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Signing, dating, and timing your verbal orders: Are you in compliance?

Suggestions from the field

It's nothing new. Compliance with verbal orders has been a struggle for hospitals for more than 25 years. Many experts *Hospital Peer Review* spoke with compare verbal-order compliance to hand-washing compliance. It's behavioral. It's something we know we have to do. And it's not a matter of ill-intentioned practitioners. It's a matter of time and logistics.

"It's something we all know is right; we all know the right way to do it. It's just a pragmatic issue of how do you get it done," says **Patricia C. Kienle**, RPh, MPA, FASHP, director, accreditation and medication safety, quality, and regulatory affairs for Cardinal Health Pharmacy Solutions. So what can you do to get your compliance rates up?

As it is now, Joint Commission-accredited hospitals must have verbal orders authenticated, timed, and dated within a 48-hour time frame. And that authentication can be handled by covering physicians. Of course, stipulations can vary state to state. The "sleeping giant," says **Ruth Elzer**, RN, MS, principal, accreditation and compliance services with Compass Clinical Consulting in Cincinnati, lies with the Centers for Medicare & Medicaid Services (CMS). According to its interpretive guidelines, beginning in 2012, no one but the prescribing provider can sign verbal orders. And everyone expects that The Joint Commission will fall in line with this, though, **Ken Powers**, media relations manager, says, "The Joint Commission will see what CMS implements before determining a response."

Minimize verbal and phone orders

You should have a policy in your hospital's rules and regulations that essentially discourages verbal orders, that states the use of verbal orders should be minimized and reserved for emergency situations, says **John R. Rosing**, MHA, FACHE, vice president and principal in Patton Healthcare Consulting's Milwaukee office. You must have this stated in your regulations, and he says The Joint Commission will want to see that. If you can't locate that or if it's not included, you might be cited.

"The first and foremost thing [with verbal-order compliance] is that we're trying to get practitioners out of the habit of using a lot of verbal orders, because there are compliance considerations that come along with

verbal orders. One challenge is to decrease the overall number of verbal orders that are given in a given day, reserving them for emergency situations, procedural times, and middle-of-the night emergencies. That will decrease the overall requirement burden just by the sheer number of orders that have to be dealt with," Elzer says.

Kienle says the hospitals she visits that are most successful have ratcheted down the number of verbal and telephone orders. But this "takes a culture shift," she says. And there always will be situations where verbal or telephone orders are necessary.

Watch your verbs with TJC

Joint Commission surveyors will check charts along their tracers, but they also will ask providers, "'How do you take a telephone order if you need to? What's the process you walk through?' And what they're looking for is a consistent answer out of everyone they ask that says very clearly, 'What we do is we write down an order — either if it's on a piece of scratch paper, preferably we have the chart with us — and we write it in the order section. But sometimes we might be down the hall or somewhere where we can't get the chart. Nonetheless, we write it down and then we read it back to the physician for confirmation.' And so the surveyor hears that three or four times and they think, 'OK I'll move on,'" says Rosing.

"If, on the other hand, they hear something different, such as 'I repeat it back and then write it down' — in other words, they reverse the order and also use the verb 'repeat' instead of 'read' — they're very riveted on this and their ears are perked up to listen as to whether the verb used is repeat or read. And if it's read, you're in good shape. If it's repeat, you're going to be in trouble," he says.

Do fines work?

Compliance, Elzer says, is a combination of many things. "Usually you try to help, you try to facilitate. You talk to the docs and say, 'What would have helped you better do this?'"

Many hospitals have implemented fines for noncompliant practitioners. Some find that helpful; some find it unnecessary. Usually the first step in becoming compliant is flagging, Elzer says — flagging orders that have to be signed and color coding the flag to identify which group of practitioners need to look — for instance, red for heart surgeons and blue for ED physicians.

But, she says, "some organizations that have dealt with this on a long-term basis haven't been able to get the physicians to turn around by gentle reminders. And they start looking at, 'How can we kick this up a notch?'"

Some hospitals, she says, have stipulated that if your verbal compliance is poor, providers must pay more of their dues, or discounts for

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Will EMRs help verbal order compliance?

The Centers for Medicare & Medicaid Services (CMS) in 2007 stipulated a five-year period in which verbal orders must be "dated, timed, and authenticated promptly by the prescribing practitioner or another practitioner responsible for the care of the patient, even if the order did not originate with him or her. CMS believes this temporary revision to the authentication requirement will reduce burden and provide flexibility for hospitals until the advancement of health information technology is sufficient to allow the prescribing practitioner to authenticate his or her own orders promptly and efficiently."

After that five-year period, in 2012, only the prescribing practitioner will be able to sign verbal orders. The time frame was given with the assumption that hospitals in 2012 will have the electronic capability to do all orders electronically. But according to a 2009 study in the *New England Journal of Medicine* by Jha et al, only 1.5% of hospitals "have a comprehensive electronic-records system (i.e., present in all clinical units)" and "an additional 7.6% have a basic system (i.e., present in at least one clinical unit). Computerized provider-order entry for medications has been implemented in only 17% of hospitals."[1]

Most experts are skeptical that in 2012 widespread electronic systems will be used. But the University of California, Davis, Medical Center has been using an electronic medical record and computerized physician-order entry, and verbal-order compliance has increased.

Alice Zeboski, RN, health information management with the University of California, Davis, along with her colleagues wrote an article in the August 2004 issue of the *Journal of AHIMA* on the compliance struggle with verbal orders.[2] In that article, the authors wrote: "It was obvious that the system of ongoing education, manual monitoring of orders, and the labor-intensive process of flagging orders was not effective. The HIM labor cost for flagging unsigned orders, post-discharge data collection, and supervisory monitoring and reporting totaled approximately $250,000 in 1998. Yet even this type of investment did not result in the level of compliance necessary to avoid Type 1 recommendations from The Joint Commission."

In 2003, fines were enforced — $10 charged to the department for each verbal order not signed. Now the system is electronic. Now, an individual department is fined if compliance is less than 90%. In December 2009, Zeboski says a total of 3,821 verbal orders were given, with 93% compliance.

Now, reports are run by order type. "We can get a count of how many verbal orders were given within that time frame and then the system records when an order is signed," she says. Verbal order with read-back is an order type; standard mode is what physicians use when they enter the order themselves.

Unsigned verbal orders are now routed to the physicians' inbasket, and they can read the order and sign those that appear in their inbasket.

"It certainly has helped in that the overall numbers of verbal orders has decreased since we went to the computer order entry, and also as the physicians' workload is now almost entirely, as far as documentation goes, in the EMR. They're in the EMR more and so they're aware of orders to sign, and they don't have to make a special effort to sign on to a separate system to look for verbal orders. They are in the system documenting, reviewing labs, and so it's just a better workflow for them to know when they've got orders to sign or work to do," she says.

Doctors also get electronic reminders if they have unsigned verbal orders. She says she still struggles with some departments that aren't in the EMR as much, such as some of the surgeons, ED physicians, and anesthesiologists. "We work with individual departments, and their administrative support pages them and reminds them to check the EMR for verbal orders."

There was a steep learning curve in going electronic, and fines during that time were not mandated. She says it was daunting to many of the physicians, particularly older ones who hadn't grown up with computers. Sometimes, she says, they would throw their hands up and say, "Forget it. I'm just going to have the nurse enter this for me."

"The nurses had to stand firm and we stuck with a policy that said verbal orders would only be accepted in emergency situations or when it wasn't practical for the physician to enter it themselves."

But the expectation was that physicians would enter their own orders. "And of course with order sets there weren't as many, the need to enter orders wasn't as great anymore because they didn't accidentally forget to order something for nausea or they didn't forget something for pain. It was all a much more structured process for order entry," she says.

"I think you have to make sure that you have a good process in place, that you have good procedures for entering the orders, and of course having the technology, having a computerized system to create and sign the order made it a lot easier on the physicians... And you have to have administrative support," she says.

Reference

1. Jha,AK, DesRoches CM, Campbell EG, et al. Use of electronic health records in U.S. hospitals *NEJM* 2009 Apr 16;360(16):1628-38. Epub 2009 Mar 25.

2. Curry MP, Trask L, Liederman E, Hutchinson D, Zeboski A. Verbal order compliance and how we achieved it *J AHIMA* 2004 Jul-Aug;75(7):38-41. ■

dues are waived. "I think what is a very effective and irritating [thing] for docs is if you take away their privileges in the cafeteria... It's an irritation factor," she says.

Rosing says some organizations he's worked with have found innovative ways to incentivize physicians to be aware of verbal order requirements. "For instance, they might take the dollars that are coming in from the fines and donate them to a homeless shelter in the community. And just make a big deal about certain people who have improved over time," he says.

He helped one hospital find a unique and humorous way to bring physicians into compliance. He found cards that play a customized recorded message when you open them. They recorded an MP3 file and attached the card to charts so when physicians opened them, they would hear the eight-second recording: "Please sign, date, and time your verbal orders. Damn it!"

"It brought awareness to the issue, and they got a little better compliance with it," he says.

But Kienle finds punitive measures such as fines and removing cafeteria privileges a "Draconian move."

"That may work for short periods of time. But we're all professionals, and that carrot and the stick thing just doesn't do much for me, especially on the punishment side," she says.

She finds more success "if administration is clear in their intent to truly do this for the right reasons. You know, that it's a safety issue. 'We want to avoid transcriptions. We want to avoid misinterpretations.' It has to come from the top to make it successful for the people who are in the trenches doing this," she says.

Rosing thinks it's helpful for someone the physicians respect to speak one on one with them, whether that be the vice president of medical affairs, the chief medical officer, or an administrator. He suggests telling physicians, "'Hey, this is simply a requirement that we have to fulfill. And we need your assistance. How can we make it easy for you? Flags? But bear in mind, we're not going to waste our time doing this if you're not going to pony up and sign it. So it's a two-way street on that,'" he says.

The other thing he suggests that resonates with physicians on a personal level is to say, "When you don't sign a verbal order, you're compromising your colleague," putting that coworker at risk by carrying out something that wasn't authorized by a licensed independent practitioner.

"That's kind of a harsh thing to say, but with some physicians that's the approach I would take. To say, 'Look you're being disrespectful here… you're putting the nurse in a compromised position and that's not fair to them. You need to hold up your end of the bargain and carry out your responsibility. You went to medical school. You have the privilege to order medical treatment, and this is part of that privilege.'"

How to use data

Rosing suggests getting away from traditional and timely QI approaches and to simply visit a department and ask a seasoned nurse there, "Who is not signing their verbal orders?"

"And they'll tell you in 30 seconds who the people are," he says.

Rosing and Kienle agree that it's usually the 80/20 rule. That is, most of the physicians are not having problems. It might be a smaller group who are not complying, but that's where you have to maintain the focus.

"You may think it's a housewide issue, but when you start digging down into the details, which is very labor-intensive to do but may be worth doing once and identifying that it's this one physician, or it's this one drug we need, or it's a certain time of day, or it may be just a staffing issue," Kienle says.

"And I have seen people successfully identify those pieces that are causing most of their problems, put a fix in, and then subsequently checking it to make sure that fix has worked," she says.

The process is labor-intensive, she says, because you have to look through the charts. "And if people are Joint Commission-accredited, there's certain criteria about sampling, how many records you would need to look at to identify problems.

"It's always a good idea to have some baseline data," Kienle says. "So I think it's worth a short period of time or a certain number of charts to take a look through that, see the verbal orders, who's writing them. Is it a specific service, is it a specific drug or lab test or whatever? Are the hospital policies being followed? Is the signature there and date and time and things like that? And then make some assessment. 'Do we need to go after certain physicians? Certain groups? Certain drugs? Certain lab tests?'"

Your root-cause analysis, when an error has been made, may offer "a little more ammunition"

as well when you speak to a physician. Kienle also advises hospitals to make sure they're complying with all of the standards regarding verbal orders, which, she says, "weaves its way among several of the [Joint Commission's manual] chapters. We used to focus on the National Patient Safety Goal and the medication management chapter. But now there's also wording about verbal orders in the provision of care chapter and in the record of care chapter. So people need to be sure, if they're Joint Commission-accredited, that they are certainly complying with all three of the standards" — MM.04.01.01 EP6, PC.02.01.03 EP20, and RC.02.03.07.

She also sees most of the burden lying in the hands of nurses. "But we have to remember, it's not just nursing. It's anyone who could take a verbal order. So it could be lab, it could be pharmacy, it could be physical therapy, it could be respiratory, and everybody needs to be doing things the same way in the facility... It's real tough for the nurse to be standing out on her own and the only one in the organization saying, 'Here doctor, write this.' It has to be a housewide issue."

She points to "ASHP: Guidelines on preventing medication errors in hospitals" as a resource, which suggests:

- use special caution when prescribing drug doses in the teens;
- when reading back, the drug name should be spelled to the provider with no abbreviations used.

She also suggests looking at recommendations from the National Coordinating Council for Medication Error Reporting and Prevention (http://www.nccmerp.org/council/council2001-02-20.html). ■

New medical staff standard still ruffling feathers

Standard seeks to clarify what should be in bylaws

When The Joint Commission revised its medical staff standard in 2007, there was tumult in the field. In response, The Joint Commission convened a task force and has released a new version of MS.01.01.01 (formerly MS.1.20), which was open for comment through Jan. 28, 2010. The new standard seeks to clarify what should be included in the hospital bylaws and how the organized medical staff and medical executive committee should function.

"The reason that we formed the task force in the first place and then suspended the adoption of our new 2007 modification to the standard was around concern from the American Hospital Association and the Federation of American Hospitals around perceived burden of having to bring in costly attorneys and completely rewrite their bylaws. While we didn't believe that was true, we did err on the side of requiring too much detail in the bylaws," says **Chuck Mowll**, FACHE, executive vice president, business development, government and external relations at The Joint Commission.

Though there's still confusion in the field, **Todd Sagin**, MD, JD, with HG Healthcare Consultants LLC in Laverock, PA, says hospitals "are going to have to read the new standard carefully, and they'll have to read through their bylaws and find those areas in which they're not in compliance. Now that in and of itself obviously is a task. And how much revision will be required in an individual hospital's medical staff bylaws is going to be a function of what's there today and how much does it deviate from the new standard."

A key change, Mowll notes, is that EPs 12-36 should be in the medical staff bylaws. "However, these requirements have associated detail, and sometimes those details are extensive, so these details can reside in the bylaws or rules and regulations or policies. That's the flexibility that we're providing to the field," he says. But many experts still believe the rule is not quite clear, and attorney **Michael Callahan**, Katten Muchin Rosenman LLP, says hospitals still might have problems distinguishing what must be in the bylaws and what constitutes "associated details" that can reside elsewhere.

Bylaw requirements

One EP requires that the history and physical process now be in the bylaws. **Ward R. (Hermit) Cassels Major (Ret)**, USAF, accreditation readiness officer at VA Puget Sound, thinks this is a good thing. "Organizations have always had issues with the timely submission of H&Ps and timely updating of them, and I think this gives it a little more teeth for the clinical executive board to enforce it better. If it's in the bylaws and all of the providers are following the bylaws, then they should be improving on the timeliness of H&Ps

especially," he says.

The fair hearing and appeals process also must now be in the bylaws, as well as credentialing processes, which at most hospitals previously resided in a separate manual. This isn't new material, Sagin says; it just must be organized in a different way.

Alice Gosfield, a Philadelphia-based attorney and consultant, sees the response in the field as an unnecessary "tempest in a teapot." There are discrepancies in just how much work this will mean for hospitals, and Gosfield doesn't subscribe to the more popular notion that it will be a costly, timely endeavor. "The fair hearing plan, the credentialing manual, which is how you get in the door and how you get privileged, which with OPPE and FPPE, becomes even more important than its been, all of that was in a separate document because it's much easier to change it if it's not in the bylaws because you're not allowed to unilaterally amend the bylaws," she says.

Cassels does believe there will be some work involved with amending the bylaws but says, "Actually in looking at the standard, it's going to be a general improvement. And I don't see a lot of extra work at all with them. The one thing I really like about them, when it goes through EPs 12-36, they're very prescriptive. These things need to be in the bylaws. And it really spells them out nicely... I do really like the part where they've given us a little more leeway because we can put things in the bylaws, rules, regulations, or policies. It kind of opens it up a little bit more. If you have a change that would be more aligned with a policy as opposed to putting it in the bylaws, we have that option now. You really didn't have that option in the past."

Sagin says: "I believe that probably in the majority of cases, the changes will be relatively easy to implement. I think most people will have to make changes. I disagree with those people who say many folks won't have to do anything differently. I think most places will have to do some revisions to their bylaws to bring them in to compliance."

Another addition is the inclusion of a dispute resolution process if there is disagreement between the organized medical staff and the medical executive committee. Callahan questions what the triggers for dispute resolution should be. "If the MEC makes a recommendation to require let's say board certification and that if you're not board certified you lose your privileges, and let's say the current policy is you don't lose your privilege, you get demoted to a lower staff category. That would typically be some rule, reg, or policy that would come up for vote. Is it one physician that can now trigger formal dispute resolution? Because if the threshold was that low or a handful or five or 10 when you have hundreds of physicians on the medical staff, you're going to be in dispute resolution forever. And so the first question is OK, what should be the standard? Is it 10% of the active staff members? Is it 5%? If it is a number, does it only involve certain kinds of issues?

"So that's kind of the first, one of the decision points that a medical staff is going to confront. What's the triggering mechanism? And then the second point is, what is the dispute resolution process? And The Joint Commission isn't telling people what those thresholds are or what that process is. They're saying, 'Look, you all figure that out.' And so that's going to be part of the dialogue," Callahan says.

With the new standard, the organized medical staff can now take an amendment directly to the board, without consulting the MEC. There is much talk in the field about whether this is a diminution of the MEC.

"It does say there needs to be a process by which the medical staff could propose changes to their bylaws to the board and bypass the MEC. In that sense, potentially you could see that as a diminution in the importance of the MEC, but the fact of the matter is that any changes of that significance have to be voted on anyway by the medical staff," Sagin says.

Neither Gosfield nor Sagin believes the balance-of-power issue is as big as some have made it. They think the field is anticipating conflicts that usually don't arise.

"If the medical staff as a whole feels the need to jump over the MEC, what is going on in the medical staff governance process?" Gosfield says.

"Again, a lot of this is people trying to create situations and anticipate conflicts that just are not out there with any prevalence," Sagin says. "The documents, the new MS.01.01.01 talks about the need for there to be this constant communication [between the medical staff and the MEC] and everybody staying in the loop, and that's fine. That's well and good. Communication is always positive, and people should know what's happening. Rank and file, leadership, governing bodies should all be well informed. I don't see that as a problem. And it's just reinforced in this particular document." ■

Do new nurses have QI skills, understanding?

One study says no

She watched the young nurse getting chastised for making an error and could see the fear in her face as her manager's voice rose in anger. The young nurse was put on indefinite leave. That's what happens when you make mistakes, she thought to herself.

According to two authors of a recent study, this is not what new nurses should think or see as an example of making an error, or reporting one. In a new study — "New nurses' views of quality improvement education" — published in the Jan. 10 issue of *The Joint Commission Journal on Quality and Patient Safety*, 38.6% of novice nurses responded that they were "poorly" or "very poorly" prepared from their education to implement quality improvement measures.[1] The study was funded by the Robert Wood Johnson Foundation.

Nurses were surveyed in December 2008, having graduated between Aug. 1, 2004, and July 31, 2005. They were asked about specific quality improvement vocabulary and techniques, whether they were engaged with them or familiar with them. Questions included: How prepared or unprepared were you by your basic nursing program in the following quality improvement areas:

- patient-centered care;
- teamwork and collaboration;
- evidence-based practice;
- safety;
- restraint and seclusion;
- infection control;
- pain management;
- using appropriate information technology or strategies to reduce reliance on memory;
- hazards to patients and/or families;
- using organized error-reporting systems for near-miss and error reporting;
- participating in analyzing errors and designing system improvements.

Christine T. Kovner, PhD, RN, FAAN, professor of nursing at the NYU College of Nursing and author of the study, says, the report shows that 46% of the nurses studied had never participated in a root-cause analysis. "That's almost half of these nurses who've been working for three years have never been part of such a process," she says.

The respondents also showed unfamiliarity with using appropriate technology. "We have a very sophisticated patient information system that we've had for 30 years with mandatory physician order entry. But students are not allowed to use the system. Because the students are only there for 15 weeks, they can't get an IV and go through orientation, and I think that's not uncommon, and I think hospitals should again rethink that," says Kovner.

She's also seen new nurses harshly criticized by managers when an error is made. "That's of course not the role modeling that we want our students to get... We teach at NYU about no-fault error reporting. And then they go out and they hear about and see people who made errors who were put on leave or fired or lashed out at," Kovner says, which neither empowers new nurses to speak up if they see errors or to report an error if they make one.

"So the question I guess I have is if they didn't do this and they say they're not doing it at work, are they not doing it at work because they didn't learn it in school or are they not doing it at work because hospitals aren't doing it or hospitals systematically don't include new nurses in these processes?" Kovner says.

"And I think another implication, it's not something we even talked about in the article, but another implication is what is the culture of the hospital that nurtures the critical thinking it takes to analyze systems and find problems and fix problems? How do they inculcate that kind of thinking in their new graduates, their new nurses? Because it's got to start early and go all the way up the organization," adds co-author **Carol S. Brewer**, PhD, RN, professor of nursing at the school of nursing, University at Buffalo and the director of nursing for the State Area Health Education System Statewide Office.

She adds that empowering novice nurses to speak up and being brought into and contribute to QI processes "takes some very deliberate work on the part of the employer."

It's the chasm between educational experience and real-world experience. Kovner says much of the faculty in nursing programs are in their fifties. "So that means they went to school 30 years ago for their undergraduate program and maybe 25 for their master's. But people weren't talking about quality improvement then... I suspect that many of the faculty don't

know quality improvement," she says.

She suggests patient safety and quality improvement officers come in to the classroom and talk to students. "And that's where we think there's an important opportunity for the educational programs and the hospitals to get together about what they're teaching in both places and how the hospitals, particularly, when the students have their clinical experience there, can participate in and help the students have clinical experiences related to quality improvement. And to me that seems like the perfect opportunity for the quality improvement officer or the patient safety officer," she says.

"My guess is that the patient safety officer has nothing to do with the education department in the hospital, which is responsible for working out the clinical practice experience for the students and the orientation for new nurses. That those are just separate worlds," that should be better aligned, she says.

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1. Kovner, C.T., Brewer, C.S., Yinqrenqeung, S., Fairchild, S. New Nurses' Views of Quality Improvement Education. *Jt Comm J Qual Patient Saf*. Vol. 36, No. 1., pp. 29-5AP. ■

Quality improvement, orientation for new nurses

Beth A. Duthie, RN, PhD, director of patient safety at NYU Langone Medical Center, wasn't surprised by findings in the study "New nurses' views of quality improvement education" published in the Jan. 10 issue of *The Joint Commission Journal on Quality and Patient Safety.*

"Actually, that pretty much affirms what I'm seeing here. It's both physicians and nurses coming out of school, and there has been on both the medical and the nursing side an emphasis that we have to begin this process. Because, again, practice drives education in a lot of respects and so we have been saying they're not as exposed to it as they should be," she says.

She says the belief at NYU Langone is that quality improvement should be embedded into the center's daily life. So they focus on teaching new nurses coming into the hospital. There are classes for orientees in both patient safety and quality, and when they are promoted into leadership positions, they get additional lessons on different topics in quality and safety.

"One year after they've been on board, we do a class on critical thinking and failure-to-rescue errors and how to prevent them. And then there is an organizationwide program for new managers on systems, theory, and how to approach errors from a systems approach instead of blaming the individual," she says.

Empowering nurses is a portion of the education. And that means emphasizing teamwork and training physicians to let the nurses know that they welcome their help. She identified fast-moving, tense working situations such as in cardiovascular ORs or heart surgery. Everyone is involved in huddles.

"And both the nurses and physicians now feel there's such a comfort zone that if I say something it's going to be welcomed whereas in the past it was contentious if the nurse spoke up; there was going to be some negative feedback. Now because they have these huddles, they talk about the fact if you call something out to help me, I understand that that's what you're doing. It's more the spirit of what we had hoped. We don't want it to be a, 'gotcha, you screwed up,' but more 'how can I help you?'

"And so both by changing the attitudes of the nurses who are bringing the information forward and by having the physicians be welcoming of it, that is really where I think you have to go to get into a culture of safety," she says.

She also recognized the opportunity for education when a new nurse makes an error and has worked with leadership to understand "if it's going to be a good learning experience in a difficult situation, that means the response from the manager has to be nurturing and supportive. And I also talked to the new nurses about the fact that when someone makes an error, if we are judgmental and blaming, that person begins to lose self-esteem and may not be able to do as well and learn from it as well as they take on that whole shame concept. So that when we see someone else making an error to be supportive of them," she says.

She recalls a near-fatal medication error made by a new nurse. She thought it could be a procedural error. But the nurse realized the error quickly and called a skilled practitioner to help her. "It was very encouraging to me to hear her say it was a very frightening experience for me but my preceptor really helped me learn from it,"

she says.

Speaking to the nurse, she told her she had good instincts and good thought processes to recognize the problem and ask for help. The problem was caused because the nurse was pulled away from what she was doing. And she told her it's often hard to say to people, "I can't do that right now," but that it's OK and sometimes necessary.

If you're looking to educate new nurses on safety and quality, Duthie suggests supporting error rates from the front line. "The way in which you get your error rates up is by showing people the good outcomes that come from error reporting," she says, and by emphasizing that we're all human, we make mistakes, and it's safe in this organization to report errors. And then taking the focus off of the individual and analyzing the context.

The average orientation program is two months; for some areas such as labor and delivery and the ICU it is longer.

Where does she see the biggest gap between real-world and classroom experience? "The biggest gap is understanding how to measure accurately what you want. So when you're doing a quality improvement project, are you going to be monitoring the correct information, and is your data collection a meaningful, reasonable process?" She says it's important to help frontline workers design measurements that will help them with their clinical questions. ■

ACCREDITATION
Field Report

Surveyors focus on informed consent, nails

With its last survey in December 2006, Faith Regional Health Services ended up in conditional status. In the last year and half, **Amy Nicolas**, RN, BSN, says the hospital did some restructuring. Changes were made at the top. The chief nursing officer was let go; the CEO also was let go and replaced, and a new vice president of medical affairs was hired and put in charge of quality. A lot of that, she says, helped the hospital remove hindrances and refocus on quality.

A Joint Commission prep team was developed, consisting of many clinical directors, a few vice presidents, and Nicolas. The team did monthly tracers in all the inpatient units, the surgical unit, the cath lab, as well as the emergency and radiology departments. Those findings are relayed to the prep team to develop work teams and action plans. Often, the same findings were observed in different units "whether it was blanket warmer temperatures or dating and timing of orders."

She admits the 2006 survey was "bad. We weren't measuring our critical test values. We had a ton of unapproved abbreviations. There was no dating and timing of orders. We didn't have a 24-hour pharmacy at that time and so we had a house supervisor. People were accessing the pharmacy after hours all the time and for nonemergent medication," she says.

"We had an essential medication list, but nobody was paying any attention to it. The leadership wasn't there. We failed our time out when The Joint Commission was here," she says.

The findings didn't compel changes, she says. The leadership staff didn't believe the hospital was at fault. "They thought we just got a group of bad surveyors," she says. At the time of the survey, Nicolas was an inpatient manager, but in February 2008, she took the quality manager position. "I read The Joint Commission's manual. OK, that was painful. But I had to read it because I had to know for myself what we had to do and what we didn't have to do," she says.

"Honestly, the whole organization needed someone who they trusted clinically to push stuff through," she says. And she had good relations on the clinical staff. "But then it really took our new CEO and the vice president of medical affairs who was really aggressive with the medical staff in saying, 'We have to do this. This is our accreditation. This is what makes sure that we get paid.' And that has helped a lot."

She took a few inpatient clinical directors to an accreditation update in fall 2008. "The gal that did that accreditation update was very blunt and very straightforward on, OK if you don't have this, you need to get it. Because even at that time, we really didn't have a concrete critical test value policy. It was kind of a mish-mash of ideas or interpretations; like [rapid response teams], we still really didn't have any-

thing housewide with those. We weren't doing time outs on the floor. Everybody had their own idea of what a time out was. For some people it was just like a time out was done and they didn't even realize there were elements you had to address, and so that helped a lot," she says.

In preparation for its December 2009 survey, the hospital shored up its communication of critical test values, time outs with the help of a new director of inpatient surgery well versed on the topic, and medication storage. "The other thing was the timing and dating of orders, which was disastrous. But with that, our medication reconciliation process really got fine-tuned from the last survey to this one," she says.

They also worked on their informed consent procedures. Nicolas says previously it had fallen into the hands of the nurses, and the dialogue was pretty vague: "You're going to have this done. Here's your consent form. If you have questions, ask me."

Ownership of that was put back into the hands of the physicians with communication that if the patient doesn't understand what he or she is having done, the procedure would be stopped.

With the informed consent policy, the provider asks patients what they believe they're having done. "So if they're having an appendectomy, they may say, 'I'm having my appendix out.' And that's what you're going to put down. And then also the nurse writes that in the medical term," Nicolas says.

And then there's checklists. "Has your physician explained the risks, benefits of this procedure with you? And then they check yes or no. They check if they have any questions or concerns. It's more kind of ensuring that the patient understands what they're having done, that they understand that a physician has explained it to them, not a nurse. And then it also has other questions like it asks them about their DNR status," she says.

Another problem area was pain management. And she had heard The Joint Commission was really monitoring that. "We have a lot of preprinted order sets like a lot of facilities. Each one of our surgeons kind of had his own preprinted order sets, but they all had a different way of using their pain medications. And we really didn't have that well tied into our pain management policy nor pain scale," she says.

"When a nurse has four different choices or three different choices of pain medication, how is she deciding what to give? So we did change our

CNE *questions*

5. According to the Centers for Medicare & Medicaid Services' interpretative guidelines, only prescribing practitioners can make and authenticate a verbal order.
A. True
B. False

6. The Joint Commission's new MS.01.01.01 standard require which of the following to be in the bylaws?
A. EPs 12-36
B. fair hearing and appeal process
C. credentialing process
D. all of the above

7. In the article "New nurses' views of quality improvement education," how many nurses studied had never participated in a root-cause analysis?
A. 25%
B. 38%
C. 46%
D. 82%

8. After Faith Regional Health Services was surveyed in 2006, leadership understood there were systemic process problems.
A. True
B. False

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

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 **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

pain policy to reflect that. So there's a little more guidance to the nurse as, 'There are three medications, you can give this. There are seven, you can give that,'" she says.

The other part was education of staff. "[T]he physicians here were kind of used to doing whatever they wanted to do. And some of that, I hate to say that has been taken away from them, but it was like you know you can't just write for whatever you want. [A patient doesn't] need seven different pain medications," she says.

A lot of the physicians she's seen don't like change. And they're not influenced by "evidence-based care." They'll just answer, "Well, I can find other studies that show the opposite." And Nicolas has to say, "'We can't do a control group and another group. We can't test on these patients. We're not going to have a control group and then an intervention group and redo these studies. You can't do that. And this is what we have. And until we have another stick to measure by, this is it.'"

The new VPMA goes to all the physician committee meetings and explains what has to be done. But he stresses that nothing is set in stone and things can be changed if needed.

The survey, she says, was much different than in 2006, more detailed. But she says the surveyors were "consultative and helpful." When it was apparent staff didn't understand, she says the surveyors would ask them if they understood. "And so it was definitely more of a relaxed atmosphere for the staff. So where they didn't feel like they were being tricked or led down a wrong road just so [the surveyors] could say, 'Oh, that's wrong,'" she says.

The surveyors focused quite heavily, she says, on informed consent and storage of medications. They looked at every fluid warmer to make they had the proper expiration dates.

Surveyors found one physician was not reviewing post-op notes because he said he dictates immediately after surgery. "But your dictation doesn't come for another day or so. So he wasn't doing that well. By the end of the week he did," she says.

She says she was surprised that the physician surveyor was "really fixated on finger nails" and whether staff's nails matched what was in the hospital's policy.

"He didn't focus as much on FPPE/OPPE than I thought he would. I know it's been a huge issue. But he just asked us what our process was. He

CNE objectives

Upon completion of this educational activity, participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

- ■ More case studies on verbal-order compliance
- ■ Are you still having problems with restraints, seclusion?
- ■ How to get your board engaged with quality
- ■ Surgical false claims liabilities

did look at some credentialing files. And wanted to see the photo ID. But he thought the files looked good. But we didn't have a really fantastic process for FPPE or OPPE but he never really dove very hard into it," she says. The surveyor asked how the process was managed and what was done with the information.

She was also surprised that the surveyors did not focus as much on the National Patient Safety Goals. They didn't ask about rapid response teams, falls, or critical values. They didn't ask if standardized kits were used with central line insertions.

"They talked about hand washing of course. They watched for hand washing. But they never watched anybody pass meds to look at are they using the patient identifiers. They talked about the high alert meds. They wanted to see, if you had high alert meds what you were doing with the high alert meds, and we do have a fairly concrete process for that," she says.

The hospital received seven direct impact RFIs while their threshold was eight. One citation was for medical restraints. "We had a time frame in there where we had said that when a physician writes an order for a restraint, not a behavioral restraint but like a line protection — the medical restraint — that he would write in for how long. And then that's what our policy says. But we had a preprinted order form, a carbon that we used, and that wasn't on that carbon form. So the policy really didn't match what the order said and so we got a direct for that since it's a CMS condition," she says.

The hospital was also cited on its last day when the physician surveyor walked into a room with a biohazard sticker, a storage room for the respiratory department. There was a dryer, and he asked to see the maintenance records. There were none, the machine had never been logged in by biomed.

The hospital was praised for its informed consent procedure and for "post-op pain orders, which followed the inpatient post-op pain orders that really tie into the pain scale, which he really liked. It's very clearly written," she says.

"A lot of the stuff that we had the directs on we corrected while they were even still here. A lot of the stuff was very easy. The post-op note, that physician started doing it. The dryer. Biomed was shocked, and they checked it out and put it on the log and changed the HEPA filter. So a lot of things we were doing as they were still here and trying to correct," she says. ■