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Hand hygiene compliance: Why hospitals aren't getting it right

Barriers to and methods of hand hygiene compliance

If clean hands can save lives, why aren't more health care workers complying with hand hygiene guidelines? The answer isn't singular in nature and neither are the methods suggested for improvement, but one thing is certain: Compliance is lacking. In response, The Joint Commission recently published a 262-page monograph, "Measuring hand hygiene adherence: Overcoming the challenges," to identify best practices for measuring adherence.

Elaine Larson, RN, PhD, FAAN, CIC, professor of epidemiology at Columbia University's Mailman School of Public Health, served as scientific advisor and chair of the panel that produced the paper. Asked by *Hospital Peer Review* what the answer is to encourage 100% hand hygiene compliance, Larson says, "If we knew that.... It's been something we've been working on for ages. I think it requires a culture change for the entire place."

By that she means encouraging and empowering all staff to speak up when a peer doesn't wash his or her hands. "There's no way in general a nurse would tell a physician to do hand hygiene 'right now.' But we know from work that Peter Provonost and others have done that if you enable and empower people to do it, then I think it becomes a cultural expectation and people help each other rather than perceiving it as spying on each other."

Infection prevention vs. quality assurance

To quality improvement directors, she says, collaborate with your infection prevention (IP) department. She sees a vacuum in identifying who exactly "owns" the hand hygiene issue. "My observation is that when I look from place to place that it's either the quality assurance [QA] department or the infection prevention department, and they don't seem to work together as much. And that's kind of a shame. Sometimes it almost feels like it's a little competitive.

"I do sense in a lot of places a sort of tension between infection prevention and QA, and obviously infection prevention is part of QA... But I think it may have to do with who owns this, instead of just working together and figuring out what's the best way to make it work combining

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our joint strategies. I think this would be part of the culture change for hospitals, where we are really working together on this."

She says the "tension" between IP and QA might in part be because infection prevention "has been around since 1970 or so and has done a huge amount in terms of methods for data collection and data interpretation and applying epidemiology. So, I think QA, as an entity, a department, if you will, is a little bit newer. And maybe there was a sense from infection prevention that maybe, 'They're going to take us over or something.'"

Acknowledging this is part of the cultural shift toward making true changes in compliance she sees as crucial.

Barbara Braun, PhD, project director in The Joint Commission's division of quality measurement and research, agrees that collaboration between IPs and QA is key. From a resource standpoint, she says, infection prevention can't do it all on its own. "Quality improvement staff can really engage the leaders and the board," so the hospital prioritizes hand washing from the top down.

She notes another barrier to compliance: People are not clear on what the guidelines call for with regard to when hand hygiene should occur.

"Everybody thinks they know — before and after patient contact — but in fact the guidelines are much more complicated, and people are either not aware or they forget the indications such as from [the World Health Organization] about before patient contact, before an aseptic task, after body fluid exposure, after patient contact, and after contact with surroundings in the environment," she says.

She suggests reviewing recently updated guidelines from WHO (www.who.int/patientsafety/en/). "Those are a little more updated than the [Centers for Disease Control and Prevention] guidelines, but they're very closely related."

Three improvement methods

The monograph touts three methods for measuring hand-washing compliance — suggested methods meant to be used in tandem and not as a simple fix-it-all answer. The paper examines the advantages and disadvantages of each method: direct observation, measuring product use, and conducting surveys.

Braun points out that each has strengths and weaknesses. "There are a lot of things that you can measure with observation that you can't get at with product [measurement]... With product measurement, you can't tell who's using what and if they're using it at the appropriate times (unless you have a very sophisticated electronic monitoring system). Observation is the only way to do that... Now observation is considered direct measurement; product measurement is considered

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Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).
Managing Editor/Writer: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).

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Editorial Questions

For questions or comments, call **Jill Robbins** at (404) 262-5557.

indirect, and then surveys really don't do a good job at all of measuring adherence to the guidelines. They're really more useful for measuring knowledge and attitudes and beliefs and things like that, which are very important to measure, but they're not useful for asking people how well they adhere because the data have shown to be an overestimate."

"Surveys, I think, are worthless," Larson says. Echoing Braun's statement, she continues, "Most people don't intentionally lie, but we overestimate how much we do hand hygiene. So that's pretty useless.

"I think a really promising way to monitor hand hygiene is to look at amount of product use... The problem is that you still don't know unless you get it per unit and per patient bed. [Otherwise] you don't really know whether a hand hygiene episode occurred... So there are some disadvantages." Over time, she says, you could establish standards given, perhaps, the patient population on the unit. "Right now the sort of gold standard is observation, and it's terribly difficult because it's extremely expensive."

Pairing monitoring and feedback

Monitoring without feedback is "not that useful," Larson says.

Indeed, Braun says one of the strategies that has seen more success is implementing education and training, plus auditing and feedback. **(See related story to the right.)** She's seen examples of organizations doing a good job at measuring and "then they share the information back to the unit levels, to the department level, and they post it," turning it into a competition. "You can really boost your rates by having a healthy internal reporting [system] and competition."

Engaging staff

"I really, truly think that the only thing that's going to work is a long-term commitment on the part of an institution or a unit. It can't be from individual to individual. It's got to be the unit culture," Larson says.

Braun says the level of compliance often depends on staff beliefs and attitudes, and she stresses the importance of role models and clinical champions. "I think there's some research on physicians that really demonstrates that the role models, the mentors, the senior folks have to be role models; otherwise people will not adhere."

In order to empower staff to get buy-in for improvement, Braun suggests forming a multidisciplinary team focused on the initiative, including "people from housekeeping up to the C-suite and physicians, because they know best what the obstacles are among their peers."

[Editor's note: The monograph is available at www.jointcommission.org/NR/rdonlyres/68B9CB2F-789F-49DB-9E3F-2FB387666BCC/0/hh_monograph.pdf. For more information on The Joint Commission requirements regarding hand hygiene visit www.jointcommission.org/AccreditationPrograms/LongTermCare/Standards/09_FAQs/NPSG/Healthcare_associated_infections/NPSG.07.01.01/Hand+hygiene.htm.] ■

Boosting hand washing with monitors, feedback

Novant uses internal marketing to get staff on board

In the photograph, a young boy in a hospital bed looks unflinchingly at you, one hand on his chest. And in big type it reads, "You could kill me with your bare hands." Novant Health's message to its staff in 2005 was clear. Hand hygiene compliance is a matter of life and death.

The hospital system knew what it was talking about. In 2004, there was an outbreak of methicillin-resistant *Staphylococcus aureus* (MRSA) in one of its NICU units. "And with the subsequent associated death to MRSA of a small baby and some transmission within the unit, it was really the president of the system's call to arms — 'This can't be,'" says **Jim Lederer**, MD, medical director for Novant Health's clinical improvement department.

So with upper-level support from management and administration, the health system set out to raise hand hygiene compliance to 90%. And after about a dozen failed hand hygiene compliance efforts, this one took, garnering the health system The Joint Commission's 2008 Ernest Armory Codman Award. Novant is now at 98% for hand hygiene compliance, and its MRSA rate is 0.16 per 1,000 patient days, a 68% reduction.

The effort was systemwide, and the steering committee included "everyone from infection prevention to nursing to senior leadership," says Lederer, an infectious disease doctor who works with occupational health and the clinical improve-

ment department, which houses both infection control and quality.

Monitors hired for observation, feedback

The guiding light became accountability, and in order to "hold you accountable for something, I need to be able to to have measurement," Lederer says. So Novant hired two monitors for each region to rotate through the facilities and observe staff for hand hygiene compliance.

The monitors were full-time, newly created positions under infection control. "Initially, they were LPNs," Lederer says, "but we found that LPNs had a difficult time challenging and correcting RNs. So we moved it up a notch to RNs." Their primary job was monitoring but also reporting feedback and providing education to staff.

He says the system used the methodology proposed by the Centers for Disease Control and Prevention and the World Health Organization's five steps. But placing two monitors to observe every hand-washing opportunity was a challenge. For the most part, Lederer says, they were placed in the general medical/surgical units upon entrance and exit, as well as the ICUs. "Because of the way our ICUs are laid out with windows into the room" monitors could observe compliance between sterile sites.

When monitors see a lapse in hand hygiene, they immediately speak to the noncompliant individual and then to the manager of the unit. But for physicians, Lederer says, the system found it was more effective to have physician-to-physician communication. So monitors would report lapses to the vice president of medical affairs in each facility who talked to noncompliant individuals.

Not only was monitoring and reporting real time, but data flowed automatically into the health system's electronic performance score card, "which is seen by all," Lederer says. "Any facility can look at any other facility and you can actually drill down to the noncompliant individual and if you click on their name, it'll pull up their name tag.

"You can't make it totally nonpunitive," he adds. "We have alcohol dispensers everywhere. There's no reason for you not to spend 10 seconds [washing your hands]. We can understand you not wanting to go into a patient's private bathroom, which may be internal inside the [patient's] room without a foyer or anteroom... We have lots of excuses, but there's not an excuse not to use a hand hygiene dispenser that's in the hall right outside the door."

When physicians are noncompliant, the incident is put into their credentialing file. For other staff, it's part of the system's progressive discipline policy. "If we catch you once, obviously you're going to get counseled, and you would follow the progressive discipline course if you got caught multiple times," Lederer says.

The system tied observation, direct feedback, and unit-based education to an internal marketing campaign. Posters, desktop wallpapers, cling stickers, and even billboards on major roadways near the facilities were used to home in on the message — washed hands can literally save lives. Messages about the importance of hand sanitization were posted at the entrances to each facility, in front of doctors' offices, on patients' tray mats, and computer pop ups.

The campaign, Lederer says, was "really meant to show employees that this is the degree to which we'll go." (All of the signage Novant used is available for hospitals' use at www.washinghandssaveslives.org.)

Barriers to compliance

Lederer sees two significant barriers to compliance. One, he says, is "the mindset and the culture that's dictated from the top. And that's why we had 12 failed prior hand hygiene [initiatives]. If you don't have that level [of support], you'll get nowhere."

And the second thing he points to is resources: making those readily available to make compliance easier. The system had to go through a learning curve after introducing dispensers at facilities in 1998. "[O]ver time," Lederer says, "we've learned that different fire marshals have different approaches." He says they've had no problems with The Joint Commission or the Centers for Medicaid & Medicare Services as far as dispenser placement but suggests learning what your local fire marshal is looking for.

He also acknowledges that once staff knew who the monitors were, they might consciously change their practices and that monitors were mostly staffed during the day — a different culture than nights and weekends. "So even today we realize there's still a challenge because it's not unconscious competency." So measurement and feedback continues, and as it does Lederer hopes it will become less of a corporate responsibility

and more of an individual unit one — with managers measuring locally and continuing to cultivate the culture of hand hygiene. ■

Consultant: Scoring, PPR requirements still unclear

What you can do to prepare

Do you understand the new Joint Commission scoring methodology? According to **Susan Mellott**, PhD, RN, CPHQ, FNAHQ, CEO/health care consultant, Mellott & Associates in Houston, the changes and their impact are still unclear to many quality professionals, and there is a lot of information still to be gleaned to prepare your facility.

In the last issue of *Hospital Peer Review*, we discussed the changes **(see *HPR*, July 2009, cover)**, and though The Joint Commission says it has spelled those out, the field remains unclear about many of the elements, Mellott says. One of the biggest areas of confusion is what constitutes conditional accreditation (CA). According to The Joint Commission, as noted in the December 2008 issue of its publication, *Perspectives*, hospitals are stratified into bands. The bands correlate with the number of survey days and the number of noncompliant direct impact findings that would trigger a more intense review from TJC's central office in which it would decide whether CA status was appropriate.

"The table is very clear to The Joint Commission and no one else," Mellott says. "I think one of the biggest misunderstandings on the health care side — not The Joint Commission side, but the health care side — is people have trouble figuring out which band they would fall into." Previously, there was a set number of findings to trigger CA. It's just not as clear now what your findings might result in. For instance, Mellott says, let's say your facility has 55 requirements for improvement (RFIs), and 10 of those fall into the direct impact category, with the remaining in the indirect impact category.

"Now what does this mean?" she says rhetorically. "And how much weight does direct have more than indirect?

"Well, we in the field don't really know because it's all a computer program that has weights in there and [TJC] hasn't told us yet. All we know is the direct weigh more in the decision than the indirect."

Situational decision rules

Her advice? First, call your Joint Commission liaison to find out what band you fit into. Second, review your standards manual and look at the pyramid in the section labeled "how to use this book."

"At the very top is the immediate threat and at the bottom is the indirect. And [TJC is] describing the immediate threat to life. Everyone kind of gets that. Then the situational decision rule, [TJC] doesn't necessarily tell you that there's very, very few of those," she says. If an organization has one or more situational findings, it can be put into immediate conditional accreditation.

Color coding can help

Situational decision rules are marked in the manual with a solid triangle that has the number two in it. If a standard is direct impact, it's marked with a white triangle with a three in it. Mellott says it's helpful to go through the book and colorcode the different categories. For example, she's colored all the direct impact rules blue and all the situational ones pink. In doing this, she found there were actually only a few situational decisions, and those have not changed from the past. They include:

- how staff function in an organization compared to their licensure;
- complying with the laws and regulations of the organizations;
- maintaining your facility's statement of conditions;
- the interim life safety policy;
- physicians only practice within the scope of their privileges;
- independent practitioners, such as physicians, are licensed.

Previously, The Joint Commission had two ways of scoring. One, Mellott says, was identifying if you were in compliance or partial or insufficient compliance. Then a score was given based on how long you had been in compliance. "They took that out this time. And I like that because I don't think they used it very often and the couple times they were used, they weren't used appropriately or standardized across all hospitals or situations."

So now, she adds, we know if the measure

requires a document, The Joint Commission is going to look to ensure there is a document. Direct impact findings are more important than indirect impact findings. If an element of performance requires a measure of success, The Joint Commission is going to look for evidence of not meeting the standard several times before it sites you, and "the magic number" appears to be three, Mellott says.

Still confused about PPR requirements?

The Joint Commission wants organizations to do periodic performance reviews (PPRs) in which you "look at every single standard, rate yourself on them, [and] send Joint Commission a report every year about the time you were last surveyed," Mellott says.

If you were surveyed three years ago in September and by September 2009, The Joint Commission has not yet surveyed you, you're still required to do a PPR, she says. But if they come for the survey in February, you wouldn't have to submit one. "So that's one confusing point," Mellott says. "Secondly, many hospitals and their lawyers said, 'Oh no, we're not sending that kind of information through the mail up to The Joint Commission. There's no way we're giving them all that information. That's too much ammunition, or potential ammunition, if someone outside The Joint Commission gets their hands [on this information.]'"

Because of this, The Joint Commission has put in alternatives, Mellott says. The first is to have TJC surveyors come in and do about a third of what would normally constitute a survey. "So if you're used to three days and two people, you would have someone come down and do a two-day survey. And they will do what they can during that time frame." The surveyor would leave you with a report, which will go back to The Joint Commission. When your action plan is complete, TJC would tell you if it is approved as being compliant with the standards.

The second alternative is to send a surveyor, who would not leave a written report but rather a verbal one and no subsequent communication with The Joint Commission is required. The last option is to tell TJC you have an action plan and when the surveyors arrive, they will ask to see it.

"Interestingly enough, some organizations that are systems have decided they want to spend the money and bring in a surveyor for two days

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when they could do it themselves. But it's a lot of work," Mellott says.

"So doing it themselves takes a lot of time. You've got to do a cost-benefit analysis to decide which is worth it." Yet another option is to bring in a consultant. Admitting she is biased as she herself is a consultant, she says bringing one in probably will cost less money than having a Joint Commission surveyor. She says a lot of organizations think that if they bring in TJC surveyors, it will give them more leverage if, for instance, there is a question at the time of the actual survey.

Unbundled EPs, standard changes

Where elements of performance (EPs) previously were bundled together, The Joint Commission has broken them out into separate EPs. Does this require more work on your part? Yes and no, Mellott says. It will require more paperwork to separately document each one. "The good thing about it is when you bundle things together, let's say there's five things in one point and you have one of those wrong, you lose the whole question," she says. "This way, you have five chances."

With the 2009 standards, she sees "some standards that have more detail in them. And that detail hasn't necessarily been pointed out to people. And in fact every time I get in there, I find something else that I wasn't aware of. And it's not that it's new; it's just phrased in a different way, or it's pulled out so it's more explicit."

Prepping: What to do

Mellott suggests the following tips to quality improvement directors and regulatory officers:

• **Check your data collectors.**

"Make sure that the people collecting the data are, No. 1, looking outside of their own department." She says it's common to see one nurse assigned a chapter, and so that nurse looks only at nursing assessments and not at physical or respiratory therapy assessments. Or assigning a lab director to know all about waved testing. "Waved testing," Mellott says, "is a laboratory responsibility, but it's testing that goes on outside of the lab. So if they only look at what they do in their place and don't look at all of the places that are doing waved testing, you're not going to get it. It's about going outside of just one discipline to look at all these standards."

• **Check cited standards.**

"Look at any published information that Joint Commission puts out on the most frequently cited standards. And focus on those."

• **Check National Patient Safety Goals.**

"Absolutely, 100%" look at your compliance with the National Patient Safety Goals. "Last year there were two patient safety goals that were phased in over the year. One was the rapid response, and the other was anticoagulant therapy. [Organizations] better be ready to support those two," Mellott says. With rapid response, she clarifies, that doesn't necessarily mean a rapid response team but an early intervention method. She says during one hospital survey, surveyors talked to one person on a clinical unit who didn't know how to call for help if he or she needed it for a patient. That hospital was cited.

When the anticoagulant and rapid response goals came out, she says a lot of hospitals responded, saying, "Oh, we already do that."

"But they don't look at the details," she says. "Because the devil is in the details."

For instance, with rapid response, she says, a hospital she consulted for had a team in place but "they weren't collecting any data on how effective it was. I mean, they had it, and it was working, but they didn't have any documentation that they needed to have for quality."

She says next year, The Joint Commission will target the infection control measures under Goal 7, which are to be phased in by January 2010.

• **Get staff involved.**

The Joint Commission doesn't "want to talk to anyone but the staff," she says. "They don't want to talk to any managers, the chief nursing officers." ■

For ED bottlenecks, look at your OR scheduling

Elective scheduling in OR drives bed capacity

"Nobody really looks at the operating room when they're talking about ED overcrowding. But that elective schedule is what drives the peaks and valleys on the inpatient side," says **Susan Madden**, MS, Press Ganey's VP for analytics.

She takes orthopedics as an example. If all of your total-joint surgeons want to work on

Tuesdays and Wednesdays, "that loads up the orthopedic floor with two- to three-day lengths of stay. So when that hip fracture patient comes into the ED, there's no orthopedic bed to put that patient in."

In looking at your wait times, she says, you should:

- focus on the operating room, as well as separating scheduled vs. unscheduled volume "so that you have separate capacity within the operating room to do both of those, and so they're not competing for the same resources";
- smooth out your elective admissions "primarily through the OR by using simulation modeling to even out the schedule." That way there is some predictability in admitting and discharging patients throughout the week to downstream units, preventing those dreaded peaks and valleys.

"What that does," Madden says, "is open up capacity on the inpatient side of the hospital so you don't have to board patients in the ED anymore. And all of that reduces wait times in the ED and the OR."

Take a step back and look at capacity across the hospital, instead of thinking in silos when talking about wait times. Hospital wait time is not just an ED problem; it's a symptom, says **Christy Dempsey**, RN, MBA, CNOR, senior vice president for clinical operations at Press Ganey.

What data should you look at?

To ease bottlenecks, Dempsey suggests first identifying where your peaks and valleys are on the inpatient side. "You can look at the variability of the admitted patients out of the ED day to day and the admitting patients out of the OR everyday." Likely what you'll find, she says, "is that the variability on those elective, totally schedulable operating room admissions are as variable or more variable than the ones coming out of the ED."

On the OR side, Madden says look at your volume of add-on cases and their pattern of arrival. You then can prepare and plan for — "rather than really slotting those cases in to wherever you have a hole in the OR schedule" — what you need to do for those cases separately and prevent clashes with your elective schedule. And look also at the volume and arrival patterns of emergency or urgent cases. Collect data such as when those urgent cases are arriving in the ED and when surgeons are calling the OR to book that case. "Some of those," Madden says, "are common pieces of data that are collected by hospitals, and some require new systems to collect those."

You have to look at cause and effect. To smooth peaks and valleys in the inpatient census, and in the OR, you have to look at where the patient is going, his or her destination unit, and lengths of stay, Dempsey says. "So that, again, you're predictably admitting and discharging all week long to those downstream units."

Also examine the utilization of the OR. For example, if general surgeons and urologists share an inpatient floor, Dempsey suggests avoiding scheduling them on the same day. Then, too, a like number of patients is being sent to downstream units throughout the week. Depending on lengths of stay, she suggests scheduling general surgeons maybe on Monday and Tuesday, with urologists scheduled for Thursdays and Fridays.

How simulation modeling can help

The easiest way to do that, she says, is with simulation modeling, which "lets you play with multiple scenarios until you find the one that's right for your organization." Simulation modeling makes the process faster and a little less intensive, but she points out you can still do it if you don't have access to simulation technology.

The most important thing is to eliminate peaks and valleys in the elective OR schedule and in so doing look also at all of your downstream units. "Most of the time, OR people don't do that," Dempsey says. "They come up with a schedule that works for the operating room. And we have to get rid of those silos so we're not thinking in terms of just the ED, or just the OR, but we're looking at organizational patient flow."

Using block scheduling

Dempsey says some hospitals allocate blocks of time for either a specific surgeon or service. For example, Dr. Smith has Tuesdays from 8 a.m. to noon every week. Most surgeons, she says, want their most intensive cases scheduled during the week — the assumption there being that they want to have the weekend free for recreation. "But the fact is," Dempsey says, "when you ask surgeons and you really boil it down, the reason they don't want their patients there over the weekend is because they feel like the ancillary support is not the same on the weekends as it is during the week."

Let's say a total joint patient comes in on Friday. Well, physical therapy then has to be available on the weekend. Dempsey says there has to be a commitment from the hospital to provide ancillary resources on the weekends if surgeons are willing to smooth their elective cases.

Madden says one approach is to isolate your elective case schedule to adjust the block schedule so that certain kinds of surgeries are spread across the week depending on which nursing units those patients would eventually go to.

Ultimately, by using both block scheduling and simulation modeling, you can "tweak your schedule and tweak your volumes and see what the impact is going to be" on the census of nursing units and the hospital overall.

Engaging staff

Dempsey says you want physicians at the table as well as surgeons, anesthesiologists, hospital leadership, vice presidents, and directors of the OR, the PACU, and some of the downstream unit nursing staff.

She says she's had good results working, in particular, with physicians. "[T]he reason is physicians are basically scientists. So if you give them good data and you let them be part of the decision-making based on those data, you're going to get physicians at every meeting.

"What physicians don't like to do," she says, "is come to meetings where no decisions ever get made, where nothing is based on data but it's based on anecdote, and no progress is made.... But you give them credible data, let them help make the decisions based on those data, and make progress at every meeting — they'll be there." ■

Skeptic learns true value of QI HAI prevention

Manoj Jain, MD MPH, an infectious disease physician and writer, in Memphis, TN, admits he was skeptical when his hospital embarked on a quality improvement initiative to reduce hospital-acquired infections (HAIs) and he admitted it openly — in a column in the *Washington Post*.

His skepticism, he says, came mostly from his training and experiences. Infectious disease doctors see ICU infections every day, he says. The cases became, to him, a "price one paid" and he had never seen a campaign that had led to an actual rate decline.

But this time it did. The program was initiated by the quality improvement team. Jain says he learned that "often administrators don't realize the cost-savings that may be obtained when they invest in the infection control part. They always think of infection control as some cost of hiring another IP and so forth; yet the savings can be enormous just by looking at the days in the ICU for a particular patient. A decrease in even one or two infections can be a significant amount of savings."

Basic elements of the performance improvement plan were implementation of bundles. One was to prevent ventilator-associated infections, including components such as ensuring that the head of the bed is up or that prophylaxis for deep vein thrombosis is given. A checklist for central-line infections also was put into use, including components such as clinicians wearing masks, gowns, and gloves.

"I think we all know that these things are important. I think the key is at least that we implement them at every situation and often it will happen that doctors sort of take this for granted and don't pay attention to them. Once they're paying attention to them, I think it makes a difference. The other part of success comes from collective thinking, or a change in culture that comes from paying attention to what's important," Jain says.

Using checklists made clinicians more conscientious, he says. For instance, nurses became much more careful when inserting lines — because they knew a great deal of effort is needed in placing the line and, perhaps more importantly, that others were watching to see if a line becomes infected.

To garner compliance, Jain says the hospital started multidisciplinary rounds. Every morning an intensivist would round with the team and discuss many elements of the checklists. Nurses were trained to verify that doctors were wearing the obligatory gloves, gowns, and masks. The team included the patient's nurse, ICU charge nurse, pharmacist, dietician, respiratory therapist, case manager, social worker, physical therapist, and a palliative care nurse.

Jain says the overall strategy for change comprised four elements. One was the physician-led

multidisciplinary rounds. The second was the use of bundles for VAP and central-line infections. The third was involving leadership and shifting the culture of thought about prevention of HAIs. The fourth was daily bed flow meetings in the ICU in which nurse managers discussed where patients were moving that day.

These bed flow meetings are held twice a day for 20 minutes to look at the hospital's status, prioritize interventions, review historical data, and set daily goals. Because they knew their average ED daily volume and were able to review scheduling for the catheterization lab and ICU, staff set out to make those beds available by 4 p.m. when the second meeting of the day was held. ■

NQF safe practice: More pharmacist involvement

In issuing its 2009 safe practices, the National Quality Forum (NFQ) recommends more pharmacist involvement. Safe Practice 18: Pharmacist Leadership Structures and Systems reads: Pharmacy leaders should have an active role on the administrative leadership team that reflects their authority and accountability for medication management systems performance across the organization.

"The whole issue of medication management is high profile in patient safety, and the improved integration of pharmacists into the whole spectrum of medication management is important, and so as part of our safe practices' ongoing maintenance program, this is one that we have chosen to profile and make important," says **Peter Angood**, MD, NQF senior advisor on patient safety.

"We are all well aware of how critical medication management is and how common the adverse events are related to medication management, so several organizations have some type of initiative going," he says, mentioning The Joint Commission's chapter on medication management and the work being done by the Institute for Healthcare Improvement, the Institute for Safe Medication Practices, and U.S. Pharmacopeia.

He says the NQF's work in integrating pharmacists and leadership is "fairly unique."

"Within the actual content of the safe practice,

CNE *questions*

5. What is Novant Health's compliance rate for hand hygiene?
A. 85%
B. 88%
C. 95%
D. 98%

6. According to Susan Mellott, PhD, RN, CPHQ, FNAHQ, there is a significant increase in the number of Joint Commission's 2009 situational rules.
A. True
B. False

7. To improve ED flow, Susan Madden, MS, suggests smoothing flow primarily in the ED.
A. True
B. False

8. For safe practice 18, the NQF suggests pharmacists do the following:
A. establish pharmacy leadership structures
B. establish a medication safety committee
C. perform walk arounds
D. all of the above

Answer Key: 5. D; 6. B; 7. B; 8. D.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

we not only provide the specifications of the practice, but we also provide a variety of example implementation approaches, opportunities for patient and family involvement, how should organizations put in the different structural components, the processes, and what are the expected outcomes for implementing these types of measures."

Some suggestions in safe practice 18 include:

- pharmacists should work within an interdisciplinary team to ensure safe, effective medication for patients across the continuum of care from setting to setting;
- establishing pharmacy leadership structures and systems to ensure awareness of medication safety gaps, direct accountability from leadership for gaps, and a budget available for performance improvement;
- supporting a culture that furthers safe medication use, providing feedback to staff, and implementing interventions to ensure safe medication use;
- identifying and mitigating safety risks and hazards to reduce patient harm;
- establishing a medication safety committee to review medical errors, adverse drug events, and near misses;
- performing medication safety walk-arounds;
- establishing a role in readiness planning for implementing a computerized physician order entry system;
- engaging in public health initiatives. ■

CMS Hospital Compare hits front page news

Hospital data are there, but are they used?

The Centers for Medicare and Medicaid Services (CMS) just added new information to its Hospital Compare site — death rates and readmission rates relating to heart attack, heart failure, and pneumonia. Alongside front page coverage, *USA Today* online recently captured the data and offered readers an interactive map and chart to view findings by hospitals. Are publicly reported data going to find a more mainstream audience — i.e., health care consumers?

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- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from The Joint Commission or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

- Ethical use of QI improvement methods
- MRI safety
- Where we are with wrong-site surgery
- Continuing coverage of health care payment reform

Robert M. Wachter, MD, is professor and associate chairman of the department of medicine at the University of California, San Francisco; chief of the division of hospital medicine and chief of the medical service at UCSF Medical Center; and prolific health care blogger. A cheerleader of transparency and public reporting, he says since the beginning of such initiatives in 2003, they have "made a tremendous difference in creating focus on certain areas in safety," with results that he's seen at his own hospital and nationwide.

However, he says, "I don't think any real people look at these numbers. If you'd said to me seven or eight years ago, we want to improve quality, we think we have some decent measures of quality, and we're going to use public reporting and transparency as our mechanism to try to move the needle, I would have said that will work only in proportion to the degree that patients or their advocates are looking at the data and making choices based on it. So what's fascinating is that the public reporting and transparency is working to generate change and resource flow and focus, but the mechanism is not that patients are looking."

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He says there are "transparency purists" who have said over the years that patients using these data for decision-making is just around the corner. But Wachter says we're not there yet. Patients aren't looking at these data to choose hospitals or doctors as they would, for example, look at an issue *Consumer Reports* to choose a car with the best crash rating.

"I think over time it's inevitable that [consumers will use online data sources for determining doctors and hospitals] although it's clear that it's going to be slower than we thought it was," he says.

He says many "big players" are showing interest in publishing hospital data, such as Google and Microsoft, and the best-selling edition of *US News and World Report* is the one listing America's best hospitals. "So there's a lot of interest in this, and I think if you just the connect the dots" and offer better tools, less clunky and more user-friendly web sites, as well as better searchability, it will move more into the consumer arena. If you "find something that is very thoughtfully packaged, I think you're going to really see it begin to move market share; it's going to take a few more years, but I think it's going to happen." ■