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AHC Media

Getting nurses to use evidence-based practice takes culture change

Give them times, tools, and empowerment, say experts

If trends hold in 2012, it will be the 13th straight year that nurses top the Gallup poll on ethics and honesty (http://www.gallup.com/poll/151460/Record-Rate-Honesty-Ethics-Members-Congress-Low.aspx). They are widely viewed by the public as being trustworthy and caring about what they do. Indeed, no one would suggest that a nurse does anything on the job that would knowingly imperil patients. Yet many nurses do not use evidence-based practices (EBP) that are known to improve outcomes, lower costs, and reduce harm. A study in the September issue of the *Journal of Nursing Administration*[1] surveyed more than a thousand nurses to find out what they thought of EBP, what they knew about EBP, and how much their institutions helped them to make use of EBP in their own practice. The findings were stark: Just over half agreed or agreed strongly that their facilities implemented EBP. Slightly more than a third of the respondents thought that their colleagues used EBP regularly. Just a third of the nurses felt they had adequate mentoring for EBP, and less than half thought that new research was the basis of new practice in their hospitals. Nearly three-fourths of the respondents thought they needed more education, and about 60% would be interested in participating in Web-based seminars about EBP.

The survey found several barriers to implementing EBP. The most common complaint was a lack of time — nurses already spend about 70% of their time on non-patient care activity, and they are often hard-pressed to do what they need to do within their shift. In descending order, the rest of the top 10 things that get in the way are a culture that is resistant to change; a lack of education on EBP; no access to information on EBP; managerial resistance; inadequate staffing/patient loads; nursing resistance; physician resistance; budgetary or payer issues; and lack of resources.

Some of the press since the survey was released has focused on nurses not implementing EBP, as if they have complete control over whether to implement or not. But for the last several years, **Margaret "Marc" Irwin,** RN, MN, PhD, a research associate at the Oncology Nursing Society in Pittsburgh, has been working with 35 organizations across the country as part of the ONS Foundation's Institute for Evidence Based Practice Change project, and in talking to nurses and organizations about EBP, she found that there was "an incredible lack of appreciation" for just how formidable

the barriers to implementing EBP are to nurses.

She collected tons of data on what helps and what doesn't, what keeps organizations from implementing EBP and what encourages it. The lack of time is something people talked about again and again. "You might say that it will not take more time to do EBP, but if they do not have the information on it, if they haven't been coached in how to foster change, then it does take more time." Even if nurses have a few extra minutes, the concern is that they would be taking time away from patient care just to change the way they deliver patient care.

Organizations often have insidious ways of discouraging even those who want to do things differently, Irwin says, recalling one hospital where a team of nurses interested in EBP were told by librarians that they only did literature searches for physicians. "We were able to go in and fix that situation, but it is an example of how many do not take it seriously when nurses want to make a change," she says.

Nurses are also focused on a lot of other changes right now, says Irwin, such as the implementation of electronic medical records. Major initiatives like that get a lot of attention and make it much less desirable to bring about some other change in practice until things slow down or calm down — as if that ever happens.

Let's say you get the buy-in from a hospital and the nurses, then you need to find the resources to get baseline data, most often by doing chart reviews, Irwin says. And whoever is doing that work isn't caring for patients at the same time, so there may be a monetary cost associated with it to hire someone to do that job.

Joanne Disch, PhD, RN, FAAN, a clinical professor at the school of nursing at the University of Minnesota in Minneapolis, lumps barriers into three categories. First is institutional, dealing with the rules and regulations that might make it hard for even an enthusiastic nurse to get the information she needs to implement evidence-based care. "You may have some rule that says no iPhones or PDAs are allowed, so nurses can't call up information in a ready manner," Disch says. Changing that rule requires changing attitudes in committees that may have nothing to do with nurses.

Second is personal. Disch says that some nurses just plain do not want to change what they do. The survey found that older nurses were more likely than younger ones to care less about EBP. A 2005 study by DS Pravikoff[2], which has been repeated, with results due to be published early in 2013, found that nurses were more comfortable asking their peers or looking on the Internet for information about clinical practices than they were using clinical databases or peer-reviewed literature. The value of research was lost on three-quarters of the nurses surveyed.

Third is something that might be termed philo-

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sophical barriers: when EBP butts up against a different world view. Think about smart people who do not believe in climate change, she says. "We believe things that make sense to our world. And if we do not like the evidence, we will not believe it." For instance, there are decades of proof that having open visitation in ICUs doesn't harm, but actually helps patients. Still, many nurses just will not allow it. Sometimes, the disbelief in known fact is more obviously harmful, she says, such as with nurses who persist in injecting saline in endotracheal tubes. They say it clears the tubes, but respiratory therapists will tell you it is bad patient care. "It is not about the facts for them," says Disch.

Cases like that are hard because it is the whole culture of the place that has to change, she says. If you have a facility that embraces change and provides the tools needed to implement it, it is much easier to get buy-in from just about everyone. And if you have some people who just refuse to believe, they will probably still change their actions, if not their beliefs, because everyone else is.

Getting buy-in from the top down and bottom up may come down to talking in the language each audience understands. For the C-suite, it might be about reducing costs; for physicians and nurses, it might be about improved outcomes; and for others it might be about the increased public reporting of data related to EBP and the pressure that brings to invest in quality and safety, says Disch.

Irwin says QI and patient safety managers can help by mentoring nurses and making it clear that they can come to the department for any assistance — whether it is as simple as finding literature, or as complex as understanding more about data collection and analysis. If they do not come to you, go out to them and tell them what you can offer, she says.

Find the nurses who are most interested in EBP and do a project or two with them, says Irwin. These nurses can then go preach the gospel to their peers. "Over time, we saw a lot of what we called igniting the spirit of inquiry," she says. Nurses participate in a QI project for an evidence-based practice; they see change and get excited; they want to know more and do more; they are more satisfied with their jobs. These people then go to other groups and committees. They feel more empowered and energized." They become your evangelists, Irwin says.

You may also need to help the nurses learn about how to sustain change. "You have a better understanding of issues related to how to keep from slipping back into old habits than they do," says Irwin.

Find the early adopters — the ones who are first in line for the next generation smartphone or who are always up on the latest research — says the lead author of the survey, **Bernadette Mazurek Melnyk**, PhD, RN, CPNP/PMHNP, FNAP, FAAN, Associate Vice President for Health Promotion, University Chief Wellness Officer, Dean and Professor at Ohio State University in Columbus. Do not try to convince people who aren't interested.

There is a kind of "coma of complacency" among some nurses because, in part, they were never taught about EBP, says Melnyk. Giving them access to that knowledge can bring them back to the "passion and purpose" and help reduce the burnout and fatigue caused by a task-oriented, high-pressure job.

Implementing EBP can improve outcomes by up to 30%, she says. Those who use EBP are more satisfied with their jobs and more empowered in the workplace. And costs are lower. It is a no-brainer, right? But knowing and doing are two different things, says Melnyk. It takes up to 25 years right now for research to move its way into common practice — and that's not just for nurses, but for other providers and administrators as well. After all, we know that 12-hour shifts aren't the best for nurses or patients, she concludes, but we persist in having them.

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Nothing new doesn't mean nothing important

Do not be complacent about NPSGs

The 2013 National Patient Safety Goals (NPSG) came out last month and did not really include any big surprises. Indeed, there was nothing new in them. But that doesn't mean you do not have to pay attention to them.

According to **Bill Metzcar**, the CEO of Ohio-based ISO Consultants for Healthcare, "this is the year that hospitals should seek to improve performance in the areas of the patient safety goals, as well as core measures and HCAHPS." Because so much is happening in health care, a break from worrying about something new in the patient safety goals can give quality professionals a chance to take a breath and perhaps look a little deeper, he says.

"Hospitals should be prioritizing their focus on the NPSGs by evaluating current performance, understanding problem-prone processes, high-risk areas and activities, and then determining through their annual planning where to devote their time for improvement," Metzcar says.

There are some process-focused building blocks within some of the NPSG's chapters, he says. "This makes TJC's [The Joint Commission's] desire to bring hospitals to a level of process management evident, but the overall approach must be considered as in-progress."

Metzcar did notice a couple of things in goal 7, which is related to infection control, specifically in NPSG.07.03.01, related to healthcare-acquired infections with multi-drug resistant organisms, and NPSG.07.04.01, related to central line-associated bloodstream infections. Both chapters include some initial steps toward process management within the elements of performance, he says. "First, within the elements of performance there are two levels of criteria. The first is specific criteria that apply to the activity, and the second level is criteria that focus on process thinking. Many years ago as I worked with experts in quality management and process improvement, there was a common statement: 'Design quality into the process rather that inspect quality in later.' When I first heard this statement, I did not understand the intention, but through maturity in process improvement and quality management, this statement is at the core of how healthcare must change in order to improve."

For example, look at some of the criteria that is process-specific in chapter NPSG.07.04.01. In the elements of performance, it states under points seven through 10 specific steps for the process. He calls them quality control points. These include hand hygiene, not inserting catheters into femoral veins in adult patients unless other sites are not available, using standardized supply cart or kit, and standardized protocols for sterile barriers. "These are all great points and should be followed and used as education throughout healthcare," Metzcar notes. "However if these points were what was needed to be successful, then once hospitals implemented the elements as standard practice, our process should perform well and we would not need this chapter included in the NPSGs."

The Joint Commission has included what he deems the most important aspects of this chapter in the first six elements. They include education, policies and practices, periodic assessment, and risk evaluation. Says Metzcar: "These are not all inclusive of the process foundation, but it is a start, and they represent a powerful tool when implemented properly and completely."

Often he says he will see hospitals implement TJC's requirements chapter by chapter in a silo model throughout the hospital. But this leads to process variation that will have to be managed by hospitals, since multiple policies and methods will have been developed independent of the overall hospital system.

Metzcar says that despite the lack of change in the goals, "there is ample opportunity for hospitals and healthcare facilities across the country to re-evaluate their processes and interactive systems to continue driving improvement and changing the culture of an organization and ultimately yielding safer care for the patient."

The complete list of goals can be found at http://www.jointcommission.org/assets/1/18/NPSG_Chapter_Jan2013_HAP.pdf. Metzcar warns that what's in the report isn't the most important thing. What counts is what yields the results, and that should be front of mind all the time, not just when the next year's goals come out. "You shouldn't need the goals or TJC to tell you what your weaknesses are. If you are looking at the data you generate all the time, you will know how your hospital relates to these goals. You should already have a strategy in place for figuring out what to do next. Do not wait for TJC to tell you."

For more information on this topic, contact Bill Metzcar, CEO, ISO Consultants for Healthcare, New Madison, OH. Email: wmetzcar@iso-forhealthcare.com ■

Creative efforts drive goals home

To help them remember, write a poem!

No one ever says "as memorable as a PowerPoint slide," do they? Or "as much fun as a white paper." If you want people to remember something important, you have to spark their interest. And when the material is as dry as patient safety goals, well, you have your work cut out for you.

But **Darla Caldwell**, RN, BSN, CPPS, director of patient safety at Baptist Saint Anthony Health System in Amarillo, TX, has a creative streak in her that makes meetings about things you have to remember much more entertaining.

The latest endeavor is a comic book related to the National Patient Safety Goals written in the rhyming meter of Dr. Seuss and peppered with Seussian characters in bright colors.

One stanza reads:

They have new goals, they are forthcoming
So many pages it is mind numbing
National Patient Safety is the theme
Quality Patient Care will be SUPREME
Each goal will have a very clear mission
We're here to make it your primary vision
Infection Prevention is where we'll start
Keep Number 7 close to heart

"We just take something that is known and change it around to teach something," she explains. "It works — they remember the patient safety goals, and you can hear them rhyming under their breath."

For a project around MRSA, Caldwell and her team once created a bug character that came to every learning session. Chester the Cheetah is another creative character that they used. He passed out cheese doodles and was used as a character in handouts for several projects. "If you add a colorful character, it helps people remember. They do not want the same old bullet point presentation. They want something new."

She learned the value of creative endeavors in nursing school, where they used mnemonic devices to remember things like the bones of the wrist — "Never lower Tillie's pants, mama might come home," she recited easily, 20 years after learning the phrase.

For the comic book, which was a large project, every person on her staff worked on creating rhymes for one of the goals. Then they came together and manipulated the poems, brainstormed ideas, and finally came up with a final version. It took a couple months to complete and get off to the printer. There were 3,000 copies printed — one for every employee in the system. For the infection control goal alone, they did a mini-comic book as well, and there is a bookmark and a PowerPoint presentation that no one finds boring.

Once you get creative, it is hard to stop. "We were doing something on proper catheter bag handling, so we had nurses pose for a series of pictures on what you should — and shouldn't — do with the bag. Like you do not hang it on the IV pole during transport, complete with a horrified-looking 'patient' in the wheelchair." They handed out the resulting picture book to anyone who came in contact with catheter bags, including imaging and transport staff. Sure enough, catheter-associated urinary tract infections declined. "It works much better than a plain old QI project," she says.

Caldwell would have loved to share the comic book with all and sundry, but the system lawyer says that while fair use laws would likely find it okay to use Dr. Seuss internally in a single organization, shipping it out to others, without knowing how they would use it might be a breach of copyright.

As a final taste of her rhyming skills, consider this from the hand hygiene section of the book and see if it doesn't stick in your head all day:

Soap, Soap, Soap
Gel, Gel, Gel
Which one's best to keep you well?
Using hand gel is the way,
unless there's C-Diff, then we say,
Soap and water MUST be used,
to kill the germs, do not get confused!
Soap, Soap, Soap
Gel, Gel, Gel
Staying clean will keep you well

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Call to Action wants more reporting

Non-punitive culture vital to quality efforts

The list of organizations that participated in the recent National Association for Healthcare Quality's "Call to Action" gives you an idea of how important people from various parts of the healthcare world think the topics addressed in the report are.

Released in October, the NAHQ report "Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems" outlines some of the problems in healthcare, most notably that we do not really know how much harm and potential harm there is, since organizations aren't very good at reporting events and near misses. Without that information, the authors note, how can you know what's wrong? And if you do not know what's wrong, how can you fix it?

The Call to Action outlines four main areas of action: to establish accountability, protect reporters, respond to concerns, and report the data accurately. It notes that many people are afraid to report incidents, and some are even harassed or threatened with adverse consequences should they choose to report something. It is peppered with responses from NAHQ surveys about harassment and intimidation that are shocking and far more common than most organizations would care to admit.

There are several things that organizations can do, the report notes, including continual education from hiring through all employees' careers about the importance of reporting adverse events and near misses, publicizing good catches, benchmarking of data, having clear policies and expectations around the issue of reporting and publicizing them. You need to have just responses to concerns, and have clear policies about the value and importance of people who report problems. Data collection and reporting should be transparent, communication encouraged, and teamwork fostered.

The complete report and its recommendations can be found at http://www.nahq.org/uploads/NAHQ_call_to_action_FINAL.pdf.

Cynthia Barnard, MBA, MSJS, CPHQ, director of quality strategies at Northwestern Memorial Hospital in Chicago was the main contributor to the report. She says that it is no secret to anyone that there is a large proportion of events that are unreported. "What we are trying to do is show that there are some specific leadership behaviors that encourage unreporting. That means there are behaviors that can encourage reporting, too."

This report needs to be seen by anyone who attends an executive quality meeting, and Barnard says quality managers should read it and present it to senior management and medical staff. "Tell them that this is what a respected consortium of healthcare stakeholders says we should do. Then ask what you can do to bring it to your front door."

There are plenty of organizations that have moved forward on this — Dana Farber and Johns Hopkins both have just cultures that encourage reporting. And both of them changed their culture after tragic events that harmed patients. Virginia Mason in Seattle is another that learned the hard way why culture change is good. "People have terrible things happen that awaken them," Barnard says. Some organizations learn from other's tragedies, too.

None of this is exciting or sexy, she says. "Doing this will not bring you fame." But not doing it might bring infamy, and certainly will not help your patients get the best care. "The public thinks you are already doing this. There are no brownie points for it. You really should be doing all of this already."

Reporting potential safety events is theoretical, she says. Reporting actual events may not even rise to the top of the CEO's to-do list. "But that's not the point. In terms of priorities, that's not how you should think about this. You should think of developing a culture that embraces the reporting of potential problems, where it is okay to speak out."

At Northwestern, where they've been working on this issue for a while, Barnard says she shared the report with quality, risk management, and patient safety staff. "I asked them to hold this up as a mirror and see what we need to do better." Seven years ago, they started monthly conferences where some bad thing that happened, whether it caused harm or not, was talked through, ideas and possible solutions shared. These are open to everyone. Every month, more than 100 people from around the hospital participate. But that's not enough. "It is not everyone. So now we have to think about how to communicate the message more broadly."

She'd like to see organizations do something similar — to hold the recommendations up to their

own mirror and see how they stack up. And she'd like to see regulatory agencies emphasize reporting of events and possible events more. "You want a saturation of awareness on how important this all is."

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Sentinel event data show little change

Could tech lead to more surgical left-behinds?

Given the lack of reporting of errors and potential errors, it should be seen as good news that the number of sentinel events reported to The Joint Commission has gone up, right? The organization figures that voluntary reporting brings it maybe 1% of the total of what's out there, but the numbers are steadily rising.

There are more reports of unintentional foreign bodies left in patients — 69 in the second quarter of this year, compared with 188 in all of last year. That might be due to more and smaller items associated with technologically advanced surgeries, says **Gerard M. Castro**, MPH, project director of patient safety initiatives for The Joint Commission. They've dug a little deeper into the data and found that sponges are still the number-one thing left behind, but "other" is gaining ground. And that's where the new things associated with new surgery techniques might be having an impact.

Wrong site/wrong patient/wrong procedure is number two on the list of "what bad thing is reported most" — 60 incidents during the second quarter, compared with 152 last year. He says that it is hard to think that someone would wonder whether these kind of events need to be reported. They either happened or they did not, says Castro.

But not everything is that straightforward. **Paul Schyve**, MD, senior director for healthcare improvement at TJC, says that he thinks delay in treatment is very underreported, with 55 reports during this quarter, and probably outstrips the number of times someone operates on the wrong body part or person. "You might not realize there was a delay, or you can rationalize it away," he says. "There are many people involved in patient care, and you might not see the delay, or the impact of the delay, even if in retrospect you can find evidence of it on a chart."

There are three things that affect the reporting of events, whether they are relatively common (at least in terms of reporting) or as rare as infant abduction (one all of last year, two in the second quarter of 2012). One is if the definition of an incident is changing, says Schyve. The second is if it is easily identifiable, and third is what kind of attention is being paid to it. "Maybe there are four, because there is also the issue of the motivation for reporting it." There isn't a lot of motivation for reporting it to The Joint Commission, for instance. And there's a lot of attention put on things like infant abductions.

We may only see a small sliver of what's out there in this report, but Schyve says you can note whether the numbers go up or down. "Every year, we put out an alert on something and the number of reports goes up. And it isn't because people are doing it more, but because it is at the front of their minds. They recognize it more." Similarly, a change in definition can impact it the other way, as in 2010, when a change in the definition of wrong-site surgery led to a drop in the reported cases from 149 in 2009 to 93.

Castro notes that if you look at the number of suicides reported, that jumped from 67 to 131 between 2010 and 2011. "Is it an increase in incidence or just reporting?" It is hard to say, he says, and hard to do more than be happy, since everyone wants to see an increase in reporting of adverse events *(see story on NAHQ's Call to Action report page 138)*.

The sentinel event statistics show that about 60% of occurrences since 2004 result in death, and that a further 9% result in some loss of function.

What's more interesting than looking at the number of reports in a given year and how that changes over time is looking at the root cause data available when there are enough of a particular kind of event to draw conclusions, says Schyve. "We can look at something and maybe see something that people hadn't considered before or recognized earlier." Like recognizing that there are more small bits and pieces associated with new technology in surgeries that might be easier to lose track of than a rib spreader, for example. "The really helpful information is in the deeper analysis of what we know about the factors related to these

events," he says.

The root cause analysis report notes that the most common root causes of reported events are human factors, followed by issues related to leadership, communication, and assessment. After those top four, the root causes drop off precipitously in commonality. While there were between about 250 and 300 of the first four causes named in the analyses, medication use has just 42 mentions.

In events that led to death, anesthesia was the most common root cause, and communication problems were the most common root cause of delays in treatment. Falls are most often the result of assessment problems. The lessons are obvious from some of these: Do better assessments and you'll have fewer falls; improve communications and hand-offs and there might be fewer delays.

It is probable that the sentinel event report will never have everything bad in it that happens in the healthcare world. But it will have more than it does now because people are putting an emphasis on creating a just culture where reporting of events is applauded.

"It is clear that having a culture of safety, where there is trust enough that people are reporting, can be instrumental in making improvements to safety," Schyve says. "And there are two ways you can look at the major elements behind that culture of safety. First is what are the policies, procedures and expectations set by the leaders. By that, I mean the governing body, the C-suite executives, and the clinical staff leadership. They have to establish those expectations, policies and procedures that create a culture of safety."

The second piece is the personal behavior of everyone in the organization, he continues. Many organizations have leaders who develop the culture of safety but struggle with the personal behavior element. "How do you make sure that people do not act in an intimidating way or other ways that can undermine that?" Schyve asks. "How do you make sure that someone will not ignore a report, that someone will not get physically attacked or have someone throw stuff at them when they bring up a problem? Disruptive behavior may be the result of extreme pressure, but it interferes with even internal reporting of events. Forget about the external reporting — it impacts internal reporting."

Schyve says that TJC is taking "every opportunity" to talk about this particular problem and how it is disruptive and corrosive to a culture of safety, that it will lead to failure to report internally and a failure to learn. "People can feel it is too risky to speak up and raise a concern. They will watch the error occur rather than speak up if they think someone will throw something."

The four statistical reports related to sentinel events are available at http://www.jointcommission.org/sentinel_event.aspx.

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The grass isn't always greener

What brought some organizations back to TJC?

Editor's Note: Last month, Hospital Peer Review *looked at some of the differences between the two largest hospital accreditation organizations, The Joint Commission (TJC) and DNV, and asked several DNV clients to talk about what made them choose DNV. This month, we look at some organizations that thought about leaving TJC and either came back after trying out DNV, or changed their minds. What brought them back?*

It was the acquisition-fueled growth of the organization that brought ProMedica to the point of having to choose what company to use for accreditation. When the integrated delivery system reached 12 hospitals in Ohio and Michigan (as well as a multispecialty practice, a payer, and other ancillary services), it was using all three major accreditation organizations — The Joint Commission, DNV and HFAP, says **David James**, MD, JD, CPE, chief medical officer and senior vice president, medical operations for the Toledo-based organization.

"As we move towards the accountable care organization model, we felt we needed to have a systemwide standard in terms of accreditation," he says. One facility used DNV, and ProMedica executives were struck by the combination of ISO certification and Conditions of Participation-based evaluation.

They were open to dropping TJC in part because so many people felt that it was an adversarial accreditation process and lacked collaboration with the organizations being surveyed. But James says he wanted more information and so asked all three bodies to provide detailed answers to a series of questions. Nursing and physician leadership, quality directors from each facility, and systemwide staff including James, best practice, performance improvement, analytics, and nursing excellence representatives, all got together as an accreditation team.

They created a list of questions and asked each of the organizations to approach ProMedica as if they were approaching a completely new business that did not know what they had to offer *(for a sampling of the questions they developed, see page 143)*.

HFAP, which got its start with osteopathic hospitals, was considered too small, with a narrow focus that did not relate to an integrated system, James says. "They were heads down to the Conditions of Participation and nothing else. If I was a small hospital, they might be a great choice. They are cheap, effective, and offer nothing but accreditation. But they aren't made for us."

DNV and TJC seemed more appropriate. The former offered an entire quality management system through the ISO 9001 certification. "What was appealing about them is they have a broad cross-industry thinking. They work with so many industries, and they have within themselves, in 9001, a well-thought-out total quality management system. We at ProMedica were looking around at ways to achieve system standards. We have pieces and parts, but not a total systemwide package."

But pursuing certification in some systemwide standard isn't something that the team felt was necessary. "I do not think that certification and awards move markets," he says. "But internally, being ISO compliant, being certifiable, that has value. And DNV is an expert in that regard."

The Joint Commission had done some restructuring, though, and was showing itself to be nimble and interested in moving in a much more collaborative direction, James says. "They are retooling, reinvigorating their relationships with clients in a real customer service approach." It was apparent during the face-to-face interview that the talk about restructure was more than talk: They were serious about change. "They saw that they had to do something different. CMS had indicated that it wanted a movement toward organization-wide quality management strategies, so they were moving that way. They also have a huge capacity for benchmarking across the country, and the most integrated delivery system experience."

TJC also has accreditation capability for many kinds of entities, and a large compendium of resources it can make available to client organizations. "Combine that with a strong effort at customer service, and the only thing really missing was an integrated approach to accreditation with a total quality management system," he says.

But The Joint Commission had an answer for that: a pilot program for ISO certification. "It all just fell into place," James says.

"They offered the 'both/and' that we need. The depth, breadth, benchmarking, accreditation, collaborative approach, and integration with a total quality management system," he says, noting ProMedica is now one of the ISO 9001 pilot sites for TJC. "It is not a perfected integration with ISO, but they are putting resources behind it and have hired some great, nationally recognized people. We feel we have an opportunity to help TJC develop how they use ISO."

James says he thinks competition has been good for TJC. "We'll always look at what's out there, and I think that all three are here to stay. But I think each will have its niche, and it will depend on the scope and size of the organization which they use. DNV does great work. I like them. But they do not have the size and scope TJC does to work with entire systems."

The Wild West

Down in Arizona, Banner Health experimented with each of its hospitals choosing its own accreditor. "After the 2006 survey, we just questioned the value of The Joint Commission," says **Sandy Severson**, RN, MBA, CPHQ, senior director of quality management systems. "There was a lot of discontent with them, and we had CMS surveys coming in with lots of problems. They were dictatorial and we thought there was a subjectivity to the surveyors we did not like. They focused a lot on governance."

In 2007, the system let each facility do its own thing. Five decided to move away from The Joint Commission. They opted to use CMS and a state certification system, which worked with the theory that doing things with a local slant was a good thing.

Because every facility was choosing its own path, the system had to set some minimum stan-

dards that met the requirements of all the options, says Severson. After the 2009 survey, they did a gap analysis to determine how the hospitals were doing compared to that minimum standard that was set. "There were certain issues of noncompliance, and we found that those who were not Joint Commission-accredited had more opportunities for improvement," she says. "We found that the lack of a systematic approach created duplication of work, so in 2010, we decided to reduce some variation and our reliance on external agencies. We wanted an internal structure for oversight."

The health system has a standardized electronic medical record, standardized clinical practices, and standard service and operations models. "As we moved forward, it became very evident that we couldn't have that variation of each facility doing what it wanted for accreditation," Severson says.

But which company to choose? They looked at DNV, but Severson says that organization did not give any added benefit to them. "We have our own internal management system," she notes. "We did not need another one." Some wanted one thing, some another, but the majority felt that the increasing collaborative style and focus on patient safety made TJC a better pick. "There were some people who just wouldn't have budged from The Joint Commission anyway," she says. Aside from one small critical access hospital for which Banner doesn't have a mandated accreditation body, they are all with The Joint Commission.

For the five that opted out of TJC initially, the return came as a relief. The surveys are shorter, the surveyors are fewer and more knowledgeable, and there is a consistency about them that was lacking under the other regimes, says Severson. "They talk about the huge change in tone of the surveys with The Joint Commission. They are seen as educational opportunities. They aren't as punitive, and they seem very interested in adapting to the change in the healthcare environment, particularly as regards accountable care organizations."

Like ProMedica, Banner will always evaluate its relationship with TJC. But Severson thinks that TJC will also be evaluating itself and looking for ways to improve. "They are always asking us what's working and what's not," says Severson.

That there are people asking clients what's good and what's bad is part of The Joint Commission's master plan, says **Ann Scott Blouin**, PhD, RN, FACHE, executive vice president for customer relations at The Joint Commission. Her role was created specifically to figure out what customers wanted, and how to ensure that their needs were met by The Joint Commission.

If someone says they are going to change accreditors, Blouin or another senior commission executive will call the client and ask them to explain. "We want to know where their dissatisfaction lies," she says. Sometimes, the problem is a recoverable error that can keep the client with The Joint Commission. Regardless, the issues raised are addressed.

Interestingly, people are happy to talk about their concerns. "Sometimes people say they did not expect anyone to call," Blouin notes. "They are happy to be asked their opinions."

The account executive responsible for the departing client conducts an exit interview, and the data from that are collated and pored over. For Blouin, this is a mission that she takes seriously, and just as hospitals are encouraged to practice based on data and evidence, she mimics that. The Joint Commission team works together to adapt its practice to meet the expectations of its customers.

For more information on this topic, contact:

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Questions for potential accreditors

Source: ProMedica, Toledo, OH

• Aside from checking our compliance with the conditions of participation, what do you offer that gives us a strategic business advantage?

• Describe your key products and services.

• What are your learning and development systems?

• Tell us about your performance improvement systems.

• How do you sustain our continuing ongoing readiness?

• What accreditation services do you offer across the continuum of care?

• What business opportunities do you offer for integrated delivery networks?

• How are you moving toward an ACO environment?

• How might you partner in development of high-reliability organizations?

• Share your view of the future of healthcare.

• What's your ability to share best practices with us?

• What is your partnering approach to performance improvement — collaborative vs. consultative — and how do you walk the line between collaboration and evaluation?

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com/. *Hospital Peer Review's* executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute. ■

COMING IN FUTURE MONTHS

■ Improving transfusions to save lives

■ Accreditation field report

■ Pressure ulcer success stories

■ Imaging and patient safety

CNE QUESTIONS

1. How much time do nurses spend on direct patient care?
   a. 30%
   b. 70%
   c. 60%
   d. 33%

2. HFAP is a small accreditation organization that is often associated with what specialty?
   a. rheumatology
   b. chiropractics
   c. osteopathy
   d. oncology

3. National Patient Safety Goal number 7 relates to:
   a. hand hygiene
   b. healthcare-acquired infections
   c. education
   d. MRSA

4. NAHQ's "Call to Action" report has four actionable areas. Which one of these is NOT one of them?
   a. Report data accurately
   b. Protect reporters
   c. Establish honesty
   d. Respond to concerns

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.

• What's your relationship with the Baldrige criteria?

• Describe your alignment or movement toward aligning standards with CMS and the National Quality Forum.

• What are the competitive advantages you offer?

• What is your relationship with CMS and influence on healthcare policy?

Editor's Note

In response to last month's cover article, The Joint Commission issued the following statement:

"While The Joint Commission is very pleased to have a positive working relationship with the Centers for Medicare & Medicaid Services (CMS), we would not characterize our relationship as it is stated in this article (DNV Healthcare, Joint Commission emphasize differences, November 2012: Vol. 37, No. 11). CMS does not meet at The Joint Commission offices weekly, the vast majority of our meetings with CMS are by phone and our face-to-face meetings are at CMS' offices, not at The Joint Commission's Washington, D.C. office. In addition, The Joint Commission's Washington, D.C. office is not used as a base for CMS staff for any purposes." ■

CNE INSTRUCTIONS

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. ■

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