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AHC Media

Joint Commission ISO announcement inspires hospital interest

TJC and SGS Group to offer certification program

In the first weeks after The Joint Commission and SGS Group announced they would be offering joint accreditation and ISO certification to interested hospitals, SGS reported a fourfold increase in calls from hospitals curious about what ISO could do for them.

The program will allow hospitals to opt for certification in ISO 9001 (management systems), ISO 14001 (environmental management), ISO 27001 (information security), OSHAS 18001 (occupational health and safety) and food safety testing and certification. Joint Commission accreditation will occur on a triennial basis as before, but ISO auditors will come in at least annually. There will be an additional cost for the joint certification, with the fee dependent on how many standards in which a hospital seeks to be certified.

A few hospitals have been making use of ISO certification for years, says **Tony Perkins**, senior vice president, Systems and Services Certification, at SGS. However, most users come from other industries, particularly manufacturing. "People use ISO certification as a framework to develop a best in class business and management system," Perkins says. "They want to see how their processes, people, departments, and procedures all interact with their customers." From a hospital perspective, those customers may be external — patients, yes, but also the practitioners, administration, and other staff.

As with manufacturers who use ISO certification, the goal is in part to reduce errors and develop a level of consistency. In healthcare, ISO can help an organization determine where there is the most risk for error or the potential for error so that a hospital can eliminate that potential, says Perkins. "Two decades ago, American cars weren't reliable," he says. "They were riddled with errors and not a single U.S. nameplate was in any of the top 10 lists for *Consumer Reports*." The root cause was similar to what Perkins sees in many hospitals: a lack of connectivity between processes. "In the auto industry, they found a lot of problems in their supply chain. By addressing it, they reduced defects by 90%."

When an organization sees where the opportunity for error is, it can correct the problem and work on consistency — something researchers say will help improve outcomes in healthcare. "You find ways to not make

the mistake, and not make it every single time," Perkins adds.

An example is the universal protocol procedures required before every single surgery. The Joint Commission standard requires that before any procedure, the providers verify that it is the right patient, the right procedure, the right body part, that the body part is marked before starting, and that there is a time-out before the first cut is made. The ISO 9001 certification in quality management systems would require auditors to ensure there are processes in place to make sure that universal protocol is followed every single time, what paperwork or forms there are to make sure it's done, and the success rate for getting it done.

While there isn't a decade of healthcare use of ISO standards, there are some organizations that have been early adopters and are willing to talk about it. Detroit (MI) Medical Center, which uses the ISO environmental management standards, has saved money by finding areas to improve in power, electric, supply, and hazardous waste use and disposal.

The facility also reports that it is in a state of continuous readiness for Joint Commission surveys because it has the annual audits from SGS. Perkins says that people so appreciate the audit process that most clients have them come in twice a year, not once. "It is a collegial event that involves a lot of coaching," Perkins says. "We review results, verify closure of any areas of non-compliance, and then re-audit. But it's not looking for areas of non-compliance, but looking for system weaknesses and areas for improvement. We let our customers tell us where they see a struggle and we give them suggestions about how to address it."

Not a response to others

Some have suggested that the rationale behind The Joint Commission linking with SGS is upstart accreditation company DNV, an Oslo-based firm that offers ISO 9001 certification alongside hospital accreditation. But **Mark Crafton**, executive director of state and external relations at the Joint Commission denies it.

"We developed this option because we were hearing from our customers that they were interested in ISO certification," he says. Board members who work in other industries — automotive comes to Crafton's mind immediately — had seen it work and wanted to know whether it might be of use in healthcare, too.

Rather than offer it themselves, however, The Joint Commission felt that getting an expert organization like SGS would be the most appropriate way forward. "We wanted to pursue it through a very credible industry registrar and do it in a very coordinated fashion." Further, Joint Commission

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surveyors have "a different kind of skill" from an ISO auditor, Crafton notes. "This isn't our area of expertise. Better to partner with a world leader than trying to acquire these skills ourselves." This is particularly true given that there are several standards that hospitals can attempt to master, not just one.

In addition, DNV doesn't give its clients a choice about ISO 9001 certification: All clients seeking accreditation with that company must also work toward meeting the ISO 9001 standards, says Crafton.

"We believe it is complementary to our accreditation," Crafton says. "It allows facilities to put additional focus on processes that are key in their organizations." For example, The Joint Commission requires that there is medication reconciliation for patients. He says bringing ISO standards to bear will help a hospital identify, study and map out the entire process and see how it works. "They can shine a spotlight, help you improve, and then document that improvement," Crafton notes.

If accreditation is the thing that defines key processes, then certification makes sure you aren't just going through a book but continuing to assess how those processes work.

Those who opt to pursue accreditation along with ISO certification can choose to do the two processes at the same time or in sequence. Currently, Joint Commission and SGS operations teams are planning the entire process out to ensure it is streamlined for those who want both teams on site at the same time. "It would be detrimental to show up at the same time and then compete with each other to see the same records or policies," Crafton says.

All of the healthcare organizations that have moved forward with ISO certification have done so with a great level of skepticism, Perkins says — just as did the automotive and aerospace industries before them. "Now, not a single car or plane has a part that isn't certified. Healthcare is just the latest segment to adopt a methodology that more than a million firms around the world have adopted."

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What are the things you should always do?

Program funds projects with positive effects

In the 25 years since the Picker Institute was founded to focus on patient-centered care, the organization has specialized in talking about the positive part of healthcare — the things that should always be done that benefit the patient and family — rather than about those never events that make headlines.

Now, Picker has created an entire program that focuses on developing pilot projects for what they call "Always Events," proving their worth, and spreading the word about their impact. Two years ago, the Picker board wanted to accelerate action on patient-centered care, says **Dale Shaller**, principle of Shaller Consulting in Stillwater, MN, and one of the key architects of the program. More than 150 people worked on creating the Always Event program, including patients and their families, physicians and other providers, thought leaders, measurement experts, and other stakeholders from the healthcare world.

Always Events are defined as follows:

1. **Significant:** Patients have identified the experience as fundamental to their care.
2. **Evidence-based:** The experience is known to be related to the optimal care of and respect for the patient.
3. **Measurable:** The experience is specific enough that it is possible to accurately and reliably determine whether it occurred.
4. **Affordable:** The experience can be achieved by any organization without substantial renovations, capital expenditures or the purchase of new equipment or technology.

Patient-centered care

In 2010, the project kicked off, with participants determining that two things were vital to every aspect of patient-centered care: communication and care transitions. Those were to be the initial focus of Always Events projects. A call for proposals resulted in more than 80 applications; Picker granted funds to 21 of them for demonstration projects, and another 19 graduate medical education grantees agreed to incorporate Always Events into their projects.

These projects are discussed by grantees at

monthly teleconferences, and results are shared with the world at large through a compendium of stories and tools available on the Always Events website (http://alwaysevents.pickerinstitute.org/).

Picker is probably best known for its family of satisfaction surveys — Consumer Assessment of Healthcare Providers and Systems (CAHPS) — which give quarterly feedback on how hospitals are doing from the patient perspective. Shaller says that it is increasingly clear that patient perception matters to outcomes. Next year, Medicare will address that fact through payments related to how a hospital does on issues of communication, transitions of care, and the responsiveness of staff, he notes. "There is more weight attached to this now."

Organizations seeing positive results

So there is data that this is important, there is increasingly money tied to it — why a program to put more emphasis on it? Because, says Shaller, "we have known for some time that this isn't just frosting; it matters. We know these things need to be done, but they aren't getting done. This is a device to get organizations to pay more attention." Playing the National Quality Forum's phrase "Never Events" in a positive way engages providers, too, he adds. "Most people get into healthcare to help people. It is an optimistic thing, and they love this idea. Rules and regulations beat them down. They feel beleaguered. This is something positive for them to respond to."

It's only been a year, but many organizations are starting to see their projects reap positive results.

At the University of Pittsburgh Medical Center, a program called Guardian Angels helps people who come to the hospital after a family member has been involved in a trauma or serious event like a transplant surgery navigate the system. The idea was hatched after staff shadowed patients and families as they traversed the healthcare system and realized that figuring out what you should or could do is difficult when you are in a state of shock over a sudden event. Nursing and social work students fill the role of angel for patients and their families. Sometimes they do no more than show people where to go.

Another example is Vanderbilt University, says Shaller, which created a fall prevention video for patients and their families and is tracking how many people watch it, whether they report it as being useful, and the rate of falls before and since it was created.

Some ideas originate from programs designed to help specific populations with special needs, like pediatrics. At St. Jude's in Memphis, parents of patients will soon have access to a mentoring program, says **Kathryn Berry-Carter**, CAVS, CVA, director of volunteer services for the facility. Those who have been through the process are trained to assist those who are new to the hospital in whatever way they need. "They know what it's like to have a child who is extremely ill and can provide a kind of support that a staff member can't," she says.

Currently, they are putting together policies and procedures and will roll out a pilot in the solid tumor clinic starting in March, with between nine and 12 families and three to six mentors. After three months, they will assess how it is going using focus groups, satisfaction surveys of staff, mentors, and families, and then decide where to go.

Berry-Carter says research indicates that parent-to-parent mentoring can reduce anxiety, improve the ability of parents to cope in the hospital, and thus allow parents to be more present for the patient. That can have a positive effect on the patient's health, too, she says. "Treating the family helps treat the child's illness."

This kind of mentoring has been ongoing in an informal way for as long as parents have met in the waiting rooms of children's hospitals and pediatric wards. "We want to formalize it, provide training and expertise, and ensure they can do an even better job," Berry-Carter says. Chaplain services, social workers, psychologists, providers, and Berry-Carter are all working on the program, along with several parents from the family advisory council.

Berry-Carter says the team has worked to develop a timeline, a name and logo for the program, the qualities and qualifications of mentors, and processes for ensuring there is a diverse group of mentors available for the diverse patient and family base that goes to St. Jude's. The group has created policies on where mentoring should occur, how to match mentors and parents, the screening and interviewing process, training, debriefing protocols for the mentors, and what items should be reported from the mentor to the staff. Confidentiality is an issue, given privacy laws, so they are creating forms and determining

how to submit them. IT is getting involved in that part, Berry-Carter adds. Importantly, the group is also creating hard goals for the program. That's key to getting a Picker grant — Always Events have to be evidence-based, which means a degree of formality is imperative.

Getting to know patients

At the University of Minnesota Medical Center and Amplatz Children's Hospital, nurse manager **Cheristi Cognetta-Rieke**, BSN, RN, was working on her doctorate and came up with a project that works for both her degree and the Picker project. Called MyStory, the idea is to ensure that children in the hospitals are not treated as a disease or a room number, but as whole human beings.

"There is a lot of literature that if you want better outcomes, children need to be involved in their care planning and care delivery," Cognetta-Rieke says. "But often, the provider will go into the room and talk to the parents, not the child." Compare that to almost any other situation where an adult is in a situation with an adult and child: The child is almost always greeted first. "We just don't involve kids in acute care settings as much as we should."

Her idea was to create some sort of document that would provide caregivers with information that the patient wanted them to know about him or her, determine its best placement, and then teach caregivers how to make use of it.

She met with patients and their families to determine what information would be most helpful for the providers to know, such as what comforts them, what frightens them, their favorite music, or their goals. One item might help a nurse who is trying to calm a patient for a procedure, while knowing what big events are coming up might help a physician tweak a treatment so that it allows the patient to attend.

After figuring out what questions to ask patients, Cognetta-Rieke had to figure out what to do with the information. Putting it on the door or just inside the door was one idea, but that wouldn't allow providers in other parts of the hospital to have access to it. If a patient was going from her room to dialysis, how would the dialysis clinic know what it should about the patient? They decided to put it in the electronic medical record. It's now one of the first fields a provider will see in the record, she adds.

Next was a way to get providers to make use of the information. "This isn't a nicety, but a necessity," Cognetta-Rieke says. "They are obligated to know this stuff." To that end, patients and parents are asked questions relating to the MyStory project and the results are to be posted quarterly for patients, the public, and providers alike to see, using a dashboard similar to any other quality improvement program.

The first set of results is due out in early January, but already there are anecdotal reports of positive results. Patients say that the care is gentler, and parents say there is more direct communication with their kids. They feel more comfortable not being in the room when a provider is there because the providers themselves know what calms and distracts the children.

Cognetta-Rieke says she can tell from her knowledge of particular patients whether it's working. One patient, for instance, put in her MyStory that she was afraid of people in white coats. Now, when Cognetta-Rieke is on that patient's unit, she can look outside the door to her room and see white coats hung up: Providers aren't wearing them in the room.

"I don't know that you can ever prove that this kind of thing directly leads to improved outcomes," says Cognetta-Rieke. "Maybe we can look at length of stay or pain management." In short order, she says she expects results to spur expansion of the program to adult inpatients and outpatient settings.

In the end, Shaller says it all comes down to asking patients and their families what they want and what they need, and then acting on it. In a year, the Picker Institute will hold a grand conference to release information about the projects involved. Meanwhile, participants and others can make use of tool kits, suggestions, and strategies available on the Always Event website.

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When bad things happen to good hospitals

Don't rely on a generic emergency plan

A report from the Health and Human Services' Office of Inspector General released at the end of October concluded that the Centers for Medicare & Medicaid Services isn't addressing some of the serious events that happen in hospitals or letting The Joint Commission know about them in a timely manner. However, hospitals are taking corrective actions, according to the report (http://oig.hhs.gov/oei/reports/oei-01-08-00590.pdf), making policy changes and providing training so that they don't happen again.

What else should hospitals be doing that they might not be when something bad happens? According to the Institute of Healthcare Improvement's re-released white paper, "Respectful Management of Adverse Events" (http://www.ihi.org/knowledge/Pages/IHIWhitePapers/respectfulManagementSeriousClinicalAEsWhitePaper.aspx), only 30% of hospitals have crisis management plans in place to deal with serious events. This is a mistake, says one of the authors of the report, James Conway.

So just what does a policy look like? At the University Health System of Eastern Carolina, being transparent is a long-standing goal, says **Joan Wynn**, chief quality officer for the system. "We started in 2008 because we wanted to be a leader in transparency," she says. "We wanted to be a learning organization, with everyone knowing what is happening and what you have to do differently." That transparency applies not just to the 10 hospitals of the system — who share information about events and near misses on a system intranet — but to patients and their families, too, when there is an error. "Transparency is a lever on building the will to get better," says Wynn.

And while some people balk at the idea of being open about errors and events, **Vicki Haddock**, administrator of risk management at the system, says that increasingly, even the most cautious of people understand that this "is the right thing to do."

The policy used for serious adverse events has actually been in place since the 1990s in some form. It is reviewed at least once a year, though, and changed as warranted, says Haddock. If a best practice is identified in literature or from another organization, Wynn notes, they may pull the policy out early for revision. Routine evaluation of the policy is done with representatives of risk management, quality, patient safety and patient advisory directors. Any changes are reviewed and approved by senior leadership.

Take the example of a medication error that results in a patient being transferred to a higher level of care, Haddock says. The staff involved call the on-call risk manager, who speaks with the physician. The physician and risk manager then meet with the patient and family to tell them exactly what is known. They also assure the patient and family that there will be a full review and any information from that review will be relayed.

Initial investigations start next and involve a review of the record, analysis by a pharmacist, and interviews of all of the providers and caregivers who were present or involved. The hospital then calls a Code E conference, which involves quality staff, accreditation, risk management, legal, on-site leadership, and medical leadership. They determine how to classify the event — serious, sentinel, or a precursor event. They determine whether a root cause or other analysis needs to be done, whether to refer the case to peer review, and whether to call in any external reviewer or ask for analysis by an outside pharmacist or physician. A specific time frame is set for any analysis requested.

The patient safety committee reviews the case and creates an action plan to prevent such an error from happening again. The entire incident is reported throughout the system as a lesson learned. The patient and family are kept advised throughout the process.

If the case is serious enough to merit media interest, the public relations staff will advise senior leadership on what action to take, along with input from risk management and legal staff, says **Barbara Dunn**, director of public and consumer relations for the system. That's only happened once in the last seven years, she says. "We were getting calls from media from around the region, and we felt it was important to address it fully, with full transparency, taking responsibility for our role in the event and assuring the public that we were working to ensure it never happened again."

The entire process can take a year or more to complete, says Haddock. Throughout that time, another element of the policy is to ensure the staff

involved have the support they need, whether it is personal counseling, an opportunity to teach others what they have learned from the event, or something else.

Wynn says organizations that are sitting down to create a crisis policy should not assume that they can quickly become as transparent as they want to be. "We created a sequential time line. It can't happen tomorrow."

If you have senior leadership that thinks such events will never happen at your facility — and thus you don't need such a policy — you need to work to shift their view, Wynn says. "Share the stories in the press of other places where this is happening. It can happen to you, too, and you need a plan for what to do."

When they created their policy, Wynn says they did a survey of what other organizations in their state were doing. Having legal departments talk to outside counsel, determine what is happening in other facilities and the legal and regulatory realities in your state and others can help bring about change.

Haddock recommends letting risk management act as a conduit between the legal department, which might be more conservative, and quality, which might see the value in this based on literature and anecdotal evidence. "We sit in the middle between quality and legal. The dialog and planning between them is important. You have to engage in conscious decision-making about whatever policy you create."

Dunn says to make use of your friends and allies in organizations and at other facilities, not just when you create your policy, but also as events unfold. "A year after we had our event, we had a call from another organization that had the same thing happen to them. They wanted to know how we dealt with the media." She was happy to share their policies and experience, and says she'd feel comfortable calling that peer or any number of other people she knows to either find out how to handle a situation, what they learned from a situation, and even if they needed any help handling something. It's just another element of transparency.

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For Baldrige winners, learning is in the journey

But what of the future for Baldrige?

They knew it was coming: The National Institute of Standards and Technology's (NIST) proposed budget didn't include any government funding for the Baldrige National Quality Awards. But it still comes as a shock, particularly to those who have participated in the program and know firsthand the benefits that participants reap. But that doesn't mean the end of the program, says **Harry Hertz**, director of the Baldrige Performance Excellence Program at NIST. The program is a partnership, and the related Baldrige Foundation is providing support for the staff while the organization looks for a "long-term funding mechanism," says Hertz. "They are committed to our future."

The exact value of the program has been calculated. One study found that benefits to the 273 winners to 2006 in cost savings, customer satisfaction, and financial gain outweigh the cost by 1,252-to-1, according to the NIST website. Further, if the value could be compared with the total cost, the 1,252-to-1 figure would probably be very conservative.

The Baldrige Foundation also took a look, this time at hospitals that had site visits as part of the application process, comparing them to the Thomson Reuters 100 Top Hospitals. Baldrige Foundation chose to conduct a comparison with the Thomson Reuters 100 Top Hospitals national study. Baldrige participants are six times more likely than peers to become 100 Top Hospitals, Hertz says, and they fall into at least the top 3% of facilities.

That isn't surprising to **Sue Hawkins**, MBA, senior vice president, performance excellence at Henry Ford Health System in Detroit, one of three healthcare winners of the award this year. It's a "grueling process," she notes. "It's not just about the application, but that you have to change the way you run your organization just to respond to the questions asked. Right out of the gate, they ask you how your senior leaders establish the vision for the organization and translate that to the workforce." It's just one of hundreds of "how" questions that force an applicant organization to look deeply at itself, evaluate its performance, learn from mistakes, and change what it does.

Henry Ford first applied in 2004. "If you are

stumped on the second question, you know you will have to become a different organization," says Hawkins. "You realize you aren't as good as you think you are and you have to be different. It becomes a lever for your own improvement."

Over the last seven years, there have been dozens of substantial changes at Henry Ford that were eventually instrumental in helping it win the award this year. Each applicant gets a feedback report that enables it to make some changes. But only the best get site visits, and it took four years before Henry Ford achieved that. Of the 70 or so applicants, only 11 merited site visits, she says.

Eight people come on site and essentially write a "better feedback report" for the hospital. "They learn more about us, verify that what we wrote in our application was true, and give us a report that includes better guidance. The award is an honor, but the feedback is the most valuable thing. We've been using it for years now." Of the 30,000 employees, affiliated physicians and volunteers in the system, some 1,200 were interviewed during the four-day visit.

Among the changes that led to the award was the creation of a strategic planning process. "We used to write a plan every year and put it on the shelf," Hawkins recalls. "We had no way of testing how we were doing against our plan. Now we have a cyclical plan that considers the long term. We have a way to evaluate how we are doing against that plan."

The very way the leadership team was organized changed due to feedback that said it wasn't clear who was in charge of what at Henry Ford.

Patients benefit, too

In terms of patient care, a big change was an improvement in the way best practices are shared. "We are team based, but we focus on internal collaborative groups now to share processes," she says. "We have monthly meetings on reducing patient harm, we pilot ideas and test changes and then we spread them. Every employee knows they are part of this. And our outcomes are better because of it." Harm has declined by 27% in the last two years and mortality is down 40%. "Fewer people die under our watch than used to, and that's a cool thing to note. People loved to talk about what they were doing to make those numbers."

The sepsis rate in the ER is another thing that dropped as a result of Baldrige work. One of the physicians invented an anti-sepsis bundle that is now used as a national standard. Inpatient sugar levels are more under control, too.

While the application is done — they can't submit another for five years — the organization still has to stay on its toes. There have been more than a dozen requests for someone from Henry Ford to come speak about what they have done — sharing is an obligation for winners — and there is still one more feedback report that will come and provide fodder for more change. "We'll pour over that to find priorities for improvement. Maybe we don't write an application again this year, but we won't let go of the process." She hopes that Henry Ford, like so many other winners, has the best year of improvement the year following the award.

Schneck Medical Center in Seymour, IN is just 93 beds, but it is one of the best of the best, a 2011 Baldrige winner. It took five years of applications to get to this point, says **Suki Wright**, MSM, CSSBB, director of organizational excellence and innovation at the hospital.

Indiana doesn't have a state Baldrige program, but Ohio does, and Schneck partnered with it in the hopes of simply getting a report back from which to work. Because of the partnership, the Ohio state Baldrige organization did a site visit that first year. The process is identical to that followed by the national examiners — two of the state examiners even participated in Schneck's eventual national site visit.

Wright says she feels pressure to keep moving forward because Schneck is now a role model for other facilities. She notes they will probably even continue to do the assessment despite the fact that they can't apply to the national program for five years — although they may apply through a new three-state joint venture between Indiana, West Virginia and Ohio.

Wright thinks that someone will come through with funding for the future. "The framework is so successful that someone else will pick it up."

Meanwhile, the drumbeat continues for the winners. "Baldrige helps you understand what is important to your organization and to think always of what is best for the patient. That has helped us with every single decision we make," says Wright. "We used to do things so randomly. This process made me think differently and ensure that what we do is coordinated. We are process literate now."

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Quality leader focuses on compliance

Approach results in reduction in fall rates

Many times it takes significant changes in processes and/or policies to effect improvements in quality performance. But before undertaking any initiatives, **Jeffrey Weinberg**, MD, a physical medicine and rehabilitation specialist at Staten Island (NY) University Hospital, opted for a different approach when addressing fall prevention.

"What we decided was rather than continually trying to develop new policies and protocols in response to increased fall rates or sentinel events, we said, 'Let's make sure everyone is following all our policies,'" he says.

"So, when someone had a fall we looked at the incident reports and then at the charts, and we found the policies were not being followed as rigorously as they could be to truly prevent a fall," Weinberg continues. "So we said, rather than changing things, let's set a process in place that holds people more accountable for following existing protocols, and only change them when we're sure people are following those and a new protocol could supplement them."

Two phases

The approach has clearly worked. In a paper published in the *Joint Commission Journal on Quality and Patient Safety*, Weinberg and his colleagues reported that over a four-year period inpatient fall rates decreased by 63.9%; minor and moderate fall-related injuries decreased by 54.4% and 64.0%, respectively. Two falls with major injury occurred during the study.[1]

The initiative was comprised of two phases, the first being the review phase. Weinberg and his colleague Donna Proske co-chaired this effort, first reviewing existing policies. "We thought they were okay," he recalls.

This phase also included chart reviews. "Early on there were so many falls we couldn't do it with every fall, but with minor or moderate injuries we would call the manager and staff nurses to a meeting where we all reviewed the charts together," Weinberg says. The attendees included the vice president of nursing; quality management; the associate vice president of nursing for that particular area; the nurse manager; the staff nurse; and sometimes a nurse's aide.

"We basically took the incident report and went through and challenged everything," says Weinberg. This included whether important procedures were conducted on every shift — for example, if the patient was checked on frequently to make sure they did not climb out of bed. "We found there were often lapses in compliance with the fall prevention protocols," notes Weinberg.

The main factor that helped to reduce the falls, Weinberg asserts, was a process whereby the protocol breaches were clearly identified and the people who committed the breaches were held accountable.

Enforcing accountability

One concern, Weinberg continues, was that the nurse manager on the unit be able to determine as quickly as possible when staff was not following protocols, so fall prevention rounds were quickly instituted.

"We determined we would handle these situations initially with education, then progressive disciplinary action — but we did not find we had to get to that level," says Weinberg. "Basically through education and awareness, and also by being identified, people got with the program."

Weinberg says people were not ignoring policy because they were lazy, but because "This is a very busy place and you have to set priorities." Accordingly, he continues, "We made sure fall prevention was a priority, and we put in a structure to reinforce that message at every level."

So every morning the nurse manager would review fall prevention assessments and strategies implemented on the unit. "If there was a fall and say, for example, the patient assessment was not done correctly or care was not planned properly, we'd go to the nurse manager and ask if they picked that up on rounds — so then they

became accountable," Weinberg shares. "What that did was not only hold them accountable, but it made people become more aware of the situation. Prior to this, people saw fall rates go up even though it seemed to them people were following protocols."

In many cases, says Weinberg, it came down to a lack of critical thinking. "We empowered people to think differently," he says. "For example, take someone who was initially not at risk for a fall; they had been assessed properly, and we did not have fall prevention protocols in place. At that point, this may have been appropriate, but then they received, perhaps, a dose of tranquilizer: that should have triggered critical thinking where someone could have suggested the patient be put on fall prevention for the next four hours. We wanted everyone to be aware of the importance of critical thinking, and make sure that reasonable efforts were being implemented in a thorough and complete way."

Adding protocols

Once compliance improved, Weinberg and his team turned to new protocols. "We formalized the use of bed alarms and chair alarms," he says. "Although they used to be used sporadically we set up criteria that resulted in them being much more widespread." Now, he says, whenever a patient gets up an alarm goes off. "Even here, however, just putting in a protocol is not enough," he emphasizes. "When it started we were not 100% compliant, so in doing our reviews we identified where it should have been done — and in a short period of time it was being used appropriately."

In addition, while there had been some prior efforts to assist with toileting, "we put in a strict protocol that patients at risk had to be offered toileting every two hours while awake," Weinberg says. "But again, it's more than just saying that's our policy, but reminding people that we are monitoring compliance. Following up with accountability led to much more compliance and further reductions in falls."

In addition, he notes, success has bred success. "As we became successful and reversed the trend of increased falls people became enthusiastic about the program; there was friendly competition among the units, who also shared best practices. It evolved from being burdensome to being something people became very proud."

REFERENCE

1. Weinberg, J, Proske, D, Szerszen, A, Lefkovic, K, et al. An Inpatient Fall Prevention Initiative in a Tertiary Care Hospital. *Joint Commission Journal on Quality and Patient Safety*, Volume 37, Number 7, July 2011, pp. 317-2AP(-314). ■

Barriers to e-prescribing remain

A study by the US Department of Health and Human Services' (HHS) Agency for Healthcare Research and Quality (AHRQ) found that e-prescribing is safe and effective, but still faces many barriers to widespread use. Published in the *Journal of the American Medical Informatics Association*, the study noted the many benefits of electronic prescriptions, including helping to reduce the risk of medication errors caused by illegible or incomplete handwritten prescriptions, and saving money and time by streamlining the process of prescriptions and renewals. The latter is the area on which the study focused.

Physician practices and pharmacies generally felt positive about new prescriptions being transmitted electronically, but the issues of renewals posed problems, and physicians and pharmacies used e-prescribing features for electronic renewals much less often than for new prescriptions.

Among other findings was that pharmacies sometimes need to edit certain prescription information manually, for things such as drug name, dosage, and quantity. One common cause reported by both physicians and pharmacists was that physicians must select medications with more specificity when e-prescribing and make decisions about such factors as packaging and drug form. Such decisions had typically been made by pharmacists for handwritten prescriptions. Pharmacies also noted that they often had to rewrite patient instructions so that the patient could understand them.

The study — "Transmitting and processing electronic prescriptions: Experiences of physician practices and pharmacies" — concludes that a broad group of public and private stakeholders will need to work together to address these issues. Stakeholders include the federal government, e-prescribing standard-setting organizations, vendors and others. It is available at http://jamia.bmj.com/content/early/2011/11/17/amiajnl-2011-000515.full. ■

NQF evaluates use of performance measures

A RAND study released in December looked at the use of performance measures and the barriers to using them. Commissioned by the National Quality Forum, it evaluated how performance measures are currently being used in the field, by whom, and for what purpose; what made them more and less likely to be used; and how to get more people to use the measures in the future.

The independent evaluation was performed as part of a contract with the U.S. Department of Health and Human Services (HHS), key stakeholder in driving use of standardized performance measures and assessing if healthcare spending is achieving the best results for patients and taxpayers.

"This report is an important first step toward helping us gain a better, more systematic understanding of how NQF-endorsed measures are being used," says **Janet Corrigan**, PhD, MBA, CEO of NQF. "We are committed to examining where and how we can make the greatest impact in improving health and healthcare through priority setting, the increased use of performance measures, and meeting measurement gaps."

Over six months, RAND researchers interviewed people who use measures, such as community collaboratives, health plans, state and federal government agencies, and consumer groups. They then reviewed publicly available documents and materials from websites.

Nearly all instances of measure use included an NQF-endorsed measure, with only 1% of organizations studied not using any NQF-endorsed measures.

Factors behind use of measures

Organizations cited a number of internal and external factors driving their use of performance measures, such as legislative requirements related to quality-based payments and public reporting contained in the Patient Protection and Affordable Care Act. Others used the measures in response to local public health issues, such as obesity, or to help operationalize their individual missions. The ability of data to construct measures was the single-most important cited factor as either facilitating or impeding the

CNE QUESTIONS

1. ISO certification is renewed
   a. Every six months
   b. Annually
   c. Every other year
   d. When you have your Joint Commission survey

2. Always Events have four key elements. One of them is
   a. Must be patient centered
   b. Must work in a pediatric setting
   c. Must be affordable
   d. Must be approved by the Picker Institute

3. IHI says how many hospitals have crisis policies?
   a. 30%
   b. 33%
   c. 13%
   d. 3%

4. Baldrige award winners are how many times more likely to be in the Thomson Reuters top 100 hospitals than their non-winning counterparts?
   a. 3 times
   b. 18 times
   c. 6 times
   d. 2 times

COMING IN FUTURE MONTHS

- A bundle to reduce readmissions
- Your survey stories
- Going from worst to best in surgical outcomes

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.

use of measures.

Respondents noted that NQF-endorsement or widespread use of a measure enhanced provider buy-in. A number of areas where measure gaps exist were pointed out, as well as areas where new specialty measures would be useful. Interview participants also stressed the need for better alignment between measures used in the public and private sectors around national priorities.

The study is being used to push forward existing programs. The National Priorities Partnership (NPP) is establishing priorities and tracking alignment with the National Quality Strategy, and the Measure Applications Partnership (MAP) is assessing the use of "best available" measure sets for payment and public reporting programs. The measure endorsement process fills critical gaps and is looking to emphasize harmonization of measures to reduce provider burden and patient confusion.

Finally, NQF's new web-based tool, the Quality Positioning System (QPS), helps make NQF measures more accessible and, along with other community-oriented work such as the Community Tool to Align Measurement, has corroborated measure gap areas.

The full report, "An Evaluation of the Use of Performance Measures," is available online. ■

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■