checking out.

Your organization must have a reasonable explanation for choosing indicators. Ideally, senior leaders select measures that are most apt to tell them what they want to know about the effect of staffing decisions on important clinical or service outcomes. Don't shy away from studying a significant issue just because the indicators are not on the JCAHO list or data are not currently being

Matrix Report of Staffing Effectiveness Indicators

	Expected Performance	Last 12 Months	Jan	Feb	Mar	Apr	May	Jun
# falls per 100 patient days	≤ 2.0	2.25	1.3	2.0	1.4	1.0	2.1	1.8
# medication errors per 100 patient days	≤ 40.0	42.0	44.0	37.0	28.0	33.0	31.0	36.0
% of patients restrained	≤ 25%	27%	18%	32%	23%	21%	22%	26%
% of positions filled by agency staff	≤ 20%	15%	23%	18%	20%	15%	18%	18%
% work hours recorded as overtime	≤ 10%	7%	18%	15%	8%	9%	8%	12%
% vacant staff positions	≤ 20%	20%	29%	25%	20%	18%	20%	15%

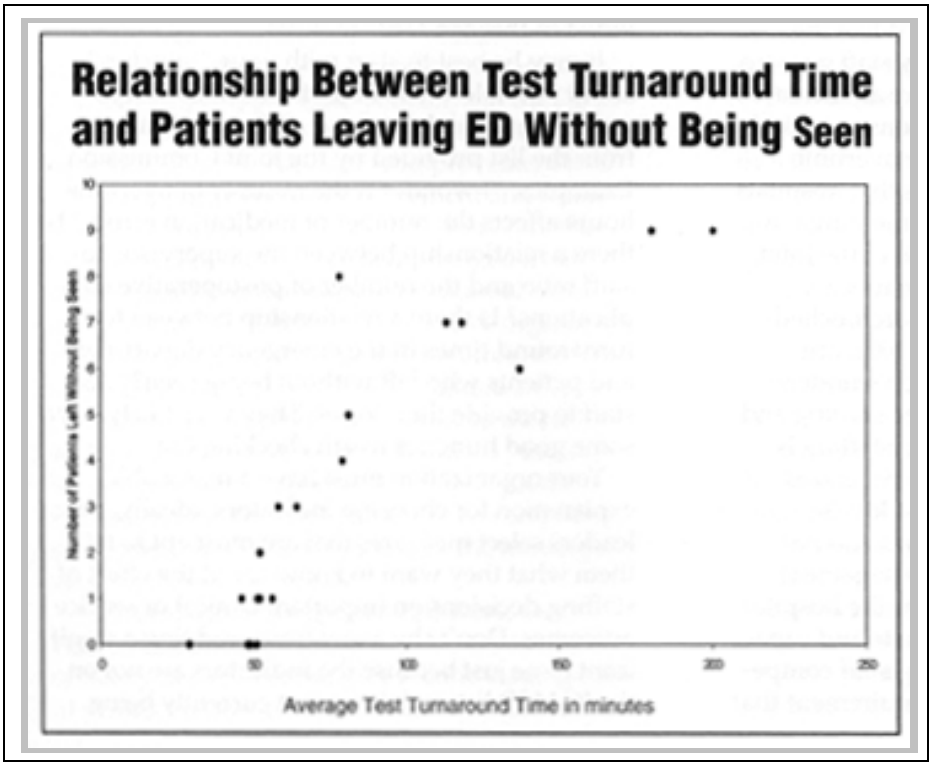
gathered for the measure. At the time of survey, you'll need to explain how the indicators you've chosen relate to your organization's improvement priorities and patient population.

Once the indicators have been selected, it's time to identify which departments are affected by the measures. Although research studies of staffing effectiveness primarily have focused on nursing staffing, the JCAHO standards apply to all departments that provide direct patient care (for example, nursing, respiratory therapy, physical therapy, social services, and chaplain) and indirect caregivers (for example, pharmacy, laboratory, housekeeping, and radiology). Suppose your organization is interested in evaluating a "hunch" about the cause-and-effect relationship between productive work hours and patient falls. Departments affected by these measures would include nursing, physical therapy, and perhaps even housekeeping and volunteer services. One variable (falls) would be compared to the other variable (productive work hours) for all the affected departments.

The results can be reported by month or by quarter, depending on the volume of data. The information should be displayed in a manner that allows people to see the relationship between the variables and performance expectations. **(For an example of a matrix report illustrating the relationship between three human resource measures and three clinical measures, see box, above.)**

Scatter diagrams can be a useful way to analyze the relationship between two variables. People can see the direction of the relationship (positive, negative, etc.) and the strength of the relationship. As more data are gathered, new data points are added to the diagram. A positive relationship is indicated by an ellipse of points that slopes upward, demonstrating that an increase in the cause variable also increases the effect variable. A negative relationship is indicated by an ellipse of points that slopes downward, demonstrating that an increase in the cause variable results in a decrease in the effect variable.

A diagram with a cluster of points such that it is difficult or impossible to determine whether the trend is upward-sloping or downward-sloping indicates that there is no relationship between the two variables.



The scatter diagram **(see diagram, p. 68)** shows a positive relationship between test turnaround times in the emergency department (the cause) and number of patients who leave without been seen (the effect). Each data point represents the results from one month. There are 20 months of data displayed on the diagram.

The measurement aspect of the staffing effectiveness standards is somewhat like correlational research in which variables are measured so that an association between some set of variables can be identified.

If a relationship is found to exist, further investigation should be undertaken. Because data from correlational research cannot conclusively prove causality, the measures used to evaluate staffing effectiveness are considered "screening indicators." Positive correlations are merely an indication that further inquiry is needed, not that staffing practices immediately need to be altered.

The group responsible for reviewing the indicators, such as the administrative council, should "drill down" on any data that vary from the expected results or reveal a positive and undesirable correlation. The drill-down process is much like a root-cause analysis; ask "why, why, why" when evaluating staffing-related issues. For example, reduced staffing levels may appear to be related to an increase in patient complaints. The solution given is to increase staffing. This may be very appropriate as one short-term option, but may miss the bigger picture. Why are patients dissatisfied? Why are expectations not being met? What other factors contributed to patient dissatisfaction and why? By answering the "drill-down" why questions, the result may lead to a better process and sustained improvement in patient satisfaction.

If performance expectations are met, no relation exists between staffing indicators and clinical or service indicators, and you are satisfied that the results are statistically valid, then change the variables you are investigating. Don't keep measuring the same indicators to evaluate staffing effectiveness. Check out other "hunches" to determine if your organization's staffing decisions are safe and adequate to provide patients with needed services. ■

Six patient safety goals must be met by hospitals

JCAHO to announce goals by July 1 each year

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, has announced plans to establish six annual national patient safety goals by July 1 each year and then require hospitals to be in compliance with them by Jan. 1 the following year. The plan is intended as a compromise in response to protests over a previous plan that would have held accredited organizations responsible for responding to *Sentinel Event Alerts.*

Advisory group to select goals

The six goals will include one or two recommendations selected from expert or evidence-based recommendations made in past issues of *Sentinel Event Alert*, the Joint Commission's patient safety newsletter that provides succinct summaries of sentinel event-specific lessons learned and recommendations for improvement. Until October 2001, the Joint Commission surveyed providers on all *Sentinel Event Alert* recommendations and planned to enact a formal system in which hospitals would have had to pick specifications to address with quality improvement projects. That plan was criticized as impractical and burdensome.

According to information released by the Joint Commission, the six patient safety goals will be selected by a *Sentinel Event Alert* Advisory Group. "The Advisory Group will assess the evidence for and face validity of past and future alert recommendations, as well as the practicality of implementation, and reach consensus on those recommendations that are to be included in an ongoing pool of expert or evidence-based recommendations for patient safety," according to the Joint Commission. "Each year the goals will be re-evaluated. JCAHO's board of commissioners will select the annual goals to be assessed during the survey process based on the recommendations of the Advisory Group."

The six goals selected by July of each year will be announced immediately to accredited providers.

Beginning Jan. 1 the following year, organizations providing care relevant to the patient safety goals will be surveyed to determine their compliance with the recommendations or implementation of an acceptable alternative. Noncompliance will result in a Type I recommendation. ■

Restraint standard revised for nurse practitioners

Complying with the standards on the use of restraints in a hospital setting now may be a little bit easier after the Joint Commission revised the rules on who can issue orders.

The Joint Commission on Accreditation of Healthcare Organizations' recently revised Standard TX.7.1.5 in the *Comprehensive Accreditation Manual for Hospitals* now allows licensed independent practitioners (LIPs) to delegate to physician assistants and nurse practitioners the writing of restraint and seclusion orders. Also, the revision allows the physician to delegate the performance of in-person evaluations of patients in restraint and seclusion. The revised standard takes effect July 1, 2002.

The Centers for Medicare & Medicaid Services offers this clarification of the Interpretive Guidelines for Rule 482.13 (d)(2): "An LIP is any practitioner permitted by law and by the hospital as having the authority under his/her license to independently order restraints, seclusion, or medications for patients. This provision is not to be construed to limit the authority of the doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel (i.e. physician assistants and nurse practitioners) to the extent recognized under state law or a state's regulatory mechanism." ■

RUS to look at ambulatory care, behavioral health

You may not be able to tell when they're coming, but at least you'll know where the Joint Commission on Accreditation of Healthcare Organizations' random unannounced surveys (RUSs) are focused. The Joint Commission recently announced the topics for RUSs, in terms of highest priority.

Five percent of accredited organizations in the targeted areas will be the focus of an RUS, according to a notice from the Joint Commission.

The RUS is separate from the scheduled triennial surveys, but they won't happen back to back. An organization can be selected between nine and 30 months after its full survey and will not receive any prior notice that a surveyor is coming. (One good note: The surprise inspection is free.)

The surveyor will include a review of both "variable" and "fixed" performance areas. Providers subject to the surprise surveys are

CE questions

Save your monthly issues with the CE questions in order to take the two semester tests in the June and December issues. A Scantron sheet will be inserted in those issues, but the questions will not be repeated.

17. According to a recent study in *Archives of Internal Medicine* conducted by Scott R. Weingarten and colleagues, subspecialists working outside of their subspecialty cared for what percentage of hospitalized patients?
    A. 11%
    B. 17%
    C. 25%
    D. 32%

18. Which of the following changes were made at M.D. Anderson Cancer Center in Houston to improve patient safety in the intensive care unit?
    A. The physician model was changed to include intensivists.
    B. The hospital established three additional nurse management positions in the unit.
    C. A consultant was hired to help create a mission statement and conduct team-building sessions.
    D. all of the above

19. Which recently revised Joint Commission standard now allows licensed independent practitioners to delegate the writing of restraint and seclusion orders to physician assistants and nurse practitioners?
    A. TX.7.1.5
    B. TX.1.2
    C. PF.4.1
    D. IM.7.1.1

20. List the element that will be Joint Commission surveyors' highest priority in random unannounced surveys in 2002.
    A. behavioral health
    B. ambulatory care
    C. pharmaceutical services
    D. equipment management

ambulatory care, behavioral health, home care (including pharmacies), hospital, and long-term care.

Once you're chosen, surveyors first will assess organization-specific performance areas based on the organization's last accreditation survey report, any complaint or performance data received since the last full survey, and other feedback and findings discovered on site during the RUS. Those are the "variable" elements. One goal of looking at those elements is to verify sustained resolution of Type I recommendations.

Surveyors also will assess the "high-risk" performance areas that the Joint Commission determined for each specific type of provider. These are the "fixed" elements. The Joint Commission reports that these elements were chosen for a variety of reasons, in particular, a high percentage of Type I recommendations, complaints, and sentinel-event statistics. Concern from the public could have prompted an element's inclusion also, even if there were no internal indicators of the problem.

The elements are prioritized "based on the degree of actual or perceived risk to patient care and noncompliance, with relevant standards in each area specific to the health care setting being reviewed," the Joint Commission says. When a surveyor doesn't have time to look at all the fixed elements, he or she will start at the top of the list and work down, the Joint Commission says.

These are the top elements for unannounced surveys in 2002, in order of priority:

- **Ambulatory care.**

Credentialing and privileging of licensed

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independent practitioners, improving performance, implementation, medication use, and competence assessment.

• **Behavioral health.**

Qualifications, competencies, and clinical responsibilities; special procedures; initial screening and clinical assessments; assessment for discharge-planning care decisions and reassessment; and medication use.

• **Hospitals.**

Management of the environment of care — planning; initial assessment; patient-specific data and information; medication use; and orientation, training, and education of staff.

• **Home care — home health.**

Home health — planning and provision of care; human resources management; home health — patient assessment; contract management; and aggregation and analysis.

• **Home care — equipment management**.

Equipment management — planning and provision of care; equipment management — maintenance, testing and inspection; equipment management — patient assessment; equipment management — specific patient rights; and equipment management — specific patient education.

• **Home care — pharmaceutical services.**

Pharmacy — planning and provision of care; pharmacy — maintenance, testing, and inspection; pharmacy — patient assessment; pharmacy — drug preparation and dispensing; pharmacy — patient-specific information.

• **Home care — hospice services.**

Hospice — planning and provision of care; hospice — patient assessment; hospice — maintenance, testing, and inspection; hospice-specific patient rights; and hospice — infection control practices.

• **Long-term care.**

Assessment; planning and providing care; implementation; orientation, training, education, and competency; and credentialing.

• **Long-term care — subacute care**.

Assessment; planning and providing care; orientation, training, education, and competency; credentialing; and resident-specific data and information. ■

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