HOSPITAL PEER REVIEW®

YOUR BEST SOURCE FOR JCAHO, CREDENTIALING, AND QUALITY INFORMATION

CELEBRATING 28 YEARS OF SERVING THE HEALTH CARE QUALITY PROFESSIONAL

28

THOMSON AMERICAN HEALTH CONSULTANTS™

IN THIS ISSUE

JUNE 2003

VOL. 28, NO. 6 • (pages 73-88)

Unannounced JCAHO surveys mean more planning, not less

Change may lead some to abandon JCAHO, expert says

The upcoming switch to unannounced surveys by the Joint Commission on Accreditation of Healthcare Organizations will require a dramatic change in how you prepare for the visit, experts say, with even more attention to the tried-and-true methods that have worked for years, plus new strategies to ensure your organization truly is ready to be inspected at any moment. Brace yourself for more work and a good dose of frustration, they say.

Some hospitals may find the new system so onerous that they will abandon the Joint Commission altogether and rely on other types of accreditation, says **Susan Mellott,** PhD, RN, CPHQ, FNAHQ, a consultant in Houston.

"Hospitals are going to hate it, absolutely hate it, because they can't predict anything the way they can now," she says. "It's going to be a huge change. I think it could lead to a lot of hospitals leaving for other accreditation agencies or just going with the Centers for Medicare & Medicaid Services [CMS]."

Leaving the Joint Commission would be a major decision for any hospital, but Mellott says it might start to make sense as the new system puts more pressure on compliance efforts.

The new system will require quality improvement professionals to educate staff and monitor standards compliance to a much higher degree than you do now, Mellott says. That means more work, and you will have to develop a system that allows you to keep compliance high all the time rather than just every three years.

Unannounced surveys will be pilot tested in volunteer organizations during 2004 and 2005; then all surveys will be unannounced in 2006. The change is part of the Joint Commission's overall improvement of the accreditation process, known as Shared Visions — New Pathways.

Russell Massaro, MD, executive vice president for accreditation operations with the Joint Commission, tells *Hospital Peer Review* that, starting in 2006, organizations will be surveyed anywhere from two to four years after their last surveys, with surveyors showing up at their doors without warning. They will use "tracer methodology" to follow the experience of

actual patients, using those examples to investigate how the organization complied with appropriate standards. The Joint Commission will continue to conduct voluntary unannounced surveys on a limited basis in 2005 and then will transition to a completely unannounced survey program in 2006. An annual 5% sample of health care organizations still will undergo random, one-day unannounced surveys through the end of 2005. After that time, random unannounced surveys will be discontinued.

The new process will require hospitals and other providers to conduct their own self-assessments before surveyors show up. The first parts of the new plan will go into effect in January 2004 for all Joint Commission-accredited organizations. A new survey system with six basic components will replace the standard triennial survey format. Instead of surveyors coming to your facility once every three years to look you over closely, an accredited organization will complete the self-assessment at the 18-month point in its three-year accreditation cycle. Then you submit your own self-assessment ratings by a secure Internet site. For any areas in which your organization is not compliant, you must detail the corrective actions that you have taken or will take to comply. A Joint Commission representative then will review your report, approve it or make further recommendations, and possibly provide advice on how to correct the deficiencies you found. Until 2006 and the unannounced surveys, surveyors will visit the site at the 36-month point, the time for the triennial survey, to verify that the corrective actions have been taken.

Big window in which survey could happen

The two-to-four years after your last survey is a big window in which the unannounced survey could happen, Mellott says. In effect, you will have to be prepared at all times for surveyors to walk in and start assessing you, she says, which is the stated purpose of the switch to unannounced surveys.

Mellott says she supports the intent of the change and believes that it eventually will produce a truer picture of how hospitals comply with Joint Commission standards. She also expects it, along with the upcoming elimination of numerical scores, to eliminate much of the pointless competitiveness that she currently sees among hospitals.

"It's going to change these situations where you feel like you have to get a 96 because the hospital across town got a 95," she says. "It will cut out that type of competition, which, in my mind, is competition for the wrong reason. It will benefit the industry if we can lose some of the competitiveness and concentrate on what we really need to do to improve our organizations."

Even if everyone welcomes such improvements to the process, the day-to-day work of complying with Joint Commission standards will be tougher and your transition to the new process may be challenging, she says.

The same old ways of doing things won't be enough in the new process, she says. You'll need to step up how often you do some things that have worked well before, and you'll need to develop some completely new systems. **(For advice on**

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Peer Review**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $429. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $343 per year; 10 to 20 additional copies, $257 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $72 each. (GST registration number R128870672.)

Thomson American Health Consultants is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Greg Freeman**, (770) 645-0702.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcpub.com).
Senior Production Editor: **Ann Duncan**.

THOMSON™
AMERICAN HEALTH CONSULTANTS

Editorial Questions

For questions or comments, call **Greg Freeman** at (770) 645-0702.

how to prepare for unannounced surveys, see article, p. 76.)

Children's Memorial Hospital in Chicago will be one of the first to undergo an unannounced full survey in 2004, and so it is among the first to change its compliance process. The hospital requested the unannounced full survey, which will take place sometime in 2004, to demonstrate its continuous compliance and show support for the Joint Commission's new way of thinking, says **Susan Cunningham**, MSed, administrator for quality at the hospital. During 2004, the Joint Commission expects to initiate pilot testing of the unannounced triennial survey process in up to 100 hospitals that have volunteered to be among the first participants.

"I think a lot of us have become very proficient at revving up for the big survey every three years," Cunningham says. "Rather than putting our focus and energy on that, we thought it would be better to consistently be vigilant and ensure that we have systems and processes in place to comply. It's going to be a major philosophical shift for everybody and will drive the whole concept of continuous standards compliance into the daily work of what we do."

Leaders at Children's Memorial are focusing more on "constant vigilance" instead of survey preparation, she says.

Instead of working backwards from a triennial survey date to determine when work should begin, hospital administrators are implementing systems that will ensure faster implementation of improvements, says Cunningham, who previously worked at the Joint Commission for four years educating surveyors. "We're going to have to act on things more urgently, rather than just saying we need to get it done before the survey. This changes the time table, the urgency by which things get accomplished and put in place, whether it's a new policy or procedure."

One of the first efforts to change the hospital's compliance strategy was the formation of a guidance team. Made up of key administrators and other leaders in the organization, the members each are responsible for chapters and standards in the Joint Commission manual. The guidance team ensures that self-assessments are performed throughout the hospital and then assesses the results for weak points.

"We were doing some of that already under the old process, but we are stepping up those efforts," Cunningham says. "We're optimistic about how we would fare under an unannounced survey, but I have to admit it's a little stressful to think that they will just show up one day without warning."

Could be last straw for some customers

With many hospitals already considering leaving the Joint Commission for other accreditation options, Mellott says unannounced surveys could be the last straw for some. They may opt to rely only on CMS certification, since they have to undergo that process yearly no matter what they do with the Joint Commission.

"There is so much dissatisfaction with the Joint Commission anyway, so I think this might lead to a lot of people just dumping the Joint Commission altogether," she says. "A lot of people are looking at moving on to something else because a lot of them feel like the Joint Commission is getting their hands in a lot of pies and maybe not being able to manage the contents of those pies well."

Leaving the Joint Commission can be a reasonable option for some organizations, Mellott says. But she cautions that you should research the options very carefully before making any decision. Don't assume that the grass is greener on the other side of the fence.

Relying only on CMS certification, for instance, may sound appealing because there is less paperwork, but Mellott says the CMS process tends to be stricter and oriented to finding problems, not educating organizations about quality improvement.

"I don't think unannounced surveys alone will make hospitals run away from the Joint Commission, but it could be the last thing that pushes them over the edge," she says.

"A group of factors can lead organizations to become dissatisfied and look for other options, but the switch to unannounced surveys could be the thing that convinces them it's really time to change. It's one more thing to make you say, 'I don't want to play this game anymore,'" Mellott adds.

[For more information, contact:

- ***Susan Mellott**, 5322 W. Bellfort, Suite 208, Houston, TX 77035. Telephone: (713) 726-9919.*
- ***Russell Massaro**, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000.*
- ***Susan Cunningham**, Quality Administrator, Children's Memorial Hospital, 2300 Children's Plaza, Chicago, IL 60614-3394. Telephone: (773) 880-4000.]* ■

Planning more important for unannounced surveys

Plan activities throughout calendar year

Careful yearly planning always has been the key to effective survey preparation, and much of what you should do is independent of how soon you will be surveyed. The move to unannounced surveys will make it even more important to plan compliance activities throughout the calendar year, says one consultant who helps hospitals prepare for surveys by the Joint Commission on Accreditation of Healthcare Organizations.

You should create a yearly calendar that shows when certain tasks should be started and completed and that prompts you to review specific goals throughout the year, says **Susan Mellott,** PhD, RN, CPHQ, FNAHQ, in Houston.

"That kind of system will still work, and it becomes even more important in 2006," she says. "Scheduling things and making sure you have an ongoing effort throughout the year will become more important now than ever before."

In the first quarter, for instance, your calendar should remind you to have all your improvement plans evaluated and any new plans started in the committee process. Ensure that in the first quarter the human resources report is delivered to the board of directors and that the board has done its self-evaluation.

In July, the Joint Commission's patient safety goals will be released. Mark your calendar to check on the release of the new goals and then establish a plan for selecting the goals you will address by the January deadline. Make a schedule to achieve those goals.

"All those are annual things that should be on your calendar every year," Mellott says. "It's not dependent on when your survey is scheduled. That's a very big portion of what you need to do to get ready every year."

All of this planning can be put on a calendar-year or fiscal-year schedule, though Mellott prefers the calendar year just because people tend to think in those terms. She suggests that halfway through the year you look at your program goals and assess how you are doing so far.

"You can say 'we slacked off on this one in the first half of the year, so we need to work harder on it now,'" she says. "Your evaluations need to be ongoing. That can take care of a big part of your survey preparation because when the survey time nears, you don't have to ask whether you've taken care of this or that. You know because you've been checking on it regularly."

Your systems should encourage documentation and force you throughout the year to accomplish the many tasks necessary for Joint Commission compliance. One example is a matrix that ensures you have completed all the necessary fire drills throughout the year, Mellott says. The same type of matrix can be used to accomplish many tasks, and it serves as a way to document that they were done.

"You have to do one fire drill per shift per quarter, so you would make a matrix that has four quarters and three blocks in each quarter. When you do the fire drill, you write in the date, hour, where it was, all the other data you need to document it as you do it," she says. "The same thing can be used for disaster drills, baby abduction drills, anything else you have to get done through the year. We're going to have to use more systems like that."

A matrix of similar tools will be valuable when surveyors drop by and you need to show them where you stand in terms of complying with certain requirements. When you had time to prepare for the surveyors on a specific date, you could prepare reports and presentations to show your compliance. With unannounced surveys, you will need working documents such as the fire drill matrix to show what you have done and what you have planned for the rest of the year, Mellott says.

Process will need to evolve over the years

Switching to such systems will take time, so Mellott advises starting soon. But there is no need to abandon your current triennial survey-based approach if you have one coming up soon. If you know when your next survey is coming, you still can use your upcoming survey date as a target, and as the survey date approaches, you can step up your planning with survey-specific preparations. Months before the scheduled survey — or as part of your readiness planning for unannounced surveys — you should consider having an internal or external mock survey. If you decide to do it internally, don't have managers survey their own departments. Instead, have them trade off and survey each other's areas.

"They know what's supposed to be in their

area, so they're going to see it whether it's really there or not," she says.

Better yet, if your facility has affiliated health care facilities in the area, have the staff trade mock surveys. Your staff will survey their facility and their staff will survey yours, to add more realism with strangers walking around and asking questions. Some providers opt to use outside consultants for the mock survey for the same reason.

There still is some uncertainty about what form the self-assessments will take under the new process, so Mellott says health care providers will have to reassess their plans when that information is available. It is very likely that you will be able to use the mock survey as a means of conducting your self-assessment, she says. The timing is right, and the mock survey would be a good way to gather the right information while also preparing your staff for actually having Joint Commission surveyors on site.

Weak areas in employee education should be identified in the mock survey or self-assessment. At this time, you also can focus on the areas in which you know the Joint Commission will show particular interest.

"This year it's the patient safety goals," she says. "They want people at the staff level to know what those are and what that means for the care of patients at their level. For patient identification, for instance, they will ask the staff how you properly identify the patient, exactly what steps do you take."

Many standard techniques still will work

As the survey window approaches, you can step up activities that keep your staff focused on important accreditation issues and help them become comfortable with discussing them. For instance, Mellott says there still will be a need for employee education activities such as a "JCAHO Fair" that provides a fun event in which participants are rewarded with small prizes for going from booth to booth and answering questions about issues important to the survey.

Those techniques have been used in the past when you could target a specific survey date, and Mellott says they will remain useful even though you can't plan them around a known survey schedule. Instead, she says, you may want to make them an annual or semiannual event. That advice will apply to many techniques that have worked in the past, she says. They'll still work, but you'll have to use them more regularly instead of only in the ramp up to the triennial survey.

To change the way you think about survey preparation, you may have to look for educational opportunities that are calendar-based rather than oriented to a survey date. One technique Mellott suggests is using holidays throughout the year to promote survey preparation.

"Lots of providers seize on themes like July 4th or Valentine's Day to educate staff with newsletters or inserts in paychecks, or posters in the facility," she says. "It just gives you an opportunity to get a message out in a creative way, and creativity never hurts when you're trying to get someone's attention." ■

NC hospital issues quality report cards

Quality reports cover variety of conditions

In a move that may become more common in the near future, a hospital in Salisbury, NC, is issuing its own quality report cards to show its community how well it fares in meeting national standards for patient care. The quality improvement leaders at the hospital say they chose to release the information now partly because they expect quality data to be released by third parties before long.

Rowan Regional Medical Center recently began issuing quality reports for a variety of health conditions, based on national standards for patient care. With future quality reports, the data show how Rowan Regional compares with other hospitals in the state and nation for treatment of more than a dozen patient conditions.

The first report, from data collected since last summer, provides a comparison of Rowan Regional's treatment of patients with congestive heart failure, says **LaVaughn Beaver**, RN, CPHQ, manager of case management at the hospital and the administrator responsible for data collection.

"When the core measures came about, we began to look at how we could proactively affect our patient outcomes using these measures," she says. "We began to incorporate them into our current pathways and current trends for taking care of patients. Our administration decided to make them public, knowing that they would be made public anyway because the Joint Commission and

others would be publishing that data eventually."

Charles W. Elliott Jr., chief executive officer at the hospital, says the time was right to release the data, and not just because Rowan Regional fared well in comparison to the national standards.

"For several years, hospitals, physicians, health care professional associations, and government agencies have been discussing how to select criteria that would provide an accurate comparison of quality measures for patient care," he says. "Our physicians and staff have always made quality patient care our No. 1 priority, and this first comparison shows the results of those efforts."

Much of Rowan Regional's performance will be compared to national data on specific conditions. The national collection of data covers 10 measures of medical treatment for four serious conditions — congestive heart failure, acute heart attack, pregnancy and related conditions, and pneumonia. Each quarter, as additional data are collected, Rowan Regional will issue a quality report about a specific patient condition.

Quality improvement experts say the treatment guidelines are factors that can be monitored to evaluate the quality of health care delivery. For congestive heart failure patients, medical records are monitored to make sure patients receive these:

- discharge instructions, which must include activity level, diet, follow-up appointment, medications, worsening symptoms, and weight monitoring;
- a left ventricular function (LVF) assessment — done by an echocardiogram or other tests;
- ACE inhibitors for left ventricular systolic dysfunction;
- adult smoking cessation advice.

Comparisons between hospitals are made on a percentage basis, showing how much the hospitals comply with the guidelines. Rowan Regional fared well on three of the four measures for congestive heart failure, coming up short on the ACE inhibitor measure. **(For the outcomes that Rowan Regional reported recently, see box, above right.)**

Each day, Rowan Regional's case management department reviews patient records to see if the selected criteria are followed by physicians, nurses, and other health care professionals. Action is taken immediately for cases that need attention, such as a patient who didn't get proper instructions about his or her activity level and diet. The goal is to address all appropriate issues during the patient's stay in the hospital.

Rowan Regional releases data about congestive heart failure now because comparative data are available from other institutions, Elliot says. Results of future quality reports will be made public and posted on the hospital's web site.

"Our case management process has been in place for nearly 10 years," Elliott says. "As a result, we were already collecting much of the data required for these reports and already had a comprehensive review mechanism for addressing issues of quality care. We expected to do very well in comparison with other hospitals. Overall, we are extremely pleased, and we recognize there are opportunities to improve all processes for patient care."

Beaver says the reaction from the community has been good so far, with many business leaders and others pleased that the hospital is reporting good patient outcomes.

"We felt that the core measures would be best to use because we have benchmarking data that are pretty substantial," she says. "It wasn't just a matter of wanting to report our good results. We knew that we would report it at some point, so when we did comparisons and saw how we looked, that was even more encouraging."

Beaver says the hospital's data collection process, in place for years, was instrumental in making the report card feasible. Without substantial,

(Continued on page 83)

Rowan Regional Medical Center Outcomes

CHF-1 (discharge instructions)	
Rowan Regional	76%
Hospitals in North Carolina	40%
National data	26%
CHF-2 (LVF assessment)	
Rowan Regional	85%
Hospitals in North Carolina	69%
National data	79%
CHF-3 (ACE inhibitors)	
Rowan Regional	64%
Hospitals in North Carolina	66%
National data	86%
CHF-4 (smoking cessation advice)	
Rowan Regional	80%
Hospitals in North Carolina	47%
National data	38%

PATIENT SATISFACTION PLANNER™

'Making it personal' improves patient care

Personal histories increase patient satisfaction

Sheila Brune, RN, BS, CPHQ, CPUR, says the quality of direct patient care is the most important predictor of patient satisfaction. In the past few years, Brune, CMC director of Utilization Management/Living History Program at Great River Medical Center in West Burlington, IA, has proved her point emphatically with an innovative program inspired by her desire to create closer connections with patients.

The Living History program involves the creation of "a living, breathing chronicle of the patient's nonmedical history." The intent of the history is to empower caregivers to deliver care to the heart and soul of the patient, Brune says.

Brune first began thinking about the program about two years ago, when her CEO returned from a training session led by Quint Studer of The Studer Group. "What impacted me were two issues," she recalls. "The first was a question: Are you part of the problem or part of the solution? The second was the assertion that you'll be judged by the people you touch."

The task she decided to undertake didn't even fit her job description. "I was director of utilization management; people always said I was the 'dollars-and-days dame,'" she notes. "But at my heart, I am a nurse."

Brune was aware that often patients would be with the hospital for a long time, and then one day she would by chance read their obituaries.

"I realized that there was a lot more to those people than we had thought," she explains. "I wanted to explore how we could get that information *before* they died. I like telling patients that I want to know what they do when they're *not* here."

It's all well and good to be curious about a patient's personal history, by why is it important from a quality standpoint? Why is it important to "deliver care to the heart and soul of the patient?"

"There are lots of reasons," Brune says. "It makes the patient feel more valued — that you are thinking about them not as a number, but as a person. What people want most is to feel valued and to be listened to. Also, I believe if you improve the patient/caregiver relationship, not only does the patient feel better, but the caregiver does, too. It increases their satisfaction with their job."

She recalls comments from nurses like: "I can't believe what you did for me with this story. We found connections that went way back."

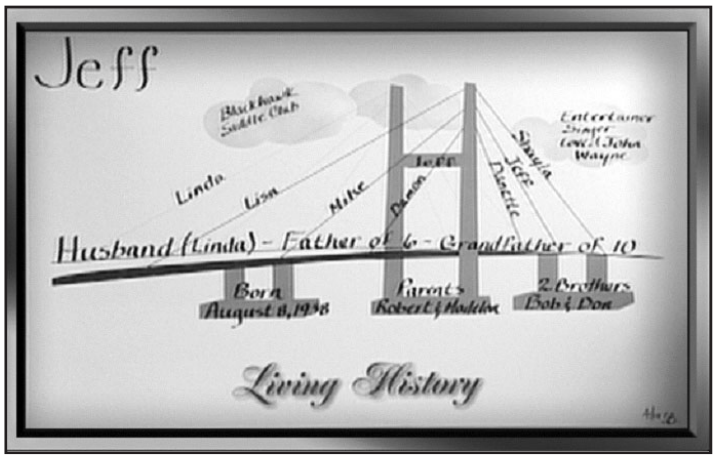
Brune cites a number of occasions where patients had actually worked with relatives of caregivers, and, in at least one case, a nurse found out much more about a relative who had passed away than she ever would have known had she not connected with the patient.

This is one of the three different ways in which caregivers are encouraged to build bridges with patients. They are:

- **Real Connections:** "I know your daughter."
- **Compassionate Connections:** "You have been through a lot in your life."
- **Scripted Connections:** "I see you like to do woodworking. What do you like to make?"

Brune decided to build the program through story writers — special employees selected to get the patients' stories.

She also determined that, initially, stories would focus on chronically ill patients with diagnoses that caused multiple admissions — i.e., seriously ill, terminally ill, or very elderly patients, and/or patients on dialysis or in hospice care. "We went through the DRGs and picked longer-stay, high-volume, high-risk patients, but now we go more



on our gut," Brune says. "Age is first, because the extreme elderly have fascinating stories. We also look at diagnoses — cancer, stroke/CVA, COPD, and CHF, as well as surgicals who will be here longer, like hips, knees, and colonoscopies. Now, we will also take referrals," she adds.

In the beginning, however, she had to spread the word. "I just went out and talked to everyone, in every department," she recalls.

She started with the CEO, who said yes; then, the senior management team, who said, 'Make it happen,' then to the middle managers, and then to staff meetings. "We also went out into the community, through TV and radio," Brune says.

"And we elicited people from each department to be story writers; almost every department was represented." This also helped involve employees who would not normally come in contact with patients. "Clinical information is not often shared with librarians," Brune notes.

In the beginning, Brune picked the story writers. "Now, I let them pick me," she says. If they show interest, their managers must sign off, because they spend an average of two hours on each assignment. (The story writer's commitment is for one story a week.)

Once the selection has been approved, there is a one-day training session, facilitated by an educator, a social worker, a recreation therapist, a journalist/editorial review writer, and Brune. Following that, the assignments are made, and the story writers visit the patients, who tell their personal stories.

Interestingly, the profile of story writers has changed over the years. "We only have two of the original story writers left," Brune says.

"The people I first picked were outwardly, openly enthusiastic, and those criteria may not have worked; maybe they were just big talkers, but short on action. My best story writers have been the 'sleepers' — those people who quietly work every day," she explains.

The Living Histories are used and shared in a number of ways. They are presented as a visual depiction, known as a bridge poster (milestone events and family facts are depicted, centered around a logo of a bridge), for the patient's room; the Living History itself is placed as the first item on the patient's chart. **(See example of a Living History, at right, and a bridge poster, p. 79.)**

There is an absolute expectation that all of the patient's caregivers will read the history. "One of our deals with our CEO is 'non-negotiables,'" Brune explains. "We say things like, always wear your name tag, always lead people who are lost to the department they need, and *always* read the Living History."

The copy that is placed in the chart is put in a plastic sleeve protector. One copy is given to the patient — laminated if they request it. They then receive as many additional copies as they want. They also receive one bridge poster — laminated, again, upon request.

The stories also live on through Meditech, the facility's computerized record medical system. "I save the stories to a Word file and then enter them into the Meditech screen, so you have a record of the patient's story and who wrote it," Brune says.

To date, 1,700 stories have been written. "We need more story writers," she says, noting that care is changing and patient satisfaction is growing. The current Press, Ganey Associates satisfaction rate is more than 90%, up considerably from two years ago. "We have no reason to believe it will not continue to climb," she says.

Brune is eager to share her success story with other institutions. "We have two hospitals starting their own programs [soon], and we probably

A Living History

Edward Luverne Hatcher

Edward Luverne Hatcher wants to be called Luverne. He was born September 26, 1925, 76 years ago, at home near Delta. Luverne's parents were Floyd and Blanche Wadsworth Hatcher. Luverne is the only child of Floyd and Blanche and he was the delight of his mother's life.

Luverne attended Indianapolis Country School and What Cheer High School, graduating in 1943.

On April 12, 1945, Luverne married Loretta Agnes Armstrong at St. Joseph's Catholic Church in What Cheer, Iowa.

Luverne and Loretta had two children. Ed was born September 10, 1946. He married Bev Arnaman. Ed and Bev live near Montezuma, Iowa. Sheila was born November 7, 1950. She married Sam Brune. Sheila and Sam live in West Point, Iowa. Luverne and Loretta have four grandchildren, Michael, Jason, Josh and Lorelle and one great-grandson, Kade.

Luverne farmed all his life. He retired at the age of 59 and rented his farm out to "the boys" - two young men who are the sons of his best friend. He then went to work for them doing farm work and driving the tractor. In 2000, he plowed 1200 acres for "the boys".

Luverne enjoyed collecting! Toys and tractors—he loves his vehicles and loves taking care of them. He rode a Honda Goldwing for years. He and Loretta traveled all over the country on it. Luverne has a toy model train set with three trains on different levels. He is an avid fan of NASCAR racing.

10/18/01

Luverne belongs to the Goldwing Riders Association. He is a member of St. Mary's Catholic Church in Oskaloosa, Iowa, and is a board member of the Indianapolis Cemetery and St. Joseph Cemetery and belongs to the Wa-Ke-Ma Motorcycle Club. He is a former member of the Lion's Club.

Farming, children, grandkids, his great-grandson, wife, friends and Cobie, his dog are the things he loves most in his life.

Luverne says he loves to eat out, be with friends, watch NASCAR races and ride his cycle. He enjoys yard work, his garden and the farm. His favorite pet is Cobie, a miniature Dachshund.

Luverne has an ornery streak. He used to love to play practical jokes and pranks on his friends, especially the two Kenny's - Gatton and Molyneux. Once the Kenny Molyneux family was the recipient of 12 farm cats courtesy of "Hatch". The story of their arrival at the Molyneux house was retold many times.

Luverne says he picked Loretta out the first day he saw her and said "That's the girl I want to marry".

Source: Great River Medical Center, West Burlington, IA.

have 20 out there who have placed phone calls, have come here or are planning to come to visit," she says, noting that the best way to contact her is via e-mail (sbrune@grhs.net).

[For more information, contact:

- ***Sheila Brune**, RN, BS, CPHQ, CPUR, CMC, Director, Utilization Management/Living History Program, Great River Medical Center, 1121 S. Gear Ave., West Burlington, IA 52655. Telephone: (319) 768-4951.]* ■

Closed-circuit TV wins fans in children's hospital

All can participate via interactive programming

An innovative closed-circuit TV (CCTV) network at a children's hospital in Atlanta has made a significant contribution to patient and family satisfaction while boosting the morale and self-esteem of bedridden children.

"Children's TV" is provided to patients at the Scottish Rite and Egleston campuses of Children's Healthcare of Atlanta. (Each campus offers its own separate programming.) The programs are attended in person by ambulatory patients, but also can be seen in patients' rooms.

Children's TV is part of a broader initiative called Child Life programming, but, "This is the only Child Life programming in the hospital that can be seen in a child's room," notes **Paula R. Fine**, MS, who joined the staff in 1993 as a Child Life specialist and host/producer of Children's TV at the Scottish Rite campus.

"This can reach everybody; it reaches the emergency department, the intensive care unit — even our clinics across the street," she points out.

Children's TV, which is aired once a week, provides a wide variety of programming, from interviews with local celebrities (such as former Atlanta Braves pitcher Dale Murphy, heavyweight boxer Evander Holyfield, CNN anchors, and local DJs) and national celebrities such as astronauts, to educational shows on the health risks of tobacco or the role of therapy pets, to fun events such as bingo. Other programs are dedicated to national holidays, such as Martin Luther King Jr. Day.

"The variety and diverse programming that I offer, most children would not otherwise have an opportunity to see," says Fine. "We also try to offer multicultural programming."

"The CCTV initiative started because, while we have play rooms on each of the floors, they only service the kids who can get out of bed," explains **Roni Mintz**, CCLF, coordinator of the Child Life department, on the Scottish Rite campus. "CCTV reaches [children] who cannot get out of bed, so they can participate and have the feeling of socializing with their peers," she points out.

Interactivity a key factor

It is the interactive capacity of the program that enables this socialization. Patients and their families are notified about upcoming programs through fliers, and through *Hospital Happenings,* a weekly schedule of all the fun programming in the hospital. **(See examples of program fliers, p. 82.)** Then, the programs are announced on the PA system 30 minutes and 15 minutes before airing. Sometimes, Fine will deliver a personal flier to the room.

Children in their rooms are instructed to tune to Channel 4 and given a telephone extension that links them to the show, enabling them to ask celebrities questions, to participate in the wide range of contest shows that are offered, and to have the same chance to win prizes as those in the audience. They can even play bingo from their beds or create art projects that are shown on TV.

Decreasing isolation

"This decreases their sense of isolation, which in turn, helps children feel positive and builds their self-esteem," says Fine. "When they call up or get their art project shown on the air, they feel part of a group, which benefits their health."

Goals for the program include:

- provide alternatives to commercial television;
- provide entertaining and educational programming;
- inform patients and their families about safety and health care issues;
- provide information to decrease anxiety about hospitalization;
- decrease feelings of isolation;
- provide opportunities for self-expression and peer support.

Children's TV, she adds, actually is a product that encompasses two separate education channels. One is for families and children, and the other is for adult education. A variety of videos

are shown with safety, health care, parenting, and nutrition information.

Children's TV fits neatly into the Child Life concept, says Mintz, who oversees 15 Child Life specialists. "Child Life includes various services to the child and family," she notes. These include activities such as pet therapy or family nights, which are not part of Children's TV.

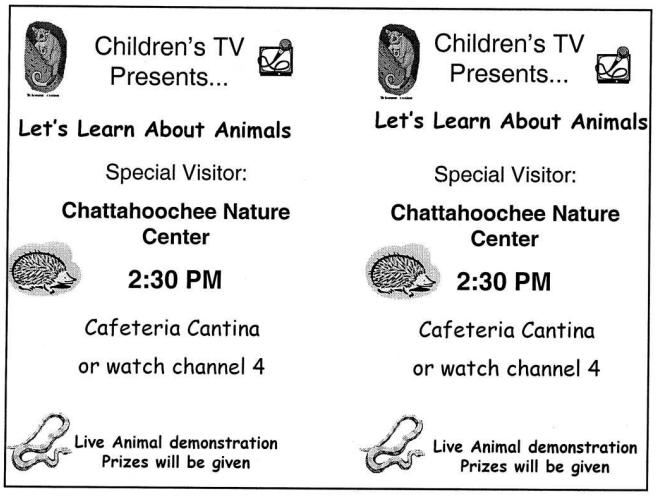
All Child Life components have three main objectives:

- preparation and teaching — explaining the procedures that will happen;
- teaching children various coping techniques to use during painful procedures and other uncomfortable situations;
- children's play aspect (Children's TV).

The sense of normalization created by Children's TV is critical, says Mintz. "Just like an adult's workday gives him self-esteem and a sense of purpose, Children's TV gives the children something to do, and an opportunity to act out whatever is going on. "Its message is, 'I may be sick, but I can certainly keep up with other things in my life.'"

Typically, what happens is there is a much stronger sense of compliance with regard to procedures, such as IV starts, because of the Child Life program.

"There is an understanding of what is going to happen," Mintz explains. "We generally rehearse the procedure with the child [with puppets and other amusing devices]. Research has proven that lengths of stay are probably shorter when there is increased compliance."



Source: Children's Healthcare of Atlanta.

Benefits are many

Mintz says that Children's TV has proved to be a valuable tool in both boosting satisfaction and improving quality of care. "The anxiety level is very high when children are first admitted," she notes. "TV helps reduce that anxiety, and when anxiety is reduced, you typically get better compliance." In addition, Mintz considers the program an effective self-esteem booster. "The child gains some sense of control back," she notes. "If Paula's playing bingo, and the child can call up and say 'I won!' over the air, they feel in control. This absolutely lowers stress levels."

It also is a family bonding tool. "Typically, the family will do something together, like the art project or bingo," notes Mintz. "It might have been a stressful day medically, but families can do this together and have fun."

"It definitely builds parent loyalty," Fine adds. "They'll come up to me and say things like, 'My child was so blue all day until you delivered that prize to her.' Another parent of a kid with leukemia told me how having his artwork shown on TV made him feel so happy."

[For more information, contact:

- ***Roni Mintz**, CCLF, Coordinator, Child Life Department, Children's Healthcare of Atlanta, Scottish Rite Campus, 1001 Johnson Ferry Road N.E., Atlanta, GA 30342. Telephone: (404) 250-2314. E-mail: roni.mintz@choa.org.*
- ***Paula R. Fine**, MS, Child Life Specialist, Host/Producer of Children's TV, Children's Healthcare of Atlanta, Scottish Rite Campus, 1001 Johnson Ferry Road N.E., Atlanta, GA 30342. Telephone: (404) 256-5252, ext. 5412. E-mail: paula.fine@choa.org.]* ■

(Continued from page 78)

reliable data to compare to the national standards, an organization will find it impossible to release a quality report that is meaningful, she says. Rowan Regional's good report can be traced to good data collection and using the national data to improve care on a local level, she says.

"Using the core measures data to put processes in place to make improvement is the big thing," she says. "You have to use the data and let the data help you make changes that improve patient care. When it's used in that manner, you're going to constantly get better."

When the first complement of national indicators came out, Rowan Regional used them to be proactive with improving patient care. Beaver recommends taking some time to improve your processes, based on the national data, before deciding to release your own report card.

"Be proactive. Have your processes in place before you go on to the reporting system. We're always comparing ourselves to nationally known data to see how we can improve, and then implementing the processes that will improve patient care," she adds. "So releasing the data on how well that works was just a natural extension of what we were doing all along."

[For more information, contact:

- ***Rowan Regional Medical Center**, 612 Macksville Ave., Salisbury, NC 28144. Telephone: (704) 210-5000.]* ■

Study shows QI helps heart attack patients

Reminders, checklists helped improve care

Combined results from three studies conducted in 33 Michigan hospitals show it's possible to improve the care provided to heart attack patients after admission by reminding physicians, nurses, and patients about proven therapies.

By incorporating a system of reminders, standing orders, and checklists into routine care, the study shows, hospitals significantly improved the percentage of patients receiving certain proven treatments and lifestyle counseling.

After the system was put in place, there were jumps in the use of individual treatments that ranged in size from 5.6 percentage points to 34.8 percentage points.

The new results come from the latest phase of a study sponsored by the American College of Cardiology (ACC) and led by members of the Michigan ACC chapter under the direction of researchers at the University of Michigan Cardiovascular Center.

They were presented recently at the ACC's 52nd annual meeting in Chicago. The study was led by **Kim A. Eagle**, MD, the Albion Walter Hewlett professor of internal medicine and chief of clinical cardiology at the University of Michigan Health System (UMHS) in Ann Arbor.

"These results leave no doubt that if hospitals and caregivers adopt tools that can help them improve care, and create systems to make sure those tools are used, they can improve their performance on quality indicators, which means better care for patients," Eagle says.

The study, called ACC AMI GAP for the ACC's Acute Myocardial Infarction Guidelines Applied in Practice, seeks to find ways to help physicians and hospitals deliver the care outlined in heart attack care guidelines developed by the ACC and the American Heart Association. The guidelines are based on the best available evidence of what drugs, tests, and lifestyle changes (such as smoking cessation and diet modification) work best for patients, preventing complications and recurrences.

The new results of the three projects conducted between the years 2000 and 2003 compare the care given to 1,892 heart attack patients treated at the 33 hospitals before the studies began, and 2,065 heart attack patients treated while the system was in place. The study measured use of aspirin, beta-blockers, and ACE inhibitors early and late in a patient's care; cholesterol tests and cholesterol-lowering drugs; and counseling on diet and smoking cessation.

"These are all proven therapies that — while not indicated for every single patient — have been shown to reduce the risk of death, additional heart attacks, and other complications in the vast majority of patients who receive them. Even though we know what works, it hasn't been easy to make sure that knowledge benefits every patient," Eagle says. "This study aimed to close the gap between what experts recommend and what patients receive."

The new results combine the data collected in three stages of the GAP project: a pilot study in 10 hospitals in southeast Michigan, a phase II study in five hospitals in the Flint/Saginaw

region of Michigan, and a phase 3 study in 19 more southeast Michigan hospitals, including UMHS.

The study hospitals were of all different sizes and types, from small community facilities to major urban and tertiary care medical centers. Both teaching and nonteaching hospitals were included, and patients had various forms of insurance — about 70% were on Medicare.

All hospitals were offered a tool kit of reminders, checklists, stickers, standard orders, reference cards, and educational materials that made it easier for physicians, nurses, and patients to follow the ACC's guidelines. The degree to which the care system was incorporated into each hospital varied. Some improvement was seen even in the hospitals that didn't use the tool kit very often — for instance, an increase of about 7 percentage points was seen in prescriptions for aspirin and beta-blockers that were written before patients left the hospital.

But in hospitals that consistently used the tools, the gains were much greater. Use of aspirin and beta-blockers early in a patient's hospital stay increased 6.6 points and 5.6 points, respectively. Pre-discharge prescriptions for the same drugs rose 12.4 points and 6.3 points, respectively. There also was a 7.7 percentage point increase in prescriptions for ACE inhibitor drugs given before patients went home. A 9.6 percentage point jump in cholesterol tests also was seen.

Diet, smoking cessation led to big gains

The biggest gains were in the area of diet and smoking-cessation counseling, and in prescriptions for cholesterol-lowering drugs, which rose by 14.3 points. A 34.8 point jump in the proportion of patients who got advice about stopping smoking and a 21.6 point rise in the percentage who saw a dietitian or nutritionist before they went home show how far hospitals have to go in helping patients understand the lifestyle changes that can help their health.

Eagle notes that none of the therapies was used in 100% of patients — the highest percentage achieved was 94%, for pre-discharge aspirin. But not every patient needs every therapy — for instance, nonsmokers don't need advice on stopping smoking, and patients who already are taking blood-thinning drugs generally should not take aspirin, too.

Eagle emphasizes that the ACC guidelines, and the GAP tool kit that incorporates them, aren't a cookbook for cookie-cutter medicine.

"These tools, and the processes that lead to their consistent use, simply function as a reminder system," he says. "These are key things that need to be thought about and either ordered or ruled out because of a contraindication. We want to help doctors, nurses, and patients consider the priorities and follow them if indicated."

The ACC developed its heart attack guidelines in collaboration with the American Heart Association to address such disparities. Based on solid medical evidence about the effectiveness of drugs, tests, interventions, and other techniques, and updated regularly, the guidelines serve as a gold standard for emergency, hospital, and follow-up care.

Available on the Internet, the guidelines give recommendations for the treatments, tests, and advice that patients should get based on their age, sex, medical history, and the severity of their condition.

These are the tools in the GAP initiative tool kit (available on-line at www.acc.org):

- standing orders for medication and tests;
- pocket cards of medications and guidelines for medical staff;
- a clinical pathway that guides nurses through their daily activity;
- a special patient information form;
- stickers for the patient's chart;
- chart that shows hospital's overall performance;
- a discharge checklist for doctors or selected nurses to review with patients;
- patient education materials — written and verbal instruction on therapy and lifestyle.

These were the guideline-recommended therapies, tests and counseling measured in the study:

- aspirin in the emergency department and before discharge to prevent clotting;
- beta-blockers to reduce heart rhythm problems;
- angiotensin-converting enzyme inhibitors, to aid the heart's recovery;
- blood cholesterol tests and, in appropriate patients, drugs to lower cholesterol;
- smoking cessation counseling (smoking doubles the long-term risk of heart attack);
- diet counseling, with emphasis on low-fat diets.

[For more information, contact:

- ***Kim A. Eagle**, Chief of Clinical Cardiology, University of Michigan Health System, 1500 E. Medical Center Drive, Ann Arbor, MI 48109. Telephone: (734) 936-4000.]* ■

'Brewing cataclysm' in emergency response?

JCAHO warns of underfunding, unpreparedness

Responding to the potential for new terrorist attacks in the United States, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has issued a report warning of a "brewing cataclysm" of underfunding, inexperience, and unpreparedness of emergency response capabilities across America.

The report was prepared in consultation with a broad-based expert roundtable which convened on two occasions in 2001 and 2002, and then participated in a national summit on Emergency Preparedness hosted by Joint Commission Resources in Washington, DC, in October 2002.

The 28-member panel included representatives of various federal and state agencies, frontline emergency care providers, emergency preparedness planners, and public health and hospital community leaders, among others.

Noting that virtually all disasters, including intentional terrorist events, will be experienced at the local level, the report emphasizes that many communities will be on their own for the first 24 to 72 hours after a disaster.

The response that must be mobilized will, at a minimum, require the active involvement of emergency medical services, fire, police, hospitals, public health agencies, and municipal and county leaders. This is no task for a single hospital or agency, says **Dennis S. O'Leary**, MD, Joint Commission president.

"Many of our large metropolitan areas, such as New York City and Washington, DC, are far better prepared to deal with terrorist attacks and other disasters than they were before Sept. 11," O'Leary says. "However, most of America's communities are at the stage of waiting for someone to call the meeting. Knowing that terrorist strikes will focus on the objective of creating fear, small-town communities and cities of modest size can ill afford complacency today."

To address the problem, the report calls for key community leaders to play a convening role in those communities that lack emergency preparedness programs. These potentially include local emergency management agencies, public health agencies, hospitals, and municipal and county leaders.

The report goes on to detail the critical elements of good emergency management programs, and then calls for the creation of a federal program to evaluate and hold accountable these emergency preparedness programs.

According to a new survey conducted by the American College of Healthcare Executives (ACHE), 84% of hospital CEOs agree that since 9/11, their hospitals have worked more closely with public agencies (e.g., fire, police, and public health departments). Further, 95% of the respondents said their hospitals already have, or within six months will have, a bioterrorism disaster plan in place, developed in coordination with local emergency or health agencies.

Providers have taken to heart their responsibility for responding to terrorist attacks and other disasters, says **Thomas C. Dolan**, PhD, FACHE, CAE, president and chief executive officer of ACHE.

"In times of crisis and need, health care executives ensure that hospitals and other health care organizations serve as safety nets in their communities by providing emergency and ongoing care, as well as accurate, timely information about public health threats," Dolan says.

In the survey, ACHE asked more than 700 hospital CEOs throughout the country to report on the status of programs related to bioterrorism preparedness. Eighty-five percent of the respondents reported that they already are working with other hospitals or hospital associations to learn about resources available for a response to bioterrorism. Of the hospitals not currently communicating with other organizations, 73% are planning to establish such relationships within the next six months.

[For more information, contact:

- ***Joint Commission on Accreditation of Healthcare Organizations**, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000.*
- ***Thomas Dolan**, American College of Healthcare Executives, One N. Franklin, Suite 1700, Chicago, IL 60606-4425. Telephone: (312) 424-2800.]* ■

THE QUALITY - CO$T CONNECTION

Reduce infections with root-cause analysis

Responding to infection-related sentinel events

By **Patrice Spath**, RHIT
Brown-Spath & Associates
Forest Grove, OR

Infection control practitioners play a vital role in reducing nosocomial infections. Collecting and analyzing surveillance data can identify patterns of occurrence so that steps can be taken to eliminate or reduce the factors that contribute to nosocomial infections. The Joint Commission on Accreditation of Healthcare Organization's recent expansion of the sentinel event policy to include nosocomial infections could represent a change in what infection control practitioners view as their traditional role. In addition to discovering the root cause of undesirable infection patterns, practitioners now may be called upon to investigate an unexpected death or patient injury.

A knee-jerk response to a possible infection-related sentinel event would be to explain how difficult it is to establish a clear and concise relationship between a patient's infection and the adverse outcome in question. Often patients who develop nosocomial infections have a host of other medical problems and contributing factors. For example, sepsis from gram-positive pneumonia is a common cause of death among patients hospitalized with severe burns. Is it possible for practitioners to determine if the severely burned patient would have recovered if not for the sepsis? The Joint Commission's revised sentinel event definition suggests that this question must be answered to determine if a root-cause analysis (RCA) is required.

The difficulty in determining whether an infection-related event is, in fact, a sentinel event may be related to our fundamental reluctance to place blame. If the answer is "yes" then it appears we are admitting that the patient care experience was flawed in some way. But nosocomial infections are common in patients with compromised immune systems (such as the severely burned patient).

Thus it is conceivable to answer "no" and blame the patient's physical condition for the death. The danger in answering "no" is that the singular event — sepsis due to pneumonia — might be the symptom of a larger system problem

Screening Questions for Adverse Events Involving a Nosocomial Infection

	Yes	No
1. Does the nosocomial infection represent a long-standing patient care problem?	___	___
2. Have previous interventions been unsuccessful in reducing infections of this type?	___	___
3. Is there reluctance on the part of the caregivers to accept ownership of the nosocomial infection problem?	___	___
4. Could the current systems of care result in a worse-case infection scenario if action is not taken?	___	___
5. Has luck prevented other patients from developing similar infections?	___	___
6. Are the patient care activities that contribute to development of this type of infection associated with any current regulatory or accreditation issues or findings?	___	___
7. Does the event represent a problematic patient care situation that appears to be very difficult or impossible to solve?	___	___
8. Will the organization's ability to achieve strategic performance goals be hampered if this event is not investigated in greater detail?	___	___

that contributes to the development of various types of nosocomial infections in other patients. The infection surveillance data may not suggest the presence of a system problem; nonetheless, it still could be present. The sentinel event RCA can uncover problems requiring corrective actions. A significant adverse event involving an infection represents a "pattern of one" that deserves more in-depth investigation.

Consider the following situation: A 72-year old patient with severe congestive heart failure is admitted to the hospital with a stroke. On the fourth day, the patient develops aspiration pneumonia and is started on IV antibiotics. On the sixth hospital day, the patient has a sudden cardiac arrest and expires. The patient's attending physician documents the cause of death as cerebrovascular accident and congestive heart failure. Pneumonia is listed as a secondary diagnosis but not labeled as one of the causes of the patient's death.

Does this mean that the patient's death should not be treated as a sentinel event?

It really doesn't matter whether the infection is a known complication or whether it was preventable. Does the event meet the Joint Commission's definition of a sentinel event?

If this question is posed to physicians and other caregivers, you are likely to hear opposing viewpoints coupled with sound rationale supporting the opinions.

It may be impossible to get caregivers to agree on whether a patient death was directly caused by a nosocomial infection. Rather than seek an answer to the sentinel event question, it's more productive to explore the great question — that is, could further investigation of the care this patient received ultimately lead to a lower rate of aspiration pneumonia cases?

An RCA of the event could uncover any number of system of care problems. For example:

- Are staff members knowledgeable about patient populations at risk and early signs and symptoms indicating dysphagia?
- Are patients at risk of swallowing problems observed for and or questioned about the following factors, for example:

— food remaining on tongue after swallowing;
— pocketing of food on side of mouth;
— excessive drooling;
— coughing or choking while eating or drinking;

CE *questions*

This concludes this CE semester. Return the enclosed survey in the envelope provided.

21. An annual 5% sample of health care organizations will undergo random, one-day unannounced Joint Commission surveys through the end of what year?
    A. 2003
    B. 2004
    C. 2005
    D. 2006

22. Which of the following hospitals requested to undergo an unannounced full Joint Commission survey in 2004?
    A. Children's Memorial Hospital in Chicago
    B. Medical City Dallas Hospital
    C. Saint Vincents Hospital and Medical Center in New York City
    D. all of the above

23. The first quality report released publicly by Rowan Regional Medical Center in Salisbury, NC, contained data on what condition?
    A. chronic obstructive pulmonary disease
    B. congestive heart failure
    C. pneumonia
    D. diabetes

24. According to a survey conducted by the American College of Healthcare Executives, what percentage of hospital CEOs claim their hospitals have worked more closely with public agencies since 9/11?
    A. 42%
    B. 57%
    C. 73%
    D. 84%

Answer Key: 21. C; 22. A; 23. B; 24. D

COMING IN FUTURE MONTHS

- QI project reduces chronic pain by 33%
- 'Dashboard reports' help you manage data, projects
- Opting out of JCAHO: How to decide if it's right for you
- How to get the most from patient safety goals
- Getting an ex-JCAHO staff member on your team

— gurgly-sounding voice after eating or drinking.
- Is an individualized care plan developed for patients at risk of swallowing problems that addresses:
  — patient's specific problem or need (i.e., pocketing food, history of aspiration);
  — realistic and measurable goals or expected behaviors (i.e., patient will protect airway during swallowing);
  — specific actions/interventions to solve the problems/satisfy needs (i.e., sit upright when eating, head slightly flexed forward; when recumbent, change position at least every two hours).

Choosing cases for RCA

Selecting cases for an RCA is not easy, especially if people don't understand the purpose and value of an in-depth investigation. **In the box on p. 86** are some initial screening questions that can be used by quality managers or infection control practitioners to determine which situations should be brought to the attention of the patient safety committee or other oversight group responsible for initiating an RCA.

Cases referred to this multidisciplinary committee then can be assessed in greater depth to determine if the nosocomial infection was a significant causative factor in the patient's death and if an RCA would yield valuable information.

Questions that could be addressed by this committee include:
- Was the infection related to any deficiencies in the systems of care?
- Was the infection a consequence of a medical error or mistake?
- Was the infection an unfortunate but unavoidable complication based on the severity of illness of the patient and other underlying host factors?

Practitioners with epidemiological training have unique skills in the areas of investigation and implementation of interventions that can enhance patient safety improvement efforts.

Hospital infection control should not be limited to collection and analysis of aggregate data. RCAs of single infectious events can uncover factors inherent in the systems or processes of care that need to be corrected. The ultimate goal of the analysis is to help the organization prevent or reduce the likelihood of similar nosocomial infections in the future. ■

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review,* CE participants should be able to meet the following objectives after reading each issue:

• Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.

• Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.

• Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions.

If you're not an *HPR* CE subscriber and would like to sign up, call customer service at (800) 688-2421. ■