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IN THIS ISSUE

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JCAHO revisits patient safety goals: What your facility must do to comply

Almost all facilities surveyed in 2003 had Type Is for safety goals

Are you relieved to find that six of the Joint Commission on Accreditation of Healthcare Organization's seven new National Patient Safety Goals are much the same as for 2003? If so, you should think again.

"This speaks volumes," warns **Kathleen Catalano**, director of regulatory compliance at Addison, TX-based Provider HealthNet Services. "The Joint Commission is saying that the facilities surveyed during 2003 have not effectively addressed the safety goals. Thus, those same goals will be revisited in 2004." Many quality managers underestimated the length of time and commitment required to implement the 2003 safety goals, she says.

"During 2003 surveys, very few facilities went unscathed," Catalano points out. "Almost everyone received at least one Type I recommendation because they failed to meet one of the patient safety goals."

As a result, the same six goals and 11 recommendations will be repeated in 2004, with only one new goal on health-acquired infections, she says.

The seven National Patient Safety Goals for 2004 are as follows:

Goal 1: Improve the accuracy of patient identification.

Goal 2: Improve the effectiveness of communication among caregivers.

Goal 3: Improve the safety of using high-alert medications.

Goal 4: Eliminate wrong-site, wrong-patient, and wrong-procedure surgery.

Goal 5: Improve the safety of using infusion pumps.

Goal 6: Improve the effectiveness of clinical alarm systems.

Goal 7: Reduce the risk of health care-acquired infections.

To comply with the 2004 goals, do the following:

- **Understand how the goals will be scored**.

"Remember that the scoring for surveys is changing along with the process in 2004," Catalano stresses.

Although the safety goals and recommendations are not standards, they are requirements of the accreditation process as part of a new "Accreditation Participation Requirement" and will be scored with a corresponding "Special Type I" grid element, she adds.

"The surveyors will be fair, but they will take into account the fact that the National Patient Safety Goals were in effect in 2003," Catalano says. "I believe they will be especially hard on organizations that have taken little or no action to comply."

- **Ensure that all managers understand goals that apply to their areas.**

The numerous Type Is received by facilities in 2003 for failing to comply with the safety goals resulted not only because of the major changes that needed to be made to processes facilitywide but also because the changes affected such a large number of people, Catalano says. "A housewide effort should be under way for each goal."

All managers and directors must know what has been implemented to comply with each goal that affects their area, she stresses. "They should be able to speak to how they are implementing each goal and recommendation that is applicable to them," she says.

- **Focus on changing behavior**.

According to Catalano, the hardest goals to comply with are reading back of verbal orders, use of appropriate abbreviations, acronyms and symbols, and wrong-site, wrong-patient, wrong-procedure surgery.

"These are the heavy hitters, in my opinion, mainly because of the need to change behavior," Catalano says. "For example, how do you ensure that everyone who takes a verbal order reads that order back to the physician? And wrong-site, -patient, -procedures surgery is another entire can of worms," she says. "How do you make physicians do what you say?"

The key is to obtain buy-in from senior management, Catalano stresses. "If you receive flack from a physician, you can then let the higher-ups know — and watch them enforce the rules," she says. "If your vice president of nursing doesn't back the rule that verbal orders are read back to physicians, you'll have a heck of a time changing behavior."

- **Be able to demonstrate compliance.**

You must be able to produce documentation to show how your various performance improvement teams addressed compliance with each goal, Catalano advises.

"Even if your facility was in compliance with the recommendations for a goal, you must still justify that you have reviewed your processes and have determined that you are handling the goal appropriately," she says.

- **Make necessary changes to comply with Goal #7.**

The only new goal requires you to reduce the risk of health care-acquired infections. Surveyors will focus on the two specific requirements for this goal, according to **Richard Croteau**, MD, the Joint Commission's executive director for strategic initiatives:

— Has the organization implemented the Centers for Disease Control and Prevention (CDC) recommendations, and are they being followed consistently? **(See related story on hand hygiene compliance, p. 120.)**

— Does the organization include in its definition of "sentinel event" all patient deaths or major injuries, even if they are associated with a health care-acquired infection, and are they doing

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a root-cause analysis on those cases when they are identified?

Quality control managers and infection control (IC) professionals should make a concerted effort to work together, communicate frequently, and share data related to health care-associated infections, says **Barbara M. Soule**, RN, MPA, CIC, president of the Washington, DC-based Association for Professionals in Infection Control and Epidemiology (APIC).

She suggests the following strategies to reduce risk:

— Take steps to understand the populations served and their risk factors.

— Use evidence-based guidelines to direct IC practice.

— Perform surveillance on high-risk populations or procedures.

— Analyze data and take subsequent action to reduce and/or prevent nosocomial infections through performance improvement processes.

Most IC professionals perform prospective surveillance on high-risk, problem-prone, or specific populations of patients, as opposed to surveillance on all patients in the hospital, Soule notes.

Therefore, as a quality manager, you should work with IC, epidemiology, and information technology specialists to develop additional methods to capture data from medical records, laboratories, and financial systems, with the goal of identifying potential sentinel events, she advises.

"The technology to provide this type of integrated information may be challenging for many institutions," Soule acknowledges.

The guidelines and practice standards published by APIC, the Atlanta-based Healthcare Infection Control Practices Advisory Committee (HICPAC), and the Mt. Royal, NJ-based Society for Healthcare Epidemiology of America are excellent evidence-based resources, Soule says.

"Quality managers should become familiar with these references to reduce risk and improve patient safety," she recommends.

These are available free of charge on the web sites of the respective organizations, says Soule, pointing to the new hand hygiene guideline recently published by HICPAC.

"It is well researched, extensively referenced, and gives both rationale and recommendations for hand hygiene that are applicable across the continuum of health care organizations," she adds.

In addition, you should work collaboratively with IC professionals to implement your facility's procedure for identifying and analyzing infection-related sentinel events, including the root-cause analysis process, Soule advises.

Infection control professionals have always investigated and analyzed serious infections, either individually or in the aggregate, and brought these to the attention of the epidemiology team, infection control committee, or others to determine improvement strategies, Soule notes.

First, you should work with both infection control professionals and risk managers to establish general criteria for what is an "unexpected" death from an infection, she recommends.

You also must develop specific strategies to investigate potential sentinel events, taking numerous factors into consideration, says Soule.

For example, you'll need to determine whether the infection was the cause of death and whether the death was unexpected in light of the patient's underlying condition, she explains.

"Some cases will clearly be a potential sentinel event, such as the healthy patient admitted for a hernia operation who gets a surgical-site infection and dies," she says.

Others will be more difficult to assess, such as an immunosuppressed oncology patient on chemotherapy with several underlying diseases or comorbidities, who requires several invasive procedures or devices, becomes septic, and subsequently dies, explains Soule.

Again, quality managers and IC professionals should work together to develop systems with three goals in mind: assessing current sentinel events, learning from past events, and preventing future events, says Soule.

"It will be important to review the Joint Commission's database of sentinel events related to nosocomial infections as it expands," she advises.

- **Comply with new recommendation for Goal #2.**

The only other change for 2004 is a new recommendation added for Goal #2, which requires that you implement a process for taking verbal or telephone orders or critical test results with verification read back of the result.

First, departments need to define what the critical results are for their area, says **Michelle H. Pelling**, MBA, RN, president of the Newberg, OR-based health care consulting firm The ProPell Group.

These typically will include "stat" tests, "panic value" reports, and other laboratory, X-ray, or

electrocardiogram results that require urgent response, Croteau says. "For most organizations, this will include all test results reported verbally or by telephone."

If a subset of "critical test results" is not defined by the organization, surveyors will consider all verbal or telephone reports of laboratory tests to be "critical," he adds.

Once you determine what constitutes critical results, the next step is for the departments to develop a process for calling in test results, and also for documenting when and to whom they reported the results, Pelling explains.

For example, technicians calling with results would ask for the name of the person they are speaking to, and then record the name and time of call in a critical value log or book, she says.

"Ideally, they should be able to record it electronically next to the critical results, so that anyone looking up the results can see when it was called and to whom," she adds.

In addition, the receiving departments, such as nursing units, operating rooms, or clinics, must establish a method for documenting the information they receive, and a method for communicating it to the physician, nurse, and other appropriate parties, Pelling says. She gives the example of "hot pink sheets" used exclusively for critical lab values.

However, those receiving the information also should use a method to document who they reported the results to, says Pelling.

"Perhaps the call with test results should always be given to a nurse, with a policy of not using a unit secretary or any other staff person to accept critical value results. If the nurse calls the physician with the results, they could then document it in the progress notes." Each organization is different and will have different capabilities and preferences, she notes.

The goals apply to the entire organization, to the extent that the requirements are relevant to the services provided, Croteau adds.

"This may include physician offices, if those offices are part of the hospital and included in the scope of the hospital's accreditation," he says.

If information is called to a clinic that is considered part of the hospital, then the requirement will be the same and staff should document it in the record, says Pelling. "Or if results are called to a physician office that is not considered part of the hospital, then the surveyors do not have an ability to review those records," she says.

"They would look to the lab or other department reporting the results for the process they are using to document when they called and with whom they spoke," Pelling explains.

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Track compliance with hand hygiene guidelines

Complying with the new patient safety goal

Rising patient infection rates. Adverse patient outcomes. Increased risk to staff. If these aren't compelling enough reasons to comply with recent hand hygiene guidelines from the Centers for Disease Control and Prevention (CDC), consider this: The only new 2004 National Patient Safety Goal from the Joint Commission on Accreditation of Healthcare Organizations addresses this area specifically.

In addition, the Joint Commission's isn't the only survey you have to worry about, says **James Marx**, RN, MS, CIC, a San Diego-based infection control and epidemiology consultant. "Both state and federal surveys in acute, long-term care, and other facilities are also focusing on hand hygiene," he stresses.

According to the CDC, 30,000 deaths occur each year as a direct result of improper hand hygiene.

The recently issued guidelines recommend the following performance indicators be used to measure improvements in hand hygiene adherence:

1. Periodically monitor and record adherence, by the number of hand hygiene episodes performed by personnel, and the number of hand hygiene opportunities, by unit or by service. Provide feedback to personnel regarding their performance.
2. Monitor the volume of alcohol-based rub or detergent used for hand washing or hand antisepsis used per 1,000 patients.
3. When outbreaks of infection occur, assess the adequacy of health care worker hand hygiene.

Here are some ways to improve hand hygiene compliance:

- **Encourage peer review monitoring**.

Health care workers are monitored by both supervisors and peers in the facility's 28 operating rooms, says **Christy Dempsey**, BSN, CNOR, director of perioperative services at St. John's Regional Health Center in Springfield, MO.

"The operating room is really a perfect place to monitor each other," she says. "The staff and surgeons often scrub at the sinks together and have an opportunity to observe each other's techniques."

On occasion, a staff member may question a surgeon's or other staff member's hand hygiene techniques, says Dempsey. When this occurs, the concern is brought to the attention of the supervisor or OR manager, who then discusses the issue with the surgeon and, when warranted, involves the infection control department, she says.

- **Address hand hygiene in performance reviews**.

During annual performance reviews, feedback is provided about hand hygiene compliance, says Dempsey. The annual performance review is an opportunity to provide feedback in all aspects of the employee's performance throughout the year, she notes.

"If a problem is identified in any area, including hand hygiene, which is critical in the surgical setting, this would be addressed in the review appropriately — depending upon the severity of the problem," she adds.

- **Monitor volume of hand hygiene items**.

Since the facility has its own distribution center, purchase orders for particular products can be monitored closely, Dempsey says.

"We are able to identify areas of underutilization of hand hygiene items by those purchase orders and trend this to the infection rates for those particular patient care areas," she says.

During monthly and quarterly infection control meetings, infection rates are discussed and each surgical site infection is reviewed in detail, says Dempsey.

The meetings are attended by representatives from all areas, including nursing, internal medicine, surgical specialties, and administration, she adds.

"We are very diligent in our hand washing, surgical scrubs, and surgical preps to insure a low infection rate," Dempsey adds. "Any issues with regard to surgical infections is researched in great detail. This may include step-by-step analysis of the surgical case, setup, procedure, preoperative, and postoperative care."

If there is a spike in infection rates, such as sternal wound infections, every process is closely reviewed, she says.

"We trend personnel in the room, and we have infection control representatives watch high-risk cases and closely monitor sterile technique," she continues.

As an integrated system, more information is obtained from physician officers since they are employed by the organization, notes Dempsey. "So, we are able to trend infections with that data that might not otherwise be reported."

- **Give inservices on an ongoing basis**.

It may be difficult to get staff to accept the new recommendation that alcohol hand sanitizers, not soap and water, are the new gold standard, Marx says. "This has been a struggle for health care professionals who have been told by infection control that alcohol was only an adjunct to soap and water hand washing."

When the facility switched to using a waterless surgical scrub, several inservices were given to staff, Dempsey explains. The vendor provided inservices on all shifts until every employee was educated on the proper use of the product, she adds.

"This is now repeated on an annual basis for all employees, so that competency is maintained," Dempsey says. "This ensures that the product is being used properly, so that the maximum benefit is provided for the patient."

- **Ask staff for suggestions.**

When the Joint Commission identified surgical site infections as a sentinel event, a task force for perioperative services was established, she reports.

"We brought staff together and explained what the Joint Commission was looking for. We asked them how we could improve, and they came up

with some fabulous suggestions," Dempsey says.

The suggestions resulted in changes in setup and draping techniques, and making sure that equipment was not brought in and out of the room frequently, she adds.

"A lot of the solutions were no-brainer kinds of things; but to have the staff come up with it and see us implement it, made a big difference," Dempsey points out.

Here are two changes that were implemented as a result of staff suggestions:

— The number of students observing in the OR was reduced, with a maximum of two per room established.

"As a result of this suggestion, the management team focused on determining which students really needed to be in the OR, and finding a way to distribute the students so that traffic and personnel in the room was kept to a minimum," Dempsey says.

— Housekeeping personnel were added to areas of high patient turnover, to ensure that these areas were appropriately cleaned, even during peak patient census hours.

- **Make it easy for staff to use hand hygiene items**.

Alcohol gel was placed in the hallways prior to the CDC guidelines, says Dempsey. After the guidelines came out, foam was added to each patient room, located on the wall in plain sight, she says.

"You need to provide systems that are easily accessible and user-friendly, and conveniently located for health care workers to use," she adds.

However, you also should consider possible safety hazards when choosing locations of alcohol hand sanitizers, Marx says, pointing to a recent statement issued by the Washington, DC-based Association for Professionals in Infection Control and Epidemiology, which recommends that these products not be placed in exit corridors. **(To access the document, go to www.apic.org and click on "Guidelines for Hand Hygiene in Health Care Settings.")**

"There is a theoretical possibility that alcohol-based products could accelerate a fire in the hallway," he explains.

"However, local fire marshals have ruled differently, so the facility should check with the local fire department," Marx adds.

[For more information on the CDC hand hygiene guidelines, contact:

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Do you address staffing effectiveness standards?

Addressing effectiveness can boost bottom line

Would you like to be responsible for a million-dollar increase in your hospital's bottom line?

By complying with the staffing effectiveness standards from the Joint Commission on Accreditation of Healthcare Organizations, you can have a dramatic impact on your facility's operations and impress surveyors to boot, says **Lisa Mead**, RN, MS, director of quality and organizational effectiveness for Scottsdale (AZ) Healthcare.

"This will be a key focus in the 2004 survey process," she underscores.

The new survey process enables surveyors to assess the unit manager's understanding of the relationship between clinical and human resource indicators and determine if data are shared with staff, says Mead.

As a quality manager, your major challenge is to explain the importance of data analysis to others, she says.

"The biggest reward is when relationships *are* identified, and action plans can be put into place to improve outcomes for our patients," Mead points out.

To comply with the staffing effectiveness standard, do the following:

- **Collect the right data elements**.

At NorthEast Medical Center in North Concord, NC, data are being collected on patient falls, medication error rate, staff turnover, and understaffing, says **Karen Holtz**, MS, CPHQ, MS, CPHQ, the facility's performance improvement specialist.

Indicators are population-based, notes Holtz. "Therefore, additional or substituted indicators are identified by departments or units to recognize special services, or in the case where there

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PATIENT SATISFACTION PLANNER™

Proven techniques to boost patient satisfaction

Expert says follow hospitality's lead

By **Polly Gerber Zimmermann**
RN, MS, MBA, CEN
Occupational health nurse, author, and lecturer
Chicago

Customer (or patient) satisfaction is gaining more attention in health care. In one recent survey, 54% of people were not satisfied with their health care.[1] Why? Health care clients judge the providers' competence from their customer service skills (not clinical skills) approximately 85% of the time.[2]

One emergency department (ED) was able to decrease their patient complaints by 70%, increase their patient compliments 100%, and significantly improve the patient's ratings of staff competencies by using these hospitality industry-proven techniques:[3,4]

✔ **Initial contact:** As the old saying goes, you never get a second chance to make a first impression, which is why staff are told to:
- **Look up and say "Hello!" when someone enters.** Then, they won't feel ignored.
- **Beam a smile.** In the book, *How to make People Like You in 90 Seconds,*[5] the author emphasizes the need for eye contact, keeping the heart's physical area open (e.g., no crossed arms), and leaning slightly forward. It signals you are interested and welcoming.
- **Use a warm voice tone.** One study found that the physician's tone of voice, particularly if it demonstrated hostility or lack of concern, directly correlated with malpractice claims.[6]

✔ **During the wait:** Waiting is a universal irritant. The key is to manage the waiting area, just like any other treatment room. You can do so by:
- **Renaming the waiting room.** Consider calling it the lobby or process area. That subconsciously projects a different impression.
- **Providing pleasant amenities.** Make the waiting room attractive and comfortable. The presence of nature, such as plants, a fish tank, or a small waterfall, has a calming effect. A television, if possible, is great but at least have reading material. (Staff can donate their used magazines, with name and address removed.) One office starts a jigsaw puzzle on a side table.
- **Eliminating the clock.** While it seems drastic, remove the room's wall clock. Offices that do this report receiving fewer time-related complaints.
- **Avoiding triggers.** Staff eating, laughing, or just standing around commonly irks people. People who witness this may perceive that staff are doing nothing, even though there honestly can be periods of time where staff must wait to proceed. Always do these types of activities out of client earshot and eyesight.

✔ **During the interview:** At the beginning of the interview, the client explains the reason for the visit. This is what is most significant to them. Avoid multitasking, pay full attention, and do the following:
- **Sit down physically close to clients.** The client will perceive that the interaction lasted two to three times longer if you do. A frequent misperception is that the nurse is hurried or abrupt if he/she stands by the doorway.
- **Initially repeat their complaints (concerns) in their own words.** Then the person feels that you've understood. The tendency is to translate. The client states, "My arm is sore." The nurse states while assessing, "You've bruised your arm," while charting "5 x 7 ecchymotic region s/p blunt trauma to the left forearm." Then, however, the client doesn't feel heard because to him or her, his complaint of soreness does not equate to a bruise.
- **Always praise what was done right.** Everyone is hypersensitive to criticism. Start on a positive note. Even if the client should have come in for treatment earlier, state that you are glad he or she came in today. Though the patient can't recall the name of the antihypertension medication, tell that person you are glad he or she is aware to take it daily.

- **Use scripted phrases.** It is hard to think of new, creative, therapeutic statements all day long, especially when rushed or distracted. It is easy to forget to express nurturing or compassion for something routine to the clinic. Develop a few statements that work well for your personality and use them regularly. Possibilities include, "I'm sorry this happened to you," "That looks sore," and "Sure, I can help you with that!" Now the client feels that you've shown empathy.

✔ **Handling a complaint:** Inevitably, things do go wrong sometimes. People remain satisfied, though, if they feel their complaints are properly handled in a timely manner.

- **Broken record.** If someone vents, acknowledge those feelings and then repeat in a calm voice the information. "I understand you've been waiting for a long time, and it will be about another 20 minutes until the physician can see you." The key is to keep repeating the same information matter-of-factly without irritation, no matter how the client repeats the complaint. Once you become angry, the focus becomes the emotion rather than the information. The temptation is to keep trying to give a better explanation that the person will finally accept, but the variety only fuels the process. The complainant then has reason to hope you will eventually change the answer to what he or she wants to hear.
- **The blameless apology.** When someone lodges a complaint, indicate you are sorry he or she had a problem. Note that responsibility is not assigned or accepted by anyone. You are simply acknowledging there was been a difficulty. "I'm sorry this paperwork has been a burden for you to complete."
- **Listen and offer self.** Initially, do not debate; do not defend; or do not interrupt the complaining person. Trying to correct him or her only enhances feelings of being misunderstood or mistreated. As the saying goes, silence is one of the hardest things to refute.

After the client is done, ask, "What would you like to do now?" Most of the time the person will say he or she just wanted "someone to know."

It is more rewarding personally and professionally when clients are able to appreciate the effort and quality of the nursing care. Present your interaction in a way that allows clients to perceive your concerning care and its value for their well-being.

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Patient satisfaction depends on staff morale

ED manager who scores high shares tips

If you want to improve your patient satisfaction ratings, don't start by looking at how happy your patients are. Start by looking at satisfaction levels among your staff. That's the advice from an emergency department (ED) manager who can boast of patient satisfaction scores in the 99th percentile nationwide.

The ED at Hackettstown (NJ) Community Hospital has earned high patient satisfaction levels in recent years, which can be directly tied to improvements resulting in better employee morale and customer service, says **Loraine Skeahan**, RN, manager of the ED.

"The lesson may be that if you want to improve patient satisfaction, go deeper than that and address the fundamentals in the emergency department like how well you're staffed and how happy your staff are," she says.

If you start off by going to patients and asking how to make them happy, you might be wasting

your time, she says. "Chances are, they don't really know what could be improved in your department to make their visit better," Skeahan says.

In a recent patient satisfaction survey conducted by The Jackson Organization, a health care research organization based in Columbia, MD, Hackettstown's ED patients gave the hospital an overall satisfaction grade of 4.27 (on a 5 point scale, where 1 is poor and 5 is excellent). This compared to an overall 3.97 grade for competing hospitals serving the area and gave Hackettstown a 99th percentile ranking among hospital EDs nationwide.

Expanded ED helped patient satisfaction

In its research, The Jackson Organization identified several key predictors of Emergency Patient Satisfaction. Hackettstown's ED scored especially well in three areas:

1. Staff Availability to Provide Assistance at all Times.
2. How Well the Hospital Did at Meeting its Mission.
3. Total Amount of Time Spent in the Facility from Arrival to Discharge or Hospital Admission.

The Hackettstown ED also ranked exceptionally well in four other key areas:

1. How Quickly Nurses Responded to Requests.
2. Kindness Shown by the Nurses.
3. Kindness Shown by the Doctor.
4. How Well the Staff Kept Patient and Family Informed about Patient's Care and Condition.

Part of the high satisfaction ranking can be related to physical improvements in the ED, Skeahan says.

The hospital recently completely rebuilt its emergency area with 13 rooms, more than double the previous six rooms. The number of ED staff were doubled, and the number of secretarial support staff were increased to speed up paperwork and data entry.

"By streamlining waiting times and increasing space and staff, we reduced the average length of stay in the emergency department to less than an hour for those who were treated and released," Skeahan says.

Doubling its size was an absolute need, she says. "The population in Northwest Jersey is growing, and we went from 30 visits a day to 60 or 70 a day."

The ED staff now make a priority of getting the patient triaged, evaluated, and to a physician as quickly as possible. Physicians now provide double coverage on high-volume days.

Peg Carolan, RN, the hospital's director of nursing and its former ED administrator, says she worked hard to create a better working atmosphere for the ED nurses, which in turn helped them provide better care to patients.

Teaching staff about a caregiving spirit

Nearly everyone in the ED, including lab and X-ray technicians, support staff, and nurses, went through a program called Spirit of Caregiving, offered by Lant & Associates in Winter Park, FL, which helped them bond as teammates and learn to work toward a larger goal of improved patient care. That kind of effort paid off over time with better morale, she says.

"Now, when a nurse calls in sick, those who are here either volunteer to take that nurse's place or else find a substitute," she says.

"The keys to our success are the ability of our staff to create a warm and caring environment and patient-focused team, as we strive to achieve our mission of reflecting God's love in healing each patient's body, mind, and spirit," Carolan explains.

Though the effort worked wonders for Hackettstown, bigger EDs with more challenges may have more trouble creating such a family atmosphere for staff.

That doesn't mean you shouldn't try, says **Marilyn Swinford**, director of emergency services at Saint Joseph Hospital, a 446-bed hospital in Lexington, KY.

Swinford's ED recently won the second place award for Overall Emergency Department Satisfaction for Large Hospitals given by The Jackson Organization.

Swinford says her ED's high patient satisfaction ratings came from some of the same morale-building initiatives used in Hackettstown, such as a new "Star of the Month" program to recognize efforts that improve patient satisfaction. But the Kentucky ED's overcrowding meant it also had to implement some specific strategies aimed at getting patients through the ED faster.

First, Swinford organized a focus group with triage and registration that helped trim registration times to an average of fewer than five minutes. Saint Joseph also put much more effort into keeping patients informed about expected wait times.

While EDs focus so much on reducing wait times, they too often overlook the importance of keeping patients informed, she says.

Patients will be much more willing to wait, and ultimately express satisfaction with their visits, if they know how long they will wait and that there is a good reason for the delay.

"Customers want to know what to expect so proactive communicating is critical," Swinford says. "We are improving in informing patients reasons for wait times, focusing on keeping them informed of the overall expectation of what is happening related to their ED visit and what to expect."

Point-of-care laboratory testing also has shortened door-to-diagnosis times. Testing processes to provide chemistry and cardiac screening were implemented in January 2003. Swinford says these devices have shortened the average test time from 90 minutes to 20 minutes — a huge change for anxious and impatient patients.

She also credits focused teamwork between the ED and cath lab, along with bedside treatment "AMI boxes" that have critical IV access and medications for cardiac emergencies, for providing smoother patient flow.

Listen to staff and give them what they need

When trying to improve staff morale as a way to improve patient satisfaction, Carolan and Swinford emphasize that you must listen to your frontline employees and remember that improvements don't happen overnight.

"Our success took several years to accomplish," Carolan says.

ED managers should pay particular attention to fully staffing the ED and providing support services to clinicians, Skeahan says.

She offers this advice for improvements that can lead to high patient satisfaction scores:

- **Provide ancillary support staff.**

Nurses and other staff can be frustrated by having to do everything, including tasks that don't require their expertise.

The Hackettstown ED operated for years without any ancillary or secretarial support, but Carolan added an ED tech position a few years ago.

Now an ED tech works in the ED every night and every other weekend. The tech acts as an extra pair of hands wherever needed to assist with tasks such as performing a phlebotomy, transporting patients, and obtaining vital signs.

"This position works side by side with the nurse, rather than replacing a nurse," Skeahan says. "It's not the same as hiring another nurse, because that nurse would become busy with everything else and couldn't jump in wherever they're needed."

- **Provide secretarial support.**

Hackettstown now has two secretaries in the ED during the day and one in the evening. This removes a great deal of the paperwork burden from the nursing staff, Skeahan says.

- **Take educational opportunities to the ED.**

Staff usually are interested in learning, but ED staff can find it difficult to get out of the department for inservices. If they don't attend, they feel left out.

If you don't offer any inservices because you think they're too busy, they may miss the opportunity to learn more about the field. The solution is to take the inservices to the ED, Skeahan says.

"When you have some downtime, go to the unit and start a troubleshooting session or discuss the latest topics like pediatrics in the ED," she says.

"They really love it because they want to learn, but you have to be very flexible with inservices in this department," Skeahan adds.

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(Continued from page 122)

are no available data for a specific indicator," she says.

Each year, strategies are developed at Scottsdale Healthcare to meet the hospital's critical goals, Mead. "Staffing effectiveness is a key measure for strategies that support two of our critical goals," she says.

Based on these strategies for the facility's balanced scorecard, relevant indicators are chosen as key measures. Each area evaluates indicators to assess staffing effectiveness, Mead continues.

The facility's indicators for fiscal year 2003 are as follows:

— staffing turnover;

— staff satisfaction;

— medication errors;

— length of stay for the diabetic patient population;

— patient satisfaction: overall, pain relief, responsiveness of nursing and other staff;

— wait times;

— mortality;

— readmissions and unscheduled returns to operating room.

- **Identify effective ways to collect and display information about staffing effectiveness**.

At NorthEast Medical Center, data are collected through the facility's self-reported quality management reports, which are compiled by corporate risk services, and through human resource and nursing administration electronic reports, Holtz says.

Excel charts and graphs are used to display staffing effectiveness data, she says. "Clinical directors use run charts to trend data and identify any correlation between their human resource and clinical indicators."

Use statistical analysis that all clinical directors can understand and use, Holtz recommends.

"One department wanted to use control charts, but in the end, all directors were educated on spreadsheets and run charts," she says. "We kept it simple."

At Scottsdale Healthcare, data are collected by system, service line, and department as appropriate, and are displayed in graph form and matrix tables, Mead says. "These data are available through our common drive, and can be viewed by anyone in our system."

Each area is reviewed by medical staff committees and the facility's leadership and management councils, and graphs are presented with analysis to the board quality committee every two months, she says.

- **When problem areas are revealed, act on them**.

If you're complying with the staffing effectiveness standards, you should be identifying areas for improvement and developing action plans to improve results, Mead emphasizes. "We have been utilizing this format for three years — one year before the JCAHO standard — so we have adopted this as a way of operating."

Retention programs and performance improvement teams are implemented on an ongoing basis, with the goal of having each area focus on their own needs and drill down to further analyze trends and develop action plans, she says.

During monthly and quarterly reviews, indicators are evaluated to identify potential problem areas, Mead points out. "Each indicator has targets based on internal and external benchmarks," she says.

For example, when indicators showed that staff turnover was 23% in 2001, an action plan was developed, which decreased turnover to 18.3% in 2002, and 15% this year. "Turnover is a huge indicator of many things," says Mead. "For every 1% drop in turnover, it's a half-million dollar increase to your bottom line."

The following steps were taken to decrease turnover:

— Individualized professional development plans were developed.

"We sit down and work with individuals to assess their strengths and weaknesses and identify their career goals, and put a plan together with them," says Mead. "This makes a huge difference in turnover."

— Tuition is reimbursed up front even for part-time staff, and bachelor's and master's degree programs are offered on site.

"For the first class, the on-site BSN program had 11 graduates," reports Mead.

Staff satisfaction is measured in an annual survey, and since the measures were put into place, it has gone up significantly, she says. "In addition, costs have gone down, and profits are going up. We are seeing all the indicators move in the right direction, on top of the staffing effectiveness ones."

At NorthEast Medical Center, staffing effectiveness "Plan-Do-Study-Act" reports are compiled quarterly, with a written data analysis identifying areas for improvement, says Holtz.

For example, a unit's clinical director would

review a fall cause analysis report to discover why or when falls occurred, or a medication event report to reveal reasons why certain drug errors occurred, says Holtz.

"In addition, clinical directors review their staff mix, competency, and whether staff were in orientation, on medical leave, or resigned during the reporting period," she says.

Based on this data analysis, improvement opportunities are identified, which often include staff education, says Holtz.

Recently, there was a correlation between the fall rate (a clinical indicator) and nurse turnover and staffing variance (human resource indicators) on a floor, Holtz says.

Data analysis revealed that all the falls occurred on the night shift, with the majority of falls related to patients trying to get to the bathroom, Holtz says. In addition, it was determined that during the time period in question, a nurse had just transferred to another unit, another nurse had resigned, and a nurse was off the floor attending orientation, she adds.

The facility's action plan included the following changes:

— Have nurses visit patients every two hours and ask if they need to use the bathroom.

— Hire two additional nurses for the night shift.

— Visit local colleges to recruit new nurse graduates and offer a sign-on bonus.

"The fall rate declined in the next quarter," Holtz continues. Nursing vacancies also are reviewed with the facility's balanced scorecard, so the effect is seen in both the staffing effectiveness graphs and the manager's scorecard, she explains.

After implementing these solutions, quarterly results decreased from 4.9 per 1,000 patient days to 3.5 per 1,000 patient days, and monthly results decreased to 1.6 per 1,000 patient days from 7.0 per 1,000 patient days, Holtz adds.

"You must continuously educate nursing leadership," stresses Holtz, adding that she continuously provides staffing effectiveness training at nursing staff meetings.

- **Provide drill-down information to surveyors**.

When NorthEast Medical Center participated in a Joint Commission pilot study of the new staffing effectiveness standards in July 2002, surveyors were looking for more drill-down information, such as units with the highest fall rates, fall rates by shift, and reasons for falls, Holtz reports.

This is something that surveyors will want to see for 2004 surveys," she says.

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ACCREDITATION
Field Report

Strong physician support pays off in recent survey

Patient safety, documentation are focus areas

[Editor's note: This column is a regular feature in Hospital Peer Review *profiling a facility that recently has been surveyed by the Joint Commission on Accreditation of Healthcare Organizations. If your facility was surveyed recently, please contact Staci Kusterbeck, Editor, Hospital Peer Review, 280 Nassau Road, Huntington, NY 11743. Telephone: (631) 425-9760. Fax: (631) 271-1603. E-mail: stacikusterbeck@aol.com.]*

During a March 2003 Joint Commission survey at the Regional Medical Center of Orangeburg (SC) and Calhoun Counties, strong support from physician leaders paid off, says **Indun Whetsell**, the facility's director of quality management.

"We had very strong physician attendance," she reports. "We kept at least one physician with the physician surveyor all the time, and many times had another with the nurse surveyor. Surveyors were very receptive to their attendance."

Physician leaders were well versed in patient safety, quality improvement efforts, and the facility's peer review committee, Whetsell adds. Medical staff leadership, including the chairman of the

executive committee and chief of staff, attended the formal presentation and made themselves available for questions, she says.

Surveyors asked physicians about the National Patient Safety Goals and how the medical staff were involved in performance improvement efforts, Whetsell points out.

"The surveyors wanted to see that they had a global understanding and knew what was going on both in the department and facility-wide." Physicians were able to recount the facility's success stories, she says.

If you don't have physicians participating, the surveyors start looking for them and wondering how involved they are, Whetsell explains. "Once it was obvious they were involved, surveyors didn't dig any deeper."

Here is what surveyors wanted to see at the facility:

- **Documentation.**

Both the nurse and physician surveyor wanted to see a physician signature for authentication of the history and physical (H&P) on the patient's preoperative chart, Whetsell explains. "We would have gotten a Type I if our medical records director hadn't gone on the web site to prove we did not need this."

The medical records director was able to obtain clarification for the time frame required for authentication of documentation, she explains. "Once we presented that, the next morning they backed off. It is a good practice, but it wasn't a rule."

In addition, the surveyor said that a handwritten H&P on an elective cesarean did not include all the components, Whetsell says. "About 95% of the time, they were dictated, but the nurse happened to take a handwritten chart that time."

As a result, the obstetrics/gynecology department determined that all H&Ps will be dictated on all elective cesareans, she adds.

- **Conscious sedation.**

"We had made some changes during the year that they liked a lot, but we didn't have a 12-month track record," Whetsell continues. "But the surveyors very much acknowledged that we already fixed the problems."

The facility now uses American Society of Anesthesiologists scoring to assess candidates for conscious sedation and has developed a form to ensure consistent practice facilitywide, she explains.

- **Same-day surgery callbacks**.

The surveyor thought the system used for follow-up calls was inconsistent, says Whetsell.

"They didn't give us a Type I, but they noted it," she says.

Nurses usually give patients follow-up calls within 24 hours on weekdays; but on weekends, the time frame may be longer, Whetsell explains. Although the facility's policy intentionally doesn't specify a time frame, surveyors took issue with this, arguing that there was a difference in the care patients received after hours, she says.

- **Patient safety.**

Surveyors went to patients' rooms and asked them questions, says Whetsell. "There was definitely an increased emphasis on patient safety. They are going to the bedside to make sure you are doing what you are supposed to."

[For more information about the facility's Joint Commission survey, contact:

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Another set of measures to add to your to-do list

Are you compiling and reporting performance measurement date from two core measures, as required by the Joint Commission on Accreditation of Healthcare Organizations? As of January 2004, you'll need to make that *three* measures.

Quality managers report concerns about the news that the Joint Commission has increased the requirement to collect and report performance measure data from two to three sets of core measures. Hospitals can choose from four core measure sets that address acute myocardial infarction, heart failure, community-acquired pneumonia, and pregnancy and related conditions.

"So far, we've been relatively successful in electronically collecting the data on our two core measures — congestive heart failure and pregnancy and related conditions," reports **Mary M. Owen,** RN, MPA, director of outcomes case management at University of California — Irvine Medical Center in Orange.

However, your core measurement collection now will require additional manual abstraction,

particularly with respect to medications, predicts Owen. "That will likely impact our ability to place resources on other performance improvement priorities within our own organization," she adds.

In addition to the Joint Commission's core measures, you have other voluntary measurement projects to contend with, such as those of the Chicago-based American Hospital Association and the Washington, DC-based Leapfrog Group, Owen notes. "My greatest concern is that prioritization will eventually be driven by external sources at the '50,000-foot level' instead of closer to the organization's own patient care population priorities," she says.

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THE QUALITY - CO$T CONNECTION

Don't get caught in the activity trap

Focus on results expected from QI project

By **Patrice Spath**, RHIT
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It has happened to everyone. A quality improvement (QI) project team is formed to achieve an improvement goal, and the group gets sidetracked on the action plan. This can happen when members of the team don't share the same sense of clarity around the problem.

The activity trap sets in when the team establishes a goal that focuses on the activity needed to solve the problem rather than on the results expected from the QI project. The activity trap must be avoided to ensure that resources are being properly leveraged and quality goals are reached.

CE *questions*

9. Which of the following is true regarding the National Patient Safety Goals for 2004 from the Joint Commission regarding a process for giving critical test results with a verification read back of the result?
   A. Hospital clinics and physicians offices are not included.
   B. Critical test results may include laboratory tests, electrocardiograms, or X-rays.
   C. Verification of telephone reporting of test results is not required.
   D. All test results are to be considered critical by surveyors.

10. Which is recommended to comply with recent CDC recommendations for hand hygiene, according to Christy Dempsey, director of perioperative services at St. John's Regional Health Center?
   A. Alcohol hand sanitizers can be placed anywhere in the facility, including by exit corridors.
   B. There is no effective way to monitor compliance with hand washing.
   C. Staff should be allowed to choose whether hands are washed with alcohol hand sanitizers or soap and water.
   D. During annual performance reviews, feedback should be provided about hand hygiene compliance.

11. Which is in compliance with the staffing effectiveness standards from the Joint Commission, according to Karen Holtz, performance improvement specialist?
   A. Staff turnover has no direct relationship with the facility's bottom line.
   B. Data should be trended to identify any correlation between human resource and clinical indicators.
   C. Department-specific indicators should not be used.
   D. There is a decreased emphasis on drill-down data.

12. Which of the following is now required by the Joint Commission regarding core performance measures?
   A. You are required to track data for three core performance measures.
   B. Most facilities only are required to gather data for a single set of performance measures.
   C. The core measure sets will be changed on an annual basis.
   D. All facilities will be required to trend data for acute myocardial infarction.

Answer Key: 9. B; 10. D; 11. B; 12. A

Let's look at an example. The quality department has been asked to solve a problem that is loosely defined as overuse of potentially confusing abbreviations in patient records. A team of physicians, nurses, and other clinicians who document in patient charts is formed. After conducting two meetings, the team defines the goal of the project: *Develop a list of abbreviations approved for use in patient records by Feb. 1.*

The team spends considerable time researching medical abbreviations and obtains lists of approved abbreviations used by other hospitals. They work hard and meet their deadline. The list of approved abbreviations is circulated to the medical staff, nursing, and other clinical departments. The team celebrates and disbands — they completed their task and all is well, right?

Wrong. The problem was that no actual change in practice took place. When departments received the list of approved abbreviations, it probably received some attention from the director and a small percentage of physicians and staff members. But within days, the urgency diminished and the outcome (no use of unacceptable abbreviations) was not satisfactory. Another high-activity project with negligible results!

Results-oriented goals

What went wrong in the abbreviation project? The process for sharing the approved abbreviation list was weak, and unfortunately, the activity of creating the list did not address the flaws in the process that allows for use of nonapproved abbreviations. What the team should have done differently was to dig into the cause of the problem and define results-oriented goals.

The team should have measured the scope of the problem by examining existing practices. How does information get documented in the patient's chart? What disciplines are responsible for the majority of ambiguous abbreviations? What will motivate people to change their long-standing abbreviation habits? Who will approach people and ask them to rewrite the chart note or order when a nonapproved abbreviation is used? Who is best qualified to discuss the patient safety concerns associated with abbreviations with medical staff and hospital departments? What format would be most effective for sharing the list of approved abbreviations? How will compliance with the new abbreviation requirements be measured?

Once these questions are addressed, the team can construct results-oriented goals. In this example, it could have been: *By Feb. 1, share information about the safety hazards associated with abbreviations with 100% of physicians and staff members who write in patient records. By March 31, identify acceptable abbreviations and those not considered appropriate. By April 30, 100% of physicians and staff members who write in charts will receive education in the use of acceptable abbreviations. Decrease the use of nonapproved abbreviations to zero by June 1.*

Notice the difference between the results-oriented goals and the original activity-focused goal formulated by the team?

Creating a list of approved abbreviations is nothing more than an activity. It is not a quality result. It does not ensure that any improvement will occur after the action is implemented. That's not to say that a list of approved record abbreviations is the wrong thing to do. In fact, such a list is a common starting point for this type of QI project. But creation of the list is an *enabling step* toward the result, not the result. Often people become so engrossed in the activity that they lose sight of its purpose or they ignore new facts that affect the end result of the project.

The activity trap is prevalent in health care organizations. Think about how many QI projects you have with goals like this: Create a database; make a recommendation; conduct a survey; provide training. These are all activity goals. They may be enablers to results, but they are often so disconnected from a real quality result that the effect is never felt. All of these activities keep QI project teams busy; however, they use up resources and can end up accomplishing very little.

Sometimes, focusing on an activity is safer than tackling the real problems that are driving the quality concerns. Teams may need an extra

push from leadership to become results driven. Right from the outset of the project, you may sense some confusion among participants when the goal is discussed. There may be lots of dialogue around the subject because everyone on the team has something to contribute; however, the group may end up being unclear as to what it actually is trying to accomplish. Teams can lose focus or enthusiasm when this happens.

To keep the team on track toward results, one very helpful technique is to ask the question: *In your own words, what is the problem we are trying to solve?* Ask the team members to take a few minutes silently and independently to write their answers on a piece of paper. Then ask each participant in turn to read his or her response to the full team. Amazingly, answers often vary widely or may even conflict. In some situations, people may indicate that they have no idea what the problem is that the team is trying to solve.

This questioning technique allows the team leader to address potential roadblocks up front. The QI project should not proceed until the team is able to develop a clear statement of the problem that makes sense to everyone. This keeps team members focused on mutually agreed upon results. A clear problem statement eliminates ambiguity and misunderstandings.

Once the problem statement is formulated, ask team members: *What will happen if we don't solve this problem now?* The answers to this question will allow the group to judge the problem's priority level.

If the consequence of not solving the problem is a potential loss of revenue or increased likelihood of patient harm, it should be viewed as a high-priority problem. If, however, solving the problem would not have a significant impact on financial or clinical outcomes, it may be difficult to garner sustained enthusiasm from the team members. Instead of tackling a low-priority problem, ask the team to redefine the challenge until everyone agrees that it makes sense to fix it now. When the QI project team is committed to a purpose, everyone's eagerness to resolve the problem grows rather than diminishes.

When organizations fall into the activity trap, many quality problems don't get completely resolved, and some even get worse. The activity trap kills motivation for continual improvement activities. To stay out of this trap, be sure QI project teams focus on results, not activities, and share the same sense of clarity, urgency, and enthusiasm around a quality problem. ■

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