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Press Ganey: Public reporting gives huge boost to patient satisfaction

Experts say internal changes, not public reaction, behind improvement

Press Ganey Associates Inc., the South Bend, IN-based patient satisfaction and quality firm, reports that "patient satisfaction leaped" after the launch of public reporting. The company cites an "unprecedented" jump in hospital patient satisfaction since March 2008, when hospitals began publicly reporting data on patients' experience of care. The company analyzed its proprietary patient satisfaction data for hospitals that in March began reporting data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures.

These improvements were specifically cited in three areas:

- likelihood to recommend "definitely yes";
- coordination of care "very good";
- overall rating of hospital nine or 10.

The analysis included data representing more than 1.5 million patients and 1,158 hospitals from January 2007 through June 2008, and indicated year-to-year comparisons for each month. **(The graphs of these Press Ganey data points are available at http://www.press-ganey.com/galleries/default-file/HCAHPS_Graphs.pdf.)**

"Our clients have seen slow and steady improvement over the years, but the comparison of one month this year over the same month last year is statistically significant — and we have not seen

Key Points

- Hospitals focus on improving satisfaction in preparation for HCAHPS.
- One-on-one transparency with patients offers best opportunity to satisfy.
- Quality managers must foster satisfaction improvements the same way they foster clinical improvement.

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that before," notes **Deirdre Mylod**, PhD, vice president of acute services at Press Ganey.

What is the link?

The first question begged by this new data is this: Just what is the link between patient satisfaction and public reporting? "The link is mostly a push for transparency within the organizations," says Mylod. "Consumers don't use most of the public data yet, but even if they are not looking at them and make decisions about them, if hospital leadership and boards see they are being publicly reported, we see tremendous attention to and seriousness with which these [patient satisfaction processes] are taken."

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Editorial Questions

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In addition, she says, "What we have found in our clients is that those who have been modeling transparency within the organization and giving nurse managers access to their own data are those that are improving more on the patient satisfaction front."

Traditionally, she notes, hospitals were required to report on patient satisfaction quality measures, which had a lot to do with processes. "But now they also have to report how patients evaluate their care," says Mylod. "So much of being patient centered is the culture; it adds a piece to not just drive the numbers, but also getting people tapped into their mission."

"Researchers have shown there's a linkage between quality improvement and public reporting, so it does not surprise me that the same thing is going on with patient satisfaction rates," adds **Patrice L. Spath,** of Brown Spath Associates in Forest Grove, OR.

"These same researchers who identified the link between increased quality improvement and the reporting of quality outcome data found that when that same data were only reported internally there were still quality management activities that occurred, but not necessarily at the same rate as in those hospitals where they were reported publicly."

Hospitals participating in HCAHPS, she continues, know their data will be publicly reported and, therefore, are making a more concerted effort to raise their patient satisfaction scores. "Those things being publicly reported are those things hospitals focus on," she notes.

Most patients don't know that these data are being shared publicly, she continues, adding that recent studies confirm this. "So, it's not the fact that hospitals say they are being transparent, but there are different levels of transparency," Spath notes. "What increases satisfaction is one-on-one transparency, like disclosing adverse events when they occur. That's more important."

Nevertheless, she says, "Satisfaction is a subset of quality and it is probably a more meaningful measure of quality to consumers than some of the clinical measures. If consumers are looking at this data, it would seem they would be likely to use those hospitals [that score higher]."

One system's response

Paul Convery, MD, senior vice president and chief medical officer, Baylor Health Care System in Dallas, agrees that most consumers are not yet paying attention to the publicly reported data. He can

also testify to how HCAHPS has impacted his system's patient satisfaction efforts.

"Public reporting has a bigger impact internally than externally at this time, and this has been true for a number of years," he notes. "Our internal managers, executives, board members, doctors, and nurses pay more attention to patient satisfaction because we circulate data internally and report them internally. When they know they're being made public they are more concerned about it than the public is."

Right now, says Convery, "the public is not paying a lot of attention to the public web sites, but the knowledge that it was going to be public in March caused us, and a lot of other systems, to begin working on satisfaction and understanding the drivers for the last couple of years. Once we knew the data were going to become public we talked about it internally, and the two years we have been working on it has really made a difference."

What exactly has Baylor learned? "We learned we have to be very focused on specific behaviors that must be done, and that it varies from department to department," says Convery. "So in the ED, for example, it may be greeting people and introducing who you are, telling the patient what you are going to do, and giving people information about how long they are going to wait. You may do regular rounds on inpatients and ED outpatients, and give that information back to the staff on a regular basis and work with them to let them know how important these things are."

He says that Baylor has undertaken "a whole series of activities in a systematic fashion," and that is what is driving its improvement. "We measure our satisfaction scores on a monthly basis, and we have broken the responses down by what the key satisfiers and dissatisfiers are," says Convery. "And we employ internal coaches who are trained to work with the staff on these line items that are dissatisfiers." Those dissatisfiers, he explains, "may be a nurse who is not communicating with the patient, or a doctor who is not explaining the medicine or the wait time."

In addition to the internal coaches, he says, "we communicate with the staff to help them understand how to perform important system activities."

Patient focus critical

Mylod says that patient-centered care is the key to improving satisfaction and, thus, looking good on those public reports. "The organizations that are listening to patients and sharing what patients say in a transparent way, those are the ones that are improving," she notes. "What improves patient satisfaction is that focus on the patient — how you communicate with them and build trust. This can be different than a process improvement, because it's both process and culture."

For quality managers, she continues, public reporting should be an impetus to galvanize and "move the needle." "They must ask themselves how they can improve," she advises. "Hospitals are less comfortable with driving behavior change and holding people accountable. What we say is you already hold them accountable on the clinical side."

Quality managers, she says, know that staff have to be accountable for behavior as well as clinical performance; they know what the staff need to do, and what will happen if it's not done.

"It's not any different when it comes to serving patients; there needs to be behavioral standards defined, they need to be noticed and tracked, and people need to know what will happen if they do not do it since it is part of the performance standards of working at the facility," she explains. "Patients need to know they can trust you, they need to share in their care, and this needs to be defined. You guys are already experts in this; you just need to define those quality standards to a different type of behavior."

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Leapfrog: Quality assurance required with CPOE systems

Wide variance in degree of adoptions, outcomes

In its first-ever evaluation of computerized physician order entry (CPOE) systems in hospitals across the country, The Leapfrog Group found reason for concern when it came to proper implementation of these systems. In fact, the organization noted "a broad variance in both the degree of

adoption and in the quality of outcomes."

The evaluation, which is now part of Leapfrog's annual survey of hospitals (more than 1,200 participated), was made possible through a tool developed by First Consulting Group (now Computer Sciences Corporation/CSC) and the Institute for Safe Medication Practices. The tool provides hospitals with an assessment of the adequacy of their CPOE system alerts for common, serious prescribing errors.

"For a long time, Leapfrog has been a proponent of CPOE in hospitals," says CEO **Leah Binder**, MA, MGA. "We believe it is one of the most important measures hospitals can take to improve safety. But they have asked us a legitimate question — is it the adoption we should measure, or should we be measuring the quality of that adoption?"

The development of the tool, she continues, involved years of research by experts in medication management and medication errors. "Since it is now part of our overall survey, the hospitals will now be required to not only have the system but to evaluate its implementation," says Binder. For this first year, however, all they had to do was test their systems. "Next year, we will be reporting their scores publicly," Binder notes. In order to fully meet Leapfrog's CPOE standard, hospitals must:

- Assure that prescribers enter at least 75% of medication orders via a computer system that includes prescription-error prevention software;
- Demonstrate their inpatient system can alert prescribers to at least 50% of common, serious prescribing errors

Learning from the report

Hospital quality managers who read their facilities' individual report will be able to home in on problem areas, Binder explains. "For example, [the report will show] if providers are able to order medications that would produce an allergic interaction, or not alert them that certain other meds the patient is taking would interfere with what the doctor wants to order," she says. "There are a variety of mistakes that can be made, and we can measure if the system alerts you to them."

In addition, she says, it also measures whether providers are alerted too often. "One of the potential problems is that providers can get alert fatigue; they start ignoring all alerts if they think they are frivolous," says Binder. "The tool really examines whether the system is performing as an effective aide for decision support."

Key Points

- It's important to realize that CPOE is not a plug-and-play system.
- Prescribers should enter at least 75% of medication orders via system.
- There's such a thing as too many alerts.

Degree of adoption is another important measurable, Binder says. "Some hospitals have CPOE systems just in the ED, or just in other departments, but not in the entire facility," she explains. "The evidence suggests you can reduce errors from 50% to 85% with CPOE. If you do not have all your medication orders handled by CPOE, you expose yourself to more errors than others might." Binder says the report also found variance in the evaluations of how well the systems were performing.

CPOE is not plug and play

One of the common technological challenges with CPOE, Binder says, is that users fail to realize these are not off-the-shelf products that can simply be plugged in; they require customization. "You've got to determine, for example, where the alerts will go and how they should be responded to," she explains. "Every organization is different in terms of how it manages medications."

One of the most positive aspects of this evaluation says Binder is that it forces hospitals that adopt CPOE to go through their own internal system for medication administration. "That alone can show you steps along the way that could potentially create errors," she says. "This requires you to look at your cultures, your systems, your workflow, and then address them."

So, for example, in terms of workflow, in some hospitals the alert may not go to the ordering physician, but only to the pharmacist. "We believe that may not be best," says Binder. "Hospitals need to examine if that is the safest way to handle the administration of medications. Those are the types of questions the organization should raise."

To help hospitals come up with solutions, Leapfrog is forming a CPOE consortium to identify best practices for implementing and addressing the errors found by the evaluation tool. "We hope to have it up and running by January 2009," says Binder. "This will be an important development that helps hospitals implement CPOE without having to 'reinvent the wheel,' and learn from best practices found by CPOE pioneers. We feel

those who have implemented CPOE are way ahead of their time, because they are rare. We want to acknowledge them for being out front and learn from them."

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Anthem's P4P program wins Eisenberg award

Door to balloon times, complication rates slashed

Anthem Blue Cross and Blue Shield of Virginia, a subsidiary of WellPoint Inc., based in Richmond, has received a 2008 John M. Eisenberg Patient Safety and Quality Award for its development and implementation of performance-based reimbursement programs for Virginia hospitals, cardiologists, and cardiac surgeons.

These programs are known as the Quality-In-Sights: Hospital Incentive Program (Q-HIPSM) and Quality Physician Performance Program (Q-P3SM). Q-HIP and QP3 reward hospitals and physicians for practicing evidence-based medicine and implementing other nationally recognized best practices.

A quick look at the program's early results (it was launched in 2004) shows why the programs gained the attention of the award committee. Two cohorts were followed; in both, 75% percent of participants achieved the door-to-balloon time goal of 90 minutes or less, although their baseline rates were about 59% and 37%, respectively. Both cohorts also cut their rates of serious complications approximately in half.

Key Points

- Program participants achieve impressive improvement in door-to-balloon time and complication rates.
- Collaborative effort involves hospitals from the very beginning.
- Results of participating hospitals are publicly reported.

Like many patient safety programs, this one got its impetus from the Institute of Medicine's landmark *To Err is Human* publication in 1998. "We had some hospital systems willing to be involved in this, and local chapters of the American College of Cardiology, so it started as a collaborative effort with various stakeholders," notes **Robert Krebbs**, program manager. There were 16 hospitals participating in the first year, he says, and today there are 69. "That's over 95% of inpatient facilities," says Krebbs, adding that the program is now "rolling over" into other WellPoint states.

Data collected regularly

Krebbs explains that on a quarterly and annual basis, participating hospitals send demographic information on their performance in "nationally endorsed, well recognized evidence-based" measures. These include, for example, The Joint Commission's National Patient Safety Goals, standards from the National Quality Forum, the IHI 5 Million Lives campaign, and CPOE. "We use a third-party organization (called the Patient Safety Organization) to collect and validate the data, and then we receive the scores back," he adds.

Krebbs says this use of a third party, trusted intermediary specializing in health care quality improvement and patient safety "provides an unbiased evaluation of Q-HIPSM submissions."

There is regular communication with the participating hospitals, he says. "We update the scorecard on an annual basis, and we share a copy with the hospitals," he says. "We have an annual meeting of all the hospitals to let them know what's coming up." In addition, he says, there is an external advisory panel with representatives from each hospital, and they also provide quarterly previews of what may be changing in the near future.

The financial rewards are set on a contractual basis, as a percentage "tacked on" adjustment to the facility's reimbursement rate. "We usually use 2% as an example on a hospital basis," says Krebbs.

Anthem's goal, he adds, is to achieve a common high level of care among all hospitals. "If you look at hospital quality as a bell curve, our goal is to tighten that curve," he says.

Public reporting begun

Effective November 2007, Anthem has made its hospital quality reports available on its web site, www.anthem.com. The Hospital Performance Reports focus on five health outcomes: cardiac

care (cardiac catheterization and angioplasty); heart attack; heart failure; pneumonia; and surgical infection prevention. Visitors can view a detailed performance report for any Anthem-network hospital that participates in Q-HIP, or a side-by-side comparison of Q-HIP-participating hospitals in a specific region. Each Hospital Performance Report identifies where a hospital scored higher than the Virginia Q-HIP average.

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DNV granted deeming authority from CMS

The Joint Commission welcomes competition

Is it the end of an era for The Joint Commission? Following on the heels of Congress' move to require the organization to reapply for deeming authority for the first time, DNV Healthcare on Sept. 26 was granted deeming authority from the Centers for Medicare & Medicaid Services (CMS). It is the first organization to gain deeming authority in more than 30 years. Just how big is this news, and how much will it affect health care, hospitals, and you?

"It's a big issue. We haven't had an alternative to The Joint Commission and the American Osteopathic Association in my lifetime," says **Sue Dill Calloway**, RN, MSN, JD, director of hospital patient safety at OHIC Insurance Co./The Doctors Company in Columbus, OH.

As far as bringing competition to a market that has seen one major player, **Nancy Foster**, vice president for quality and patient safety for the American Hospital Association, says: "At the AHA we recognize that having a choice of accrediting organizations could be good for patients and for hospitals. Both The Joint Commission and DNV Healthcare will work with hospitals to reach their goal of quality improvement — they'll just take different paths to get there. We look forward to learning more about DNV Healthcare's approach and how well it works to help hospitals achieve better quality."

Houston-based DNV Healthcare, a subsidiary of the Norwegian company Det Norske Veritas, first applied for deeming authority in December 2007 and learned in early March from CMS that its application was complete. CMS then had 210 days to either approve or reject DNV's application.

Key Points

- DNV first organization to be granted deeming authority in 30 years.
- Now hospitals can get accreditation from Joint Commission or DNV, which bases its program on ISO 9000 standards.
- ISO 9000, which originated in manufacturing industry, focuses on processes for quality improvement.

Of the application process, President **Yehuda Dror**, says, "the barriers to entry I would say are quite high, justifiably so, because you cannot come to CMS with a program that shows what you will do. You have to come in with a program that shows what you have done." You have to prove to CMS that you are "committed" and "are in it for the long haul," he says.

In the three years the company worked toward achieving deeming authority, it accredited 27 hospitals using its National Integrated Accreditation for Healthcare Organizations (NIAHO) program. Those hospitals, Dror says, are a testimony to the strength of its program as they "went through our accreditation process without gaining any favors or benefits from CMS." They also gave DNV the experience it could bank on in applying with CMS.

The ISO difference

"The major difference [between DNV and The Joint Commission] is that in our program we have taken the Conditions of Participation from CMS and we have married it to ISO 9000," Dror says.

"We like this standard," he adds, "not just from the certification point, but from the fact that is what I would call one of the better attempts to standardize common sense, as oxymoronic as it may sound."

ISO 9000 is an internationally recognized family of standards for quality management originally used in the manufacturing, aerospace, agriculture, banking, and steel industries among others.

With the rise in popularity of quality and process management systems such as Six Sigma, Lean, and others used in industries including aviation and manufacturing, how does ISO measure up? And is this the way quality and safety should be moving?

The Joint Commission has "essentially become a monopoly in the last half of the last century

and it was very focused on health care," says **Martin Merry**, MD, CM, adjunct associate clinical professor of health management and policy at the University of New Hampshire and partner, Dynamic Health Systems. "It really was relatively slow to incorporate, in my opinion, some of the quality systems such as manufacturing."

He says many hospitals he sees across the country already have been looking for alternatives to Joint Commission accreditation, often opting instead to go through state certifying organizations, and a number of hospitals, though it previously didn't give them deemed status, have been ISO certified.

"In fact, here in my home state of New Hampshire, many hospitals have opted out of The Joint Commission. They don't even worry about The Joint Commission. They've made the judgment, whether for better or for worse, that The Joint Commission was not offering them adequate value for the expense that these surveys cost," says Merry, who serves on the advisory board of TUV, which was acquired by DNV in 2007.

In talking with hospitals that have ISO certification, he says, "they found quite great value in working with the ISO standards, and it gives them what most of them reported as a much greater depth of understanding of quality management standards than the very broad Joint Commission standards."

He acknowledges that ISO doesn't focus as broadly on health care as The Joint Commission, focusing instead on "true quality management support systems" for companies that he says are serious about quality and process improvement.

"I've often said, tongue in cheek, that The Joint Commission standards can be a mile wide but not that deep, while ISO is relatively narrow," he says.

But he sees a sea change in health care. "Health care has been kind of cloistered; it's not been a part of the real world. It has a preindustrial-based culture, and The Joint Commission classically represents that culture," he says. If he were an investor, he says he would hedge his bet with ISO, but for his clients and audiences he recommends that they compare the accreditation programs side by side and that they look "very seriously" at what ISO has to offer in terms of quality and process development.

And though he welcomes a competitive field, he sees a potential threat. "The trouble with the whole compliance industry," he says, "is that it can be gamed." People find out what surveyors are looking for and try to give them just that. Corporations such as General Motors tended to require their suppliers to get ISO certification, but it was never compulsory and appealed "to those who really wanted to do something in quality." Merry says. Now that DNV is an accrediting organization, he says, it, too, could fall into the gaming trap.

"Every two or three years, everyone scrambles around [in preparation for a Joint Commission survey]. They put everything in the corridor," Merry says.

But The Joint Commission, he adds, has been aware of that problem and has improved processes with new survey methods, tracking systems, and surprise visits.

With DNV, surveys still will be unannounced, but more frequent, and surveyors will all be cross trained in ISO methodology. "It's a shame with an audit that takes place every three years," Dror says. "It makes it a show. Our system is different. We want it to be a way of life, and in order to assure it is, we do it once a year."

He says hospitals won't need to prepare and spend overtime and hire more personnel in preparation for their audits. The method DNV uses, he says, is more about system creation and improving that system in a less prescriptive way than The Joint Commission. Hospitals' responsibility is to "meet the objectives in whichever way they do" and if there's a problem, he says, you change it.

Robert Wachter, MD, professor and associate chairman of the department of medicine at the University of California, San Francisco, doesn't think the move to DNV will be an automatic one. "At this point," he says, "the name recognition of The Joint Commission remains pretty powerful."

Peter Angood, MD, vice president and chief patient safety officer for The Joint Commission, which must reapply for deeming authority in two years, says, "We've been very successful in the marketplace and have been for over 50 years. So the fact that there is a new competitor in the hospital marketplace is fine by us.

"But we have a long-standing legacy of excellence. We've got over 80% of the hospitals accredited by us, and in sum total, we do well over 10,000 more types of health care facilities in an accreditation program. And in so many ways we are the gold star of accreditation in America."

He says The Joint Commission is evaluating DNV standards "but it looks like they're more or less focused on the CMS standards and haven't gone much beyond it."

As far as its stake in the industry, he says, The Joint Commission "will respond as a competitive

organization and we expect to have success as we have for over 50 years."

However, Joint Commission and ISO certification are not necessarily exclusive of one another. **Mickey Christensen**, president of TQM Systems, a quality management consulting company, suggests dual certification. "I don't promote ISO 9001 [part of the ISO 9000 series] in lieu of The Joint Commission or the American Osteopathic Association or something like that because ISO 9001 doesn't have the clinical aspect The Joint Commission does.

"I think the two complement themselves very well," he says, but adds that he sees gaps in The Joint Commission standards and CMS CoPs in terms of looking at quality management systems.

"I don't want this to come out sounding negative, just stating the facts. If the IOM report ["To Err is Human: Building a Safer Health System"] is correct, and I have no way of knowing for sure whether it is or isn't, that we kill up to roughly 98,000 people a year due to medical errors, and 80% of the hospitals are accredited by The Joint Commission, then there's gaps in there somewhere," he says.

Many clients, he adds, think The Joint Commission has included things that aren't value-added and doesn't address issues related to, for example, dealing with ancillary support (i.e., housekeeping, dietary functions, maintenance, purchasing) and running an efficient business.

Exactly how it will play out remains to be seen, but Dror says he has gotten many calls since Sept. 26 about DNV's program. Dill, too, reports fielding a lot of questions about the new accrediting body from her clients.

"There's a buzz in the field. There's someone new. They want to test us out," Dror says.

"We'll see. Time will tell." ■

New Sentinel Event Alert addresses blood thinners

Anticoagulants once again hit center stage

Anticoagulants, or blood thinners, have taken the mainstream media by storm with salacious tales of medical errors and tragic stories of babies' deaths. While you are dealing with the phase-in period on National Patient Safety Goal 3E, another call for alarm has been sounded on anticoagulant use and management.

The Joint Commission's new Sentinel Event Alert urges greater attention to be paid to this high-risk set of medications. *(For the complete sentinel event information, including suggestions, visit http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_41.htm.)*

Also, in preparation for implementation by Jan. 1, 2009, The Joint Commission says hospitals should now have completed pilot testing on strategies for managing blood thinner use in conjunction with NPSG 3E. "As hospitals are struggling to come into compliance, we know a lot of them are actually behind," says **Sue Dill Calloway**, RN, MSN, JD, director of hospital patient safety at OHIC Insurance Co./The Doctors Company in Columbus, OH. "We've heard a lot of hospitals say that there's just no way they can meet that deadline."

Recommendations in the newest Sentinel Event Alert include:

- Assess the risks of using anticoagulants.
- Use best practices or evidence-based guidelines regarding anticoagulants.
- Establish standard dose limits on anticoagulants and require that a doctor confirm any exceptions.
- Clearly label syringes and other containers used for anticoagulants.
- Clarify all anticoagulant dosing for pediatric patients, who are at higher risk because these drugs are formulated and packaged for adults.

"The Joint Commission has had medication management standards in place for a long time," says **Frank Federico**, RpH, content director, Institute for Healthcare Improvement. "The fact that we're highlighting the anticoagulants, as they have with the National Patient Safety Goals, is just because it's not happening. We're not seeing improvements."

The problems that are occurring are numerous and multidimensional. But telling staff to just work harder, to be more vigilant, to pay more attention is not the answer, says Federico. And **Mark Chassin**, MD, MPP, MPH, president of The Joint Commission, agrees.

"It is important that we stop relying on the idea that if only everyone in the medication delivery process tried harder that doctors, nurses, pharmacists, and other caregivers could eliminate every single error by just trying harder," he said in a press conference on the new alert.

Where errors are occurring

In general, Chassin said, this set of drugs is challenging because the difference between a harmful dose and an appropriate one is so narrow. **Peter**

Key Points

- Hospitals should be in pilot phase in preparation for implementation in accordance with NPSG 3E.
- Some of the most frequent problems with anticoagulants occur with failure to adminster a single dose or failure to resume therapy.
- There should always be physician verification when an unusual dose is ordered.

Angood, MD, vice president and chief patient safety officer at The Joint Commission, said compliance is hampered by these persistent problems: the storage of the medication, the legibility of written orders, and the transcription of the orders.

"The cases show that errors occur at every stage the medication is processed — from ordering, to transcribing or documenting, dispensing, administering, and monitoring. And they happen in almost every unit in the hospital," said **Diane Cousins**, RpH, vice president, Center for the Advancement of Patient Safety, United States Pharmacopeia.

Some of the most frequent errors occur in admissions, she added, including:

• failure to administer a single dose but also failure to initiate a course of therapy when it's ordered;

• failure to resume therapy (for example, after surgery).

Among the top 10 most frequent causes for harm, she listed:

• poor communications;

• knowledge deficits among health care personnel;

• inadequate or absent monitoring;

• inaccurate computer entry, including computerized physician order entry;

• performance deficits, in which trained personnel still make errors because of distractions, workload increases, and inexperienced staff.

Federico says all health care professionals should look at the errors occurring across the United States and ask themselves, "Could this happen here?" Process evaluation and improvement are essential.

The second thing he stresses is taking a system approach. "Although education and training are necessary, they are not sufficient," he says, especially in lieu of sound system development.

Chassin said health care organizations should take a look at other companies in other industries and reliable systems that "anticipate, look for, track the small errors that people make every day before they result in harm." The first step, he said, should be undertaking an in-depth assessment to evaluate "how these processes fail."

Angood added that patients, before receiving anticoagulant therapy, should be screened for the "appropriateness" of receiving the medication and for any possible contraindications or adverse drug reactions.

He also emphasized that hospitals should standardize the way blood thinners are "prescribed, delivered to the bedside, and administered," strengthen communication about lab values, and determine dose limits when dosing is out of the "usual and expected" range. This last point, he said, should always be a checkpoint. "Unless there's a specific physician order that says, 'Yes, that's an OK dose,' those drugs should not be administered."

Cousins recommended all caregivers in the hospital setting "understand what the proper dosing is and stay up to date on proper dosing regimens. They should be aware of what those products look like and the various strengths that are available."

Federico suggests minimizing look-alike, sound-alike medications and emphasizes the importance of monitoring the patient. Some facilities, he says, use clinical pharmacists in the monitoring role because they can "monitor lab values, monitor patients, and make appropriate adjustments."

He also stresses identifying and managing high-risk patients: the frail and elderly and infants. It's a much different discussion with these patients than dealing with a healthy "normal" patient. Federico says two questions must be asked. First, can the patient comply with the regimen? Second, what's the risk of putting this patient, for example, on warfarin vs. not putting the patient on warfarin?

"Those are the kinds of issues that I think are the next step in the evolution toward a safer system," Federico says.

Another central element to anticoagulation management: education while patients are in the hospital and upon discharge. "There are some studies out there that report that self-managed anticoagulation is probably better than some of the other methods out there, Federico says. So an engaged patient who knows what to look for and when to call for help is probably a much better-cared-for patient."

Lastly, he emphasizes that anticoagulants are effective drugs and save many lives. "So the message we want to send out is we don't want to create so much fear that people won't use them. What we want to do is develop systems so people use them safely."

(Editor's note: Revisit the guidelines for National Patient Safety Goal 3E for new notations and clarifications.) ■

The technology factor: Is it our friend or our foe?

New study highlights errors with bar coding

While The Joint Commission is asking health care facilities to use computerized physician order entry and bar coding technology as an adjunct to arm themselves in managing high-risk medications including anticoagulants, a recent study highlights the errors implicit in this kind of information technology support.

Peter Angood, MD, vice president and chief patient safety officer for The Joint Commission, points out that while technology is helpful, it is not a panacea. "The expectation is that technology will solve the problem," he says. "And it does not."

A first-of-its kind study tackles the problems inherent in IT systems often praised and recommended as first-line defense against medication errors. The study examining flaws in barcode medication administration (BCMA) systems was published in the July/August issue of the *Journal of the American Medical Information Association*.

Led by **Ross Koppel**, PhD, lecturer/adjunct professor in the department of sociology at the University of Pennsylvania, researchers looked at five hospitals in the Midwest and on the East Coast and found 15 types of workarounds in which clinicians overrode the BCMA system to compensate for difficulties in the system.

One of the major findings, Koppel says, is "contrary to what is ordinarily discussed in the literature." In the study, he says, about 11% of medication bar codes were unreadable because they were:

- torn, smudged, ripped, sodden, or covered by another label;
- the scanner was outside of the Wi-Fi range for that patient's room.

In other instances, clinicians couldn't use the BCMA system because they were perhaps near the MRI machine or in an X-ray room.

Koppel says the team also found 4% to 5% of patient IDs were unreadable. Some of the reasons include:

- they were from another floor in the hospital;
- patients with dementia had torn them off;
- children ripped them off;
- there was no room for IDs on premature babies with tubing, so they were attached to the crib or the incubator, and Koppel points out these IDs might not be moved when the infant is moved;
- they were covered by sterile gauze dressings;
- they were removed so clinicians could perform clinical procedures, such as taking blood.

"So the usual claim that the bar codes worked 99 point something percent turns out not to be true," Koppel says. So that clinicians could do their jobs, he says, the research team found "tens of thousands of situations" where extra copies of bar codes were made and found on places like door jambs, taped on places like refrigerators or scanning machines, or worn as bangles on nurses' arms that already held all their other patients' IDs.

But Koppel stresses that these instances are not a result of clinicians who are lazy, uncaring, or stupid. It's that systems don't support the reality of processes that need to occur in health care settings, he says.

"No one has thought about the process in its entirety," Koppel says and he gives this example: A nurse has a 94-year-old patient and needs to access a refrigerator two floors down. Instead of wheeling the infirm patient down two floors and a long hospital corridor, the nurse decides to just make an extra copy of the bar code to scan.

"I don't think anyone is bright enough to predict problems [that can occur with BCMA] a priori," Koppel says, suggesting instead continuous observation of BCMA use and coordinated multidisciplinary discussion.

"Ultimately, it comes down to the quality people, who have to simply not accept vendor claims that nothing can be done or local IT claims that it's not their fault and somebody has to take responsibility for this," he says. In working with vendors, the hospital must have the last word and the final decision. Vendors, he says, can only do their part in fixing the problems but must be directed to priorities by the hospital team.

The future of IT in health care

"Koppel's study is a very important part of a larger literature that's emerged in the last three to five years on the consequences of information technology," says **Robert Wachter**, professor and associate chairman of the department of medicine at the University of California, San Francisco, and

Key Points

- Bar code IDs often torn, smudged, ripped or sodden.
- Copies of bar codes often made and placed away from patient.
- Make sure to work closely with vendors in setting up BCMA system.

blog author.

"Whenever there's a glitch with a new technology, people always get very wistful and romantic about how good things were before we had it," however unjustified that may be, he says. But in this instance what we had before IT development wasn't working either, he adds.

Early systems are always laden with things to learn, Wachter says, and "no one has done studies like Koppel's study to observe what isn't working and fix it."

Though we're "clearly not" there yet with IT and he applauds Koppel's study, Wachter says, if you take it "the wrong way" and decide to "stop the IT train" than you're just not getting it.

He recently wrote an article about The Joint Commission performance measure on door-to-antibiotic time for pneumonia patients in the emergency department. "It was a mistake," he says, resulting in some patients receiving antibiotics who didn't need them. It was subsequently modified from four to six hours. "Naysayers look at that and say, 'See. We weren't ready for transparency,'" he says. "But you wouldn't get to the place we need to get unless you started somewhere and recognize there's going to be glitches... We have to be smart enough to learn from the experience."

That is what he says progress looks like, learning from errors to improve processes to get to where you want to be.

"If I was buying a bar code system, I would do it with [Koppel's article] in hand and ask the vendor: How do you know these things aren't going to happen? What are the steps that you've taken to ensure they won't happen?" ■

Wristband standardization: Why we aren't there yet

AHA issues quality advisory on wristband colors

In September, the American Hospital Association issued a quality advisory on implementing standardized colors for patient alert wristbands, citing a near miss when a nurse mistakenly placed a wrong-colored bracelet on a patient, confusing the color codes of the two hospitals for which she worked.

The dangers in confusion about wristbands are well noted, and the AHA is encouraging the adoption of three consensus colors on a nationwide basis — red for allergy, yellow for fall risk, and purple for do not resuscitate — while emphasizing that the final word on all patients' care is the medical record.

"This is really an issue I like to give state hospital associations credit for," says **Beth Feldpush**, AHA's senior associate director for policy. "They've been really engaged for several years with this. Now over 25 state hospital associations have adopted a voluntary initiative for these three consensus colors."

She says "it made sense" for the AHA to encourage all U.S. hospitals to adopt the three consensus colors while emphasizing that hospitals have to choose "what makes sense to them" in implementation — for example, using what they have before purchasing new bands.

State laws, however, can conflict. Ohio's law reads that the DNR wristbands be clear with the DNR logo. But **Tiffany Himmelreich,** of the Ohio Hospital Association, says state legislators and the Department of Health are currently looking to revise the DNR wristband guidelines.

"The hope is, going into the future, Ohio can join in with this national standard," she says.

The reasons nationwide standardization has not yet taken hold are multidimensional and represent a larger truth about the health care system, says **Robert Wachter**, MD, professor and associate

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chairman of the department of medicine at the University of California, San Francisco.

"There's sort of a macro issue and a micro issue," he says.

The larger issue is that "you've got to get a lot of different stakeholders to sit down and agree on something."

The micro issue?

"We didn't even start thinking this way until four or five years ago. It wasn't seen as odd or unusual that every hospital in the country would have its own way of doing it — it's a metaphor for a larger problem in health care," Wachter says.

He cites the aviation industry and the strict standardization there. Get on any 747, he says, and it will look the same as any other 747 you've been on. "People will speak in the same language with standard terms and that creates a huge amount of predictability and safety," he says, something you don't see in hospitals because facilities and physicians like to do things in their own ways.

"The reason I find the wristband issue interesting is not that it's the most important thing in the universe — it's not — but it's a nice metaphor for this larger issue of the importance of standardization, and it's something we really haven't thought about much in health care."

Wachter favors nationwide use of standard colors. He points to The Joint Commission's list of high-risk abbreviations. "When The Joint Commission came out and said, 'Here's a list of high-risk abbreviations that are dangerous. We want you to purge them from the lexicon of medicine,' they didn't allow every state to come up with a different list. And that's actually eased implementation tremendously," he says.

"The same thing should be true for something like wristbands."

Though he favors standardized wristband colors, **Peter Angood**, MD, vice president and chief patient safety officer for The Joint Commission, says wristband use is not without risk. "The color coding could be put into place wrong, there can be loss of bracelets, there can branding of the patients by what kind of color they have, there can be lack of understanding of why they have those bracelets on, [patients] can remove them or take them off.

"A reliance on what seems like a simple solution is not without risk," he says. "In general, we support appropriate use of bracelets, but they are not a replacement for good, solid patient identification and the strong processes of patient care."

(Editor's note: To view the AHA advisory, go to http://www.aha.org/aha/advisory/2008/080904-quality-adv.pdf.) ■

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