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Nurses may be your best tool for improving quality of care

Don't rely too much on policies nurses might overlook

Nurses can greatly improve the quality of care by reporting their concerns about patient care, but all too often, those comments never reach the ears of hospital management or quality leaders. Even when you have policies and procedures in place that encourage nurses to report concerns, you might be surprised at how many nurses think no one wants to hear from them.

The problem plagues many hospitals and other health care providers, says **Sharon LaDuke**, RN, patient documentation analyst at Claxton-Hepburn Medical Center in Ogdensburg, NY. The health care community often talks about "empowerment" of nurses and other staff, and most hospital leaders accept the idea that employees in the trenches should be encouraged to report concerns about patient care. Many facilities even have a policy in place that officially encourages such reporting, sometimes with a specific procedure for doing so.

Most hospitals have developed what administrators would consider plenty of opportunities for nurses to report concerns about patient care, but they might not be working. A policy may look good on paper, LaDuke says, but that won't necessarily improve the quality of care.

"The leaders are very aware of these policies and imagine that those resources also are very available to the nurses. But nurses don't participate in these processes at the level that makes them intimately familiar with them," she says. "They didn't sit in on a committee that formulated them, and they don't have time to study the policies when they're handed out. So you have leaders who think they have plenty of resources and processes available, but the nurses are not sufficiently aware and comfortable with those processes."

As a result, nurses often don't use the reporting systems that the hospital has set up, she says. And then, the hospital leaders often think that a lack of reports means there are no problems.

Surveys help gauge nursing concerns

Hotlines a better solution for physicians

Anonymous surveys can help nurses report their concerns without any fear of retaliation, says **Cole Edmonson**, RN, MS, director of nursing operations at Medical City Dallas Hospital and North Texas Hospital for Children in Dallas. Edmonson has been working for years to encourage nurses to report their concerns about quality of care, and he says it should be an ongoing effort. No one tool or strategy will achieve the goal.

Edmonson's institutions recently implemented a system of regular surveys of nursing staff, along with a physician hotline. The first survey was done six months ago, and the quality improvement professionals are in the process of reviewing the results. The hospitals send out surveys to a random portion of the nursing staff, selected from various units and using other factors to make the sample representative. Nurses fill out the survey anonymously and drop it off or mail it back to the quality department.

"The survey helps us determine what kind of interventions we need to make a safer environment," he says. "We ask if they feel comfortable reporting an error or a dangerous situation to their supervisors. We also ask if they think the institution supports a nonpunitive reporting environment and whether there are any systems in place to facilitate reporting. It's important to know what awareness they have of the methods we've already made available."

The initial analysis of the survey results indicated that some nurses still think there is a punitive environment and that there could be negative consequences for reporting their concerns. That was somewhat of a surprise, since hospital leaders were confident that they had promoted a nonpunitive environment.

"We went back and looked at some policies and saw that there were still some words in there that could scare off someone who is afraid of the consequences," Edmonson says. "We need to revise those policies so that any words related to a punitive reaction are removed. It's really a change in wording more than a change in policy."

For physicians, the Dallas hospitals recently implemented a hotline. According to Edmonson, the phone hotline can be a better solution for physicians because they come and go frequently and it is easier for them to pick up the phone than to track down the right person in the hospital. The hospitals promote the hotline number to physicians and promise that an appropriate hospital representative will respond to every hotline message within 24 hours. The medical staff also review all the hotline comments on a monthly basis.

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"I recently asked a lawyer at another facility about a hotline they set up for staff to report their concerns anonymously," LaDuke says. "He said the only calls they'd gotten were from visitors. No one was using the hotline the way the hospital leaders expected."

Part of the problem involves how policies and procedures sometimes are presented to nursing staff, she says. Administrators and committees often overlook the workplace demands on nurses, as well as some of the cultural divisions that have been in place for many years in the health care profession. Time constraints are a major concern, LaDuke says. No matter how well designed the policy, nurses won't know about it if they have to read a three-page memo. Most nurses are so overworked by their primary concern — taking care of too many patients at once — that they can't take the time to study a lengthy memo.

"Many nurses will stop reading the policy after the first couple of sentences, especially if the title or policy statement contains phrases that don't resonate with them," she says.

"If you send out a policy that encourages nurses to report their patient care concerns on a hotline but you introduce it with a term like 'corporate compliance,' you'll lose your audience unless considerable care is taken upfront to explicate the connection between this term and what

COMING IN FUTURE MONTHS

- Hospitalist programs improve quality of care
- Collaboration in network reduces drug errors
- California tests standardized tool for credentialing
- Quality of care varies by age, race, other factors
- Patients benefit when physicians use clot busters more freely

Use concrete examples to show how policy affects nurses

It's one thing to have a policy that encourages nurses to report concerns about patient care, but getting nurses to use the system is something else entirely. Here are some tips for making sure the policy and procedures are put to use:

- ✔ **Understand nurses' time constraints.**
  Nurses are extremely busy, and their patients can't wait while they study a long memo or attend a day-long seminar about a new policy. There are a variety of ways to introduce a policy or new process to nurses, but always keep in mind that they have other things to do. Keep it short and to the point.
- ✔ **Try to use in-person presentations rather than written communications.**
  When possible, a face-to-face presentation may be more effective than communicating the policy on paper. It's too easy for nurses to overlook the written explanation or put it aside because they're too busy. It can be a good idea to point out that you are presenting this policy in person because it is so important. But keep it brief.
- ✔ **Enlist the aid of a nursing leader.**
  A nursing leader should be involved in the creation of the policy and process, and that person can be instrumental in getting the message out. Preferably, this person should be someone admired and respected by other nurses. The nurse's involvement, especially in actually delivering the message, will help overcome some natural skepticism about whether the hospital really wants to hear the nurses' opinions.
- ✔ **Don't depend too much on e-mail for disseminating the policy.**
  When nurses are taking care of 10 patients at once, they don't have the time to sit down and study all the information they're sent. E-mail may be a tempting way to disseminate information because it is so convenient, but many people get too much e-mail and ignore much of it. Some people also associate e-mail with information of a lower priority and lesser value than information delivered by other means.
- ✔ **Use concrete examples to make the policy relevant.**
  Hospitals often make the mistake of issuing a single policy statement that says staff are encouraged to report their concerns about a violation of law or policy, but they don't make it relevant to nurses. With generalized wording, it is easy for nurses to conclude that the policy doesn't really apply to them. Even if the policy addresses the need to report billing fraud, you can give nurses examples that apply to them, such as a physician ordering too many tests.
- ✔ **Acknowledge the power differential between nurses and physicians.**
  Concerns about patient care usually involve a physician, and that can make nurses reluctant to report their concerns. Make sure your policy and procedures have safeguards built in so that the nurse reporting a concern cannot be punished in any way by the physician. Explaining these safeguards and assuring the nurses that they work will be one of the biggest hurdles when getting the message out. ■

the nurse observes at the bedside," LaDuke adds.

Another common problem is that the policy and process are never fully disseminated to the nursing staff who work off-site or odd hours. **(For tips on how to effectively communicate a policy, see box, above.)**

Any effort to improve nurses' reporting of patient concerns must start at the top of the leadership ladder, says **Maureen Connor**, RN, MPH, director of risk management and infection control, at Dana-Farber Cancer Institute in Boston. This kind of change is so dependent on an overall culture within the organization, not just a few well-meaning individuals, that the CEO and similar leaders must buy in from the start, she says.

"If you don't have the support of executive leaders, I don't think you can make this happen," she says. "You have to have leaders who make patient safety a top priority, who believe that supporting a nonpunitive culture is fundamental to getting staff to discuss errors."

Connor agrees that a written policy is only a starting point. In fact, Dana-Farber doesn't yet have a formal written policy establishing a nonpunitive reporting environment, depending instead on a process that has occurred over time. (It is creating a formal policy now.) A 1995 sentinel event, involving two patients who received overdoses of chemotherapy drugs, spurred the institute to revamp its efforts.

"We looked at our systems and realized that when errors occurred, it is often not that staff are careless or don't care, it's because you have systems in place that set the staff up to fail," she says. "It is very important that you promote an atmosphere in which people are willing to tell you that, to show you the weaknesses, before a tragedy occurs."

One strategy employed at Dana-Farber is a system of multidisciplinary patient safety rounds. Begun in the last year, these rounds involve a number of staff from risk management, nursing, and pharmacy. The team visits patient care units and encourages nurses to share any concerns they have about quality of care. If a problem is identified, a team quickly gets to work on the issue and — here's a crucial element — reports back to the nursing staff about what action was taken. Connor says it is vitally important that nurses see some result from their reports.

Dana-Farber also enlists nurses to participate in its medication event subcommittee. This group meets monthly and reviews every medication event (an error or near miss) reported in the previous month. Each event is analyzed in great detail, almost like a miniroot-cause analysis, and the nurses are encouraged to voice their practical insights regarding how processes work on the patient care units.

"Not only is their input valuable, but they can see the systems approach we take to error investigations, that it's not about pointing the finger at someone," Connor says.

"They can take that back to their colleagues and tell them how this system works," she adds.

Nurses have long felt stymied by their relatively low ranking in the health care community, too often feeling that physicians and administrators don't value their opinions. Overcoming that perception is the biggest hurdle to implementing any policy that encourages nurses to speak up. Nurses are highly motivated to do the right thing, but they can feel that no one else wants to hear from them, LaDuke says, or that there will be retaliation for pointing a finger at someone higher on the ladder.

"Sometimes, the nurses either do nothing, feeling they have no influence over the system and nobody cares. They think they have no avenue or organizational standing to address the issue," she says. "Or they will do things that are ineffective and expose themselves to various kinds of unfortunate consequences, making them vulnerable. They feel they have to do something, so they do something ineffective and ultimately self-destructive, all because they lacked the system savvy to use the channels that were already in place to address their concerns."

No matter how many times you tell nurses that you want them to be "empowered" and that you value their input, they won't believe it until they see evidence. That means that changing the culture of a health care organization takes time. Fortunately, that culture change has been under way at many hospitals for years now, and some nurses are becoming more comfortable with the idea that the administration really wants to hear their concerns.

"This isn't something that can happen overnight, but you can get fooled into thinking you've had a good system in place for years and it's working fine," LaDuke says. "The big message here is that you can't just write a policy and think that's it. You have to make sure nurses understand it, know that you're serious, and know how to use it and feel protected when they do."

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Quality project improves ventilator weaning

Rehab hospital takes multidisciplinary approach

Nurse practitioners, a multidisciplinary approach, and consistent standards of care were the keys to a quality improvement project that significantly improved the rate of ventilator weaning at a rehabilitation hospital in South Carolina.

Ventilator weaning was a priority for quality improvement leaders at Spartanburg Hospital for Restorative Care (SHRC). Unlike at most acute-care hospitals, a high percentage of patients at SHRC are ventilator-dependent, and many will never be weaned without a concerted effort, says **Dianne Smith**, RN, MSN, coordinator of performance improvement.

The SHRC system uses an interdisciplinary approach that helps promote the system's benefits beyond the institution, she says. "Our average length of stay is 25 days. All patients are referred from acute facilities, so it's very important to get buy-in from the medical department staff there, so they will refer patients to us."

The hospital wanted to reduce the length of

time patients were on ventilators and also to increase the wean percentage. The one-year outcome for ventilator-dependent patients usually is not good, so the hospital wanted to work toward results that would set it apart from the typical facility. The multidisciplinary approach helped the hospital staff shed some territorial concerns, Smith says, and benchmarking with other respiratory care centers across the country helped establish standards of care.

In the recent Premier Awards for Quality, given by Charlotte, NC-based Premier Inc., SHRC won in the improvement achievement category for increasing survival rates and decreasing the length of time patients are kept on ventilators. The project was headed by SHRC medical directors **Bert Knight**, MD, and **Wilson Smith**, MD.

Ventilator weaning is ideal QI effort

Knight explains that ventilator patients represent a good opportunity for quality improvement efforts. "We've been doing a much better job of keeping them alive than we did a few years ago, but weaning them off the ventilator has taken a back seat to other efforts sometimes," he says. "We thought we could do better and improve their quality of care and their quality of life."

The interdisciplinary team also included rehabilitation staff, house staff, nursing staff, respiratory care staff, health management staff, medical nutrition therapy, pastoral care, and private physicians who supervise their patients' treatment plans at SHRC. The team focused on the special concerns of its rehab patients, Wilson Smith says.

"Patients who have been on a ventilator for more than a couple weeks require a different approach for weaning the use of the ventilator than those on one for just a short time," he says. "This program has followed a team approach involving nurses, respiratory therapists, rehabilitation therapists, nutritionists, doctors, and even chaplain services to try and address the complex needs of these patients. It is in many ways like training an athlete, only the reward is not a gold medal but the ability to breathe again on one's own."

Although technological advances in health care have improved patient management, patients requiring prolonged mechanical ventilation (longer than 21 days) have become more common, Wilson Smith says. The impact on clinical outcomes and health care resources of patients who fail to wean from mechanical ventilation is enormous. The objective of the project was to develop an organized, research-driven process to provide a standardized approach to weaning care at SHRC.

While the major goals of the project were to improve patient outcomes and safety through decreased ventilator days and decreased lengths of stay, Dianne Smith notes that achieving those goals also should reduce the cost of care in this resource-intensive patient population.

Prior to 1998, there were no protocols for the care and weaning of ventilator-dependent patients at SHRC. The weaning process depended upon physician presence at the bedside and the physician's personal practice preferences. In March 1998, SHRC began using a method called T-Bar Trials as the primary weaning method, but the length of time to wean ventilator-dependent patients remained widely variable. The quality improvement team began reviewing the literature and benchmarking with other long-term acute-care hospitals caring for the ventilator-dependent population, and an interdisciplinary team made a site visit to Barlow Respiratory Hospital in Los Angeles.

After returning to SHRC, the team developed a research-based weaning protocol.

Knight says the SHRC team learned a lot from Barlow, and that helped them avoid a lot of trial-and-error attempts.

Wilson Smith agrees, saying that being able to use Barlow's work on standards of care was a huge step forward.

"Up until recently, I think medicine was physician personal preference, but now with our best practices, I think patient care is improving," Dianne Smith says. "Having your physicians use the same general practice guidelines is crucial to success. Conversely, not using them can be the death knell of a program."

The ventilator-weaning program was managed by an interdisciplinary team including two board-certified pulmonologists, two nurse practitioners, respiratory care services, nursing care services, rehabilitation services, medical nutrition services, health management services, and chaplain services. Implementation of the weaning protocols was accomplished after appropriate staff were educated.

Weaning times remained somewhat variable throughout the next few months, but in June 2000, the hospital revised the weaning protocols with re-education of the staff. The revised protocol includes a daily evaluation of hemodynamic

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status and ventilator settings.

"One thing our program does that not everyone does is utilizing a nurse practitioner," Dianne Smith says. "We do multidisciplinary rounds on all our patients. Even the chaplain takes part in rounds. I've been a nurse for years, and this is one of the first truly multidisciplinary initiatives I've been involved in."

A pulmonologist also makes daily patient rounds with members of the interdisciplinary team. In addition to daily rounds, members of the interdisciplinary team, pulmonologists, and nurse practitioners meet the first and third Wednesday of each month. This schedule allows for prompt action regarding changes in the weaning process and plan of care on a daily basis with a global review done every other week. A pulmonologist and a nurse practitioner are available on site during daytime hours and by pager as needed. A house physician is available on site from 9 p.m. until 6 a.m. to assist attending physicians as needed during off-hours.

Dianne Smith says the key characteristics of the SHRC weaning program are administrative support, communication, a research-based approach, data-driven decision making, interdisciplinary collaboration, expert clinicians (the median experience level for the ventilator weaning team is 10 years), and uniformity of process. She says there have been very few negative outcomes, most notably two documented cases of ventilator-acquired pneumonia in the past four years. Certain factors ensure patient safety while trying to wean patients off ventilators, she says:

- Daily education / re-education of patient and family regarding the weaning process and expectations of care.
- Increased communication among members of the interdisciplinary team.
- Daily interdisciplinary patient rounds with the pulmonologist and nurse practitioner.
- Availability of physician and nurse practitioner on site.
- Shift-to-shift reporting by respiratory care services and nursing.
- Daily updates to the director of respiratory care services regarding progress in weaning each patient.
- Increased patient monitoring.
- Hemodynamic monitoring.
- Oxygen saturation monitoring.
- Direct visualization of each patient either in the intensive care unit or by in-room video monitors.
- Point-of-care testing: Arterial blood gas analysis at the bedside for immediate assessment and intervention.
- Hourly rounds by respiratory care services.
- Presence of respiratory care therapist at bedside for continuous monitoring with each change in ventilator settings.
- Alarm systems for ventilators and cardiac monitors are tied into the call system, which allows for immediate response to the bedside by clinical personnel.
- Increased staff-to-patient ratios: 1:4 for respiratory care services, 1:6 for nursing services, and 1:6 for rehabilitation services.
- Utilization of a highly educated and experienced staff.
- In-depth orientation process specifically tailored to the employee's knowledge base and skill levels.
- Annual staff competencies to ensure continued proficiency.
- Median experience for the pulmonologists — 25 years.
- Median experience for respiratory care services — nine years.
- Median experience for nursing — 14 years.

To track patient outcomes, the team analyzed these data: length of time on the ventilator prior

to transfer to SHRC; Apache III scores from the transferring facility (if available); Apache III scores upon admission to SHRC; length of time on ventilator at SHRC; method of weaning; status of weaning at time of discharge from SHRC; discharge disposition; SHRC mortality rate; survival at one, two, and three years post-discharge.

Patient outcomes have improved significantly since the project started. SHRC has narrowed vent-weaning indicators to median vent days, percentage of patients successfully weaned, survival rates, and cost savings. In 1998, with no established protocols, baseline data for these four indicators show the median number of vent days was 32, 47% of patients were successfully weaned, the survival rate was 24%, and cost savings were $8,100. In 1999, using established protocols, key changes in the indicators were noted. There was a decrease in median vent days to 23 days, an increase in the percentage of patients successfully weaned to 60%, an increase in the survival rate to 33%, and additional cost savings of $116,051.

Further refinement of the vent-weaning protocols in 2000 proved successful for SHRC based on the indicator values listed. The median vent days decreased to 20 days, the percentage of patients successfully weaned increased to 84%, and the survival rate increased to 45%.

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ACGME clamps down on hours for residents

New standards set limit of 80 hours per week

The board of directors of the Accreditation Council for Graduate Medical Education (ACGME) in Chicago recently took strong action to impose sweeping new limits on duty hours for participants in 7,800 medical residency-training programs across the country. The ACGME is responding to growing concerns about changes in the health care and educational environment for residents and the possible detrimental effects of sleep restriction on patient safety.

The standards affect residency programs in all health care disciplines in which medical school graduates complete their education by providing care under close supervision at academic medical centers and other institutions. Concerns about residents' schedules have become more acute as the pressures of shorter hospital stays for patients, more medical procedures to manage, and less support have combined to make balancing education and patient care more difficult, says **David Leach**, executive director of ACGME.

"Residents have more to do, in less time, with less support than ever before," he says. "As the principal body to ensure quality educational programs in the context of quality patient care, the ACGME has responded with clear standards, strict compliance mechanisms, and strong sanctions for violators."

Because of the need to gain medical experience in a specified period of time, residents must be available to take advantage of opportunities to learn through performance of multiple procedures, Leach says. Residents also help maintain continuity of care for patients and manage the process of transferring care to other residents and attending physicians. These factors combine to require extended duty shifts. The new standards for resident duty hours include these points:

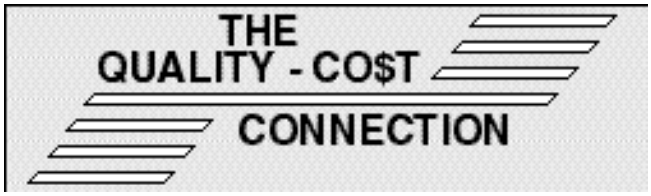
- A limit of 80 hours per week, with some flexibility to increase hours up to 10% if the sponsoring institution can show an educational rationale and that the approach will promote safety of both patients and residents.
- Strengthened limitations on moonlighting to ensure control over total duty hours that residents are working.
- At least one (24-hour) day out of seven free of patient care duties.
- On-call duty no more than every third night.
- Minimum rest period of 10 hours between duty periods.
- Continuous time on duty limited to 24 hours, with additional time of no more than six hours allowed for patient transfers and educational activities. Residents may not assume responsibility for new patients after 24 hours.

The ACGME convened a Work Group on Duty Hours and the Learning Environment that has been studying these issues for the past year. The new ACGME standards go beyond the issue of duty hours to address supervision and accountability at participating institutions and programs, says **Charles Rice**, chair-elect of ACGME. "Patient care and resident education is a collective responsibility, requiring close faculty supervision and

strong institutional oversight and support," he says. "These standards address the complete context of patient care and medical education. Limiting duty hours is not enough."

Rice says the new standards ensure that faculty are available for residents at all times and make institutions responsible for resident duty hours and faculty schedules. Faculty and program directors must assess residents for signs of sleep loss and fatigue, and institutions are responsible for educating staff and faculty about sleep issues. In addition, participating institutions must give residents adequate backup support, especially for routine activities or when patient care responsibilities are especially difficult or prolonged.

The ACGME has strengthened compliance systems as part of the new standards. The enhanced compliance program shortens the time frame for addressing duty-hour citations, invokes procedures for "Rapid Response to Egregious Accreditation Violations" for resident duty-hour problems, and expedites the process wherein a program can lose accreditation. Loss of accreditation from ACGME is tantamount to a "death sentence" for a residency program and also would result in the loss of Medicare funding for graduate medical education for the violating institution, Rice says. "These sanctions are real and severe. The ACGME is very serious about enforcing these reforms." ■



Health information disaster planning 101

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Many health care facilities have an emergency disaster plan for dealing with patient care priorities, but the plan for handling information technology disasters may be vague or nonexistent. Although patients' well-being is very important during a disaster, institutions also need to protect the technology supporting patient care. Anticipating and preparing for management of and recovery from information system disasters is just as important as preparing for continuation of patient care in the event a disaster occurs. It is not enough to have an emergency plan that only deals with maintaining patient care functions. Health care institutions also must have an information disaster recovery plan.

The Joint Commission on Accreditation of Healthcare Organizations standards for information management require evidence of planning for and assurance of data and information security, broadly defined as protection "against loss, destruction, tampering, and unauthorized access or use." This requirement encompasses issues of confidentiality, or protection of a patient's privacy rights concerning health information, and security, which address the operational requirements of maintaining an information system. The Joint Commission's information management standards cover both patient care and business data systems.

The accreditation standards of other organizations have requirements similar to those of the Joint Commission. For example, the Accreditation Association for Ambulatory Health Care requires organizations to have a comprehensive emergency plan that addresses internal and external emergencies and the necessary personnel, equipment, procedures, and training to carry out the plan. The Tucson, AZ-based CARF, The Rehabilitation Commission, standards for rehabilitation facilities require disaster planning, including a plan for providing critical patient care information during service disruptions.

The provisions of the 1996 Health Insurance Portability and Accountability Act (HIPAA) include many requirements directed at the information resources of health care organizations. The HIPAA regulations include a requirement that institutions have a formalized disaster recovery plan for information systems that has been tested. It is not clear at this time what type of testing is acceptable for compliance.

Development of an emergency preparedness plan for information system disasters involves:
1. information gathering;
2. formulation and testing of the plan;
3. plan maintenance.

Information gathering

In a hospital setting, the chief information officer or health information management department director probably will take the lead in

mobilizing an information management disaster team. People directly involved in patient care and business processes should be represented on the work group charged with plan development and maintenance. Once the team is formed, conduct an impact assessment. Have the team members answer questions such as:

- What are the most critical information functions or systems in my unit / department?
- Are these paper-based or electronic systems?
- Which of these systems are most critical to patient care? To business processes?
- What would be the impact if these systems were severely interrupted?

Documenting information management technology, systems, and processes already in place is a crucial starting point in the disaster recovery planning process.

Next, conduct a disaster risk assessment. The risk will vary by type and cause of the disaster. Determine what types of disasters might compromise your organization's health information system and the relative risk of an occurrence. Whenever possible, risk assessments should be based on historical trend data and input from knowledgeable people in the community. The information-gathering phase should include meetings with steering and work teams, a tour of the facility, collection of current documentation, and question-and-answer sessions.

Now it's time to develop your recovery strategy. Determine how you will operate during a severe disruption of services to ensure that all critical information management functions can be performed. How will you get the health information management department back up and running? Review your on-site and off-site backup and recovery procedures. For example, are you backing up critical patient information that is stored electronically? What provisions do you have for backing up critical information that is stored in paper-based information systems? Will backup information be affected if a fire or flood occurs in your building? How will electricity outages affect access to primary and backup information sources?

What if you can no longer perform work in your facility — do you have an alternative location where information management functions can be performed? Explosion, earthquake, fire, tornado, hurricane — these phenomena can damage or destroy your facility. Getting patients and medical professionals out of the building and into another is one problem; getting patient records transferred is another. If a hospital has a computerized charting system, the information can be downloaded onto a disk, while hard copies of charts must be gathered and carried out.

Formulating and testing

Once the disaster risks and possible recovery plans have been identified and thoroughly discussed, it's time to write the emergency preparedness plan. The plan should document all components and steps from recognizing a disaster, what to do during recovery, and how information services will be restored.

The information systems disaster plan should be contained in a notebook that is kept at the institution, at employees' homes, and at any off-site data-storage facilities. The notebook should include sections on the current environment as well as the recovery environment and action plans to follow at the time of a disaster or severe disruption, specifically describing how recovery (as defined in the strategies) for each system, process, and application is accomplished. If technology plays a key role in managing patient care information, the disaster plan also should include information about network configuration, communications closet layouts, cable diagrams, port connections, server configuration, and backup schedules.

Be sure to test the plan before an actual disaster. This will allow everyone in the organization to practice his or her responsibilities and also help to reveal any shortcomings. Testing can be done through the creation of sample scenarios that simulate likely problems. Once people have reacted to these scenarios, detailed scripts can be written up describing the steps to take in case of such an event. These scenarios and scripts should be added to the disaster plan notebook to serve as learning resources for everyone in the organization. The better prepared the organization is, the faster the recovery will be if a disaster actually occurs.

Plan maintenance

Although the disaster recovery process may never be put into action, the plan should not get obsolete. When changes occur in the work force, system, equipment, or process, the plan needs to be updated to reflect these changes. The information management disaster team should hold regular meetings (ideally quarterly) to discuss any new technologies or processes that may have

Disaster Planning Resource

- *Practice Brief: Disaster Planning for Health Information* (2000); published by the American Health Information Management Association (AHIMA), Chicago. This document is available on the association's web site: www.ahima.org.

been added. The team also should test disaster scenarios and develop new action plans if necessary to maintain and refine the plan. The information systems disaster plan notebook should be updated appropriately and the changes communicated throughout the organization.

As organizations become more dependent on data communications networks and telecommunications, it is critical to be able to recover quickly from a disaster. A professional audit, at least biennially, of all systems and vendors involved may be necessary to maintain the proper links of communication and to ensure the integrity of the disaster recovery plan.

Health care organizations must practice preventive medicine within their information infrastructures. Information technology is becoming the backbone of hospitals, clinics, and physicians' offices. More providers are implementing electronic patient record systems, and network configurations between hospitals and remote clinics now allow for instantaneous transfer of patient data. If these technologies are disrupted during a disaster, then patient services are threatened.

While disasters are, by nature, sudden and destructive, they should not be unexpected, and they don't have to destroy caregivers' ability to access critical patient information. A well-executed and maintained recovery plan that specifically addresses information management problems is the best prescription for continuity of patient care during the worst of disasters. ■

CE questions

5. What is the average length of stay for ventilator patients at Spartanburg (SC) Hospital for Restorative Care?
   A. 22 days
   B. 25 days
   C. 27 days
   D. 29 days

6. New standards from the Board of Directors of the Accreditation Council for Graduate Medical Education dictate that medical residents must not have on-call duty more than how often?
   A. every other night
   B. every third night
   C. every fifth night
   D. once per week

7. According to research presented recently at the 62nd annual meeting of the American Diabetes Association, diabetes patients' relationship with their primary provider predicted blood glucose control and psychosocial adjustment.
   A. true
   B. false

8. Which of the following Joint Commission on Accreditation of Healthcare Organization standards addresses the privileging of volunteer Licensed Independent Practitioners during emergencies?
   A. MS.4.1.1
   B. MS.4.2.1.6
   C. MS.5.14.4.1
   D. MS.6.2.2.3

Answers: 5. B; 6. B; 7. A; 8. C

Treatment approach key in diabetes self-management

Study focuses on psychosocial factors

Diabetes is a disorder requiring significant self-management by patients, and the organization of the health care system has a great effect on how patients manage the condition, according to research presented recently at the 62nd annual meeting of the Alexandria, VA-based American Diabetes Association.

The findings suggest that more effective organization of factors related to the health care system can improve the physical and psychological well-being of people with diabetes, says **Richard Rubin**, PhD, lead author of the presentation and associate professor of medicine and pediatrics at the Johns Hopkins University School of Medicine in Baltimore and a member of the International DAWN Advisory Panel. "Diabetes is a lifelong condition and requires lifelong management to reduce the risk of complications," he says.

"Our findings show that among many factors — including patient age, sex, and beliefs about diabetes, and the type and duration of the diabetes — it's the health care system's organization and accessibility that are the most powerful predictors of successful management," Rubin adds.

Other findings presented at the meeting show that while diabetes care providers recognize the importance of psychological problems in their patients and devote significant efforts to addressing them, many providers have insufficient resources to deal with them. Both studies were part of a larger international study called DAWN (diabetes attitudes, wishes, and needs), the largest global psychosocial diabetes survey of its kind ever conducted. The full DAWN study addresses the perceptions and attitudes of more than 5,000 people with diabetes and 3,000 diabetes health care professionals in 13 countries.

The study on factors affecting diabetes management was based on a DAWN study subsample of 500 U.S. patients. For each patient, the researchers assessed, as key outcomes, self-reported indicators of successful diabetes management, including: adherence to recommendations for diet, exercise, and self-monitoring of blood glucose; blood-glucose control; and psychosocial adjustment to the disorder. The researchers also assessed possible predictors of these outcomes, including the patient's gender, age, and duration of diabetes; and relevant health care system organizational factors such as accessibility of providers, patients' relationship with their primary care provider, availability of the health care team, communication among providers, patient belief that health care providers are primarily responsible for diabetes management, and patient belief that diabetes care is burdensome and complicated.

The researchers found that organizational factors related to the health care system were the strongest predictors of successful management. Examples of specific findings include:

- Accessibility of health care providers predicted all outcomes except adherence to self-monitoring of blood glucose.
- The patient's relationship with the primary provider predicted blood glucose control and psychosocial adjustment.
- The availability of team care predicted blood glucose control.
- Communication among providers predicted patient adherence to exercise recommendations.
- Patient belief that providers have primary responsibility for diabetes care predicted diet adherence but worse psychosocial adjustment.
- Patient belief that diabetes care is burdensome also predicted worse outcomes in terms of psychosocial adjustment, blood glucose control, and diet adherence.

"Clearly, effective organization of health care resources can enhance patient physical and psychological well-being," Rubin says. "In particular, ensuring patient access to the health care team and communication among team members with each other and with the patient can go a long way."

"There is an important psychosocial side to diabetes and its treatment that must be addressed, but many care providers have insufficient skills, time, and / or resources to do so," says **Mark Peyrot**, PhD, lead author of the study and professor of

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sociology at Loyola College in Baltimore.

"Our findings suggest that training diabetes care providers in the recognition, treatment, and referral of patients with psychosocial needs could make a major contribution to the quality of their care." ■

New privileging standard addresses emergencies

A new hospital standard from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) addresses the problem of privileging physicians quickly when disaster strikes. The issue was raised recently in light of last year's terrorist attacks and the threat of more to come.

The new standard addresses the privileging of volunteer Licensed Independent Practitioners (LIPs) during emergencies. Standard MS.5.14.4.1 states: "In circumstances of disaster(s), in which the emergency management plan has been activated, the chief executive officer or medical staff president or their designee(s) may grant emergency privileges." JCAHO reports that while the use of volunteers is not mandated, the standard provides a means for hospitals to use volunteers in emergencies.

In a statement released with the new standard, JCAHO explains that the standard outlines acceptable sources of identification of volunteer LIPs, including a current license to practice, a current picture hospital I.D. accompanied by the LIP's license number, or verification of the volunteer practitioner's identity by a current hospital or medical staff member. The standard is effective immediately.

"This standard was created following JCAHO's debriefing of health care personnel involved in last year's Houston flood and in response to the terrorist attacks in New York City and Washington, DC," the accrediting body reports. "These personnel identified a specific need for rapid access to clinicians to assist in meeting patient care demands in emergencies." ■

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