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Effective strategies to comply with Joint Commission's universal protocol

Is your plan to avoid surgical mistakes really foolproof?

It's every quality manager's worst nightmare: Your facility is the lead story on tonight's news because the wrong person was operated on. "These days, if you operate on the wrong patient or do the wrong procedure, you're going to be on the front page of the newspaper," warns **DeNene G. Cofield**, RN, BSN, CNOR, administrative director of surgical services at Medical Center East in Birmingham, AL.

To address this, the Joint Commission on Accreditation of Healthcare Organizations has approved a "Universal Protocol for Preventing Wrong-Site, Wrong-Procedure, and Wrong-Person Surgery." The requirement, which applies to all surgical and invasive procedures, becomes effective July 2004.

Above all, the key to preventing surgical mistakes is to implement a team approach, says **Jodi L. Eisenberg**, CPHQ, CMSC, coordinator for accreditation and licensure for quality strategies at Northwestern Memorial Hospital in Chicago. "No one person can take this responsibility," she says. "A policy and procedure must be put into place that is followed consistently by all of the team members."

For quality managers, one of the best ways to help perioperative services comply is to share actual examples of near misses and sentinel events, Eisenberg suggests. "Everyone thinks, 'It won't happen to me.' But it continues to happen."

Your No. 1 priority is to bring home the importance of this to every staff member, Cofield says. As a result, the universal protocol requirements now are included in general orientation for nursing and hospital staff and are continually reviewed at staff meetings. "One thing we learned is that a one-time inservice doesn't cut it," she says. "If leaders aren't constantly talking about safety, then the staff are, perhaps, going to let it become a second-level concern."

Initially, some physicians were reluctant to participate in the universal protocol's requirements, Cofield acknowledges. "There was a general lack of knowledge about the true intent of the protocol. We addressed that with education," she says. "There is nothing like knowledge-based information."

By and large, medical staff have been very supportive, with the exception of a few who ultimately were won over, she reports. This was accomplished by discussing patient safety at every medical staff, committee, and professional meeting, Cofield explains.

Media stories and published studies are brought to light, to underscore the reality of the problem, she adds. "I think it helps everyone to appreciate the prevalence of issues occurring. With that understanding comes better compliance."

The biggest obstacle to implementing the universal protocol is lack of urgency on the part of physicians and staff, says **Christy Dempsey**, BSN, CNOR, director of perioperative services at St. John's Regional Health Center in Springfield, MO. "Most surgeons don't think this is a problem until it becomes one," she says.

To address this, she recommends role-playing exercises to demonstrate the consequences of not following the safety measures, and the devastation it can cause to patients. A recent scenario involved a fire in the OR caused by a staff member's placing a Bovie holster on drapes, which caught on fire. Staff were used as actors playing the patient, first scrub, assistant, anesthesia, and circulator.

"Staff learned the details of evacuation and were able to put the policy into action; so that if this were to ever happen, they know exactly what their responsibility is: Who shuts off the gases; what do we do with the wound; how do we actually evacuate the room; who notifies the fire department," she says. "These are things that are probably in every policy book out there. But when it's actually demonstrated live, it makes a much more lasting impression."

To measure compliance, real-time monitoring is the most optimal, Eisenberg says. She recommends retrospective review of the following:

- percentage of films taken without sides marked with lead markers;
- percentage of sites marked by patient (or by caregiver);
- percentage of preoperative checklists completed;
- percentage of time-outs prior to incision;
- percentage side/site noted correctly on consent;
- "Left" and "right" are spelled out in medical record documentation (pre-, during, and post-procedure), and all are in agreement.

Here are requirements of JCAHO's universal protocol and effective strategies for each:

1. **Preoperative verification process**. Nurses go through a preoperative checklist before the patient is taken to the operating room, Cofield says. "This is a process where we are reconciling the findings and results of all aspects of the chart," she explains.
2. **Marking of the operative site.** Convey to patients that their help is needed with the surgical process, Dempsey advises. "It's important and recommended by JCAHO that patients and their surgeon actually do the marking," she says. "We have the patient mark the site preoperatively."

To ensure that all patients are marked, there is ongoing monitoring in the holding area for both inpatients and morning admission patients, says Cofield. "If patients haven't been marked prior to getting to the operating room, we are following up on each of those incidents," she says.

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Editorial Questions

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Currently, the facility is considering how to handle patients who refuse site markings, says Cofield. "We've had a surgical site marking policy since the mid-1990s and never had a patient refuse, but we're in dialogue right now about what our policy would be if a patient did refuse," she explains.

In this scenario, the best strategy would be a bedside consult to occur with the physicians and the staff performing the procedure, so everyone in the room understands where the surgical site is located and what the patient's reluctance to being marked is, she suggests.

The facility has made an "interpretive exception" to following the universal protocol to the letter, notes Cofield, referring to the requirement that the person performing the procedure do the actual marking. This just isn't feasible, she explains.

This is because so many processes are occurring simultaneously to get the patient ready for surgery, she explains, making it impossible for the surgeon in the OR to do the marking.

Instead, a nurse does the marking with the patient or designated family representative. If a family member isn't available, two nurses verify the site and do the marking after they have reconciled the consent and the X-rays with the history and physical in the chart.

For spine marking, the staff and patient verbalize what part of the spine they are having surgery on, and mark "yes" at either the cervical, thoracic, or lumbar spine area, and the physician uses the North American Spine Society protocol for determining the specific level floroscopically.

For patients with dark skin, you'll need a different-colored marker so the word "yes" is clearly visible, notes Cofield. "We had to try a variety of different markers to find some that would show up. We now use a red Sharpie for dark skin."

3. **Taking a timeout immediately before the procedure**. This is monitored in two different ways, says Cofield. "We have found that just chart review alone isn't enough, so we are also doing direct observation and quality control checks," she says.

   The facility's staff development coordinator monitors procedures using a checklist, to ensure that staff are adhering to sterile technique during the prepping and draping process, and that surgical timeout occurred at a standardized time and included all members of the surgical team, including the physician, anesthesiologist and the nursing staff, and that this is documented, Cofield says.

   Staff are surveyed as to whether they actually are implementing the surgical timeout, and whether they are encountering any reluctance or backlash from other members of the health care team, Cofield says.

   The first survey included just the OR staff, whereas a second survey was sent to the staff in the morning admission area in addition to the OR, she says. "A third survey will include the nursing staff on floor," says Cofield. "We are really trying to reach outside the operating room."

   The following steps are taken for the surgical timeout before a procedure occurs:

   — The patient's X-rays are placed on the view box, and the patient's chart is opened to the consent form.

   — When the nurse finishes preparing the patient, the timeout occurs when the surgeon and anesthesiologist both are in the room.

   — The nurse verifies the site marking is there, reads the name of the patient and the procedure, and holds the consent up for everyone in the room to acknowledge.

   — Nurses document that the timeout has occurred.

4. **Adaptation of the requirements to nonoperating room settings, including bedside procedures.** The timeout process is adapted for bedside procedures by keeping a copy of the chart and consent at the bedside, Cofield says. "Those procedures may not have an X-ray, so the process is to mark the site with the patient, and verbalize the patient's name and procedure with the surgeon present," she says.

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Are you ready for your first unannounced survey?

Get a jump-start on continuous preparedness

Although unannounced surveys from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) haven't begun yet, one thing is clear: Surveyors will be looking for a true culture change at your facility, resulting in a constant state of readiness. Since this change can't occur overnight, you should be actively preparing now, says **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting, based in Metamora, MI.

"The No. 1 challenge is being truly committed to changing systems and processes, as opposed to just getting ready for JCAHO," she says. "Leadership and the quality staff need to be committed to that culture."

The main challenge now is to educate staff on the new survey process, says **Mary M. Owen**, RN, MPA, director of outcomes case management at University of California, Irvine Medical Center in Orange. "We are preparing staff for ongoing readiness and telling them to forget worrying about when JCAHO is coming, because we won't know in the near future!" she says. "We'll be surveyed in January 2004 — the first ones to experience the new process."

Your main goal should be to allocate resources to design for more effective systems, Homa-Lowry says. "If your systems and processes are running smoothly, then accreditation should be a by-product of that," she says. "If done appropriately, leadership would probably have less work and be able to cut down on committees and task forces measuring things that aren't meaningful."

Here are some effective strategies:

- **Give employees and physicians clear goals, and measure improvement**.

Each year, one of the facility's incentive goals pertains to quality, Owen says. "In the past, the measure of our success of this goal was based on either the score from an actual survey or the use of consultants or score 100," she says.

Since they won't receive a score next year, the measures have changed to the following:

— a successful survey (*i.e.*, accreditation);

— measurement of compliance with three key national patient safety goals of patient identification, verbal order read-back, and hand hygiene measures. A survey tool was created to measure compliance with these patient safety goals.

This has been very successful, with more than 400 surveys turned in for the baseline measurement this quarter, says Owen. "We plan to use the same team to measure each quarter, with success at the end of the year based on percent improvement from the baseline," she explains.

- **Conduct weekly patient tracer rounds.**

In preparation for the facility's January 2004 survey, a project timeline was developed to ready the staff to comply with the new patient tracer methodology, Owen says. "And this year, we're doing it without consultants," she adds.

To educate employees and physicians about the new tracer methodology in short order, weekly patient tracer rounds are being conducted by a senior leader, an infection control nurse, and a performance improvement project manager. At the beginning of the week, an in-house patient is selected for the tracer, and sample questions are developed to assist the team in the process.

The team works through the entire continuum of care, including everywhere the patient has been and where the patient potentially may go. **(For some of the questions asked, see p. 153.)**

A recently selected patient was a burn patient, so the team started in the emergency department with the trauma call process, and followed through to the facility's burn clinic, where the patient was anticipated to receive follow-up care.

"We attempt to cover the patient safety goals in the questions so we can continue to educate the staff," says Owen. "We make it realistic, yet also fun, so everyone enjoys the process."

- **Make sure departments truly are collaborating**.

If you take a global approach to preparedness, you can see where the breakdowns are occurring, Homa-Lowry explains.

She says that potential problems can occur when you assume that other departments are doing their job. For example, a nurse manager on a unit may assume that biomed is checking the equipment. "But sometimes they don't actually give a report of the fact that the equipment is being checked. Or if they do, their particular unit is buried in a massive report and isn't specific to the unit," Homa-Lowry says.

At times, even if it is specific to their unit, staff don't literally spot check pieces of equipment to be sure that the process is working, she adds.

There still are people operating only within their own department, and not collaborating with other departments to make sure the system goes

smoothly, Homa-Lowry says.

"If dietary are the ones to check the refrigerators, does nursing get an ongoing report? Or does dietary ever sit down to talk about when things are missed or out of range?" she asks.

Sometimes, quality control data are not centrally recorded, "That may not be a routine part of the reporting structure," Homa-Lowry says. "Sometimes, the data are not reported until they get to the quality council, instead of the two departments sitting down with one another to try and fix the process."

Some organizations still have the quality staff primarily supporting the medical staff issues, while ancillary support services are left to their own evaluation and monitoring, she says. "Whoever is heading up quality needs to make sure there are a good flow of the operational issues in the organization, with important department issues and medical staff issues."

- **Include unit staff in data collection processes.**

If you notice that the infection rate for a given area is increasing, it may be dealt with by the infection control committee and members of the medical staff, Homa-Lowry says. "But when does it actually get down to the nurse unit level, and how are the staff nurses trained in data collection and doing follow-up monitoring to ensure compliance?" she asks.

Your organization may have good management information capabilities to collect data, but unit staff have to be trained in defining measures and collecting data and sampling methodology, Homa-Lowry says. "Without this, it can be difficult to really do adequate analysis. The people at the bedside know much better what the impact is, operationally."

Many times, they inherit the data, but they have no chance to collect their own data, analyze it, or take corrective action, she explains. In some departments such as nursing, it also may be a result of staffing storage, Homa-Lowry notes.

Sample Survey Questions

Questions for Admissions

- ✔ What information typically is provided to the patient before and upon arrival?
- ✔ What do you tell the patient about his or her rights and responsibilities?
- ✔ What is the process for advanced directives?
- ✔ What happens if the patient doesn't speak English?
- ✔ Do you put an identification band on the patient?
- ✔ How do you check that you are putting the right band on the right patient?

Questions for Preoperative Staff

- ✔ When and how are the risks and benefits of the procedure explained to the patient?
- ✔ What documents would you review prior to surgery?
- ✔ What labs would you check?
- ✔ What would you do if something was missing?
- ✔ Do you do any preoperative teaching?
- ✔ Who consents the patient and how?
- ✔ What medications are given to the patient and how are they documented?
- ✔ How is the skin prepped?
- ✔ Are antibiotics given? When?

Questions for OR Staff

- ✔ How do you make sure that the right patient gets the right procedure?
- ✔ Explain the process prior to surgery?
- ✔ Where are the medications given preoperatively documented?
- ✔ What monitors would you be using in this type of surgery?
- ✔ How do you test these monitors?
- ✔ Would you use blood products with this patient? If so, how does that process work?
- ✔ What is your most common infection?
- ✔ What do you do to prevent infections?
- ✔ How is the skin prepped?
- ✔ Are antibiotics given? When?
- ✔ Are you aware of any performance efforts involving the OR?
- ✔ How do you know that the physician is capable of performing this particular procedure?
- ✔ How do you verify counts?
- ✔ What, if any, medication was drawn up before this surgery? Explain how this medication is treated.
- ✔ What happens to the organ?
- ✔ Do you sign the patient out?

Questions for Recovery Staff

- ✔ How is the patient transferred to the recovery room?
- ✔ How is the patient assessed and monitored?
- ✔ What teaching occurs in the recovery room?
- ✔ How do you know what medications the patient received postoperatively and during the operation?
- ✔ How do you assess and manage pain?
- ✔ How do you make sure the right patient gets the right medication?
- ✔ When is the patient transferred to the unit?
- ✔ How does that transfer happen?
- ✔ Who communicates with whom on the unit?

Source: University of California, Irvine Medical Center, Orange.

- **Compare policies and procedures with actual practice**.

"It may be enlightening to look at what you have in the books vs. what you actually have in practice," says Homa-Lowry. She recommends looking at what Joint Commission surveyors have asked you to look at in open and closed medical records, and comparing those requirements with their own policies and procedures to see if they are consistent, and if they really are being executed in an interdisciplinary manner.

For example, you may have an organizational policy for restraint with a nursing component that has not included the other disciplines, says Homa-Lowry. "Where is the physician monitoring and evaluation, where is the feedback to medical staff on restraint issues other than to a quality committee? And what is the training level in radiology or respiratory for staff who are actually working with those patients?" she asks.

"What you need to do is look at the patient, and identify all the people who would touch that patient as they move through the system," she says. "This may include admitting and other disciplines, depending on what is happening with the patient." Staff also need feedback on monitoring, says Homa-Lowry. "For example, restraint monitoring tends to go back to nursing because nursing are the ones that usually implement it, but appropriate medical staff and ancillary staff need to hear about it too."

- **Spend more time in patient care units.**

"I don't know how many quality coordinators actually make it a point to go into departments and patient care units," Homa-Lowry says. "People need to be visible."

She recommends spending at least a half-day in the departments you are responsible for working with, to develop more of an appreciation for how the department systems run and what the major issues are, and in addition, having a monthly face-to-face meeting.

Units need feedback when they do send reports out, with an emphasis on how it affects patient care, she recommends. "Ask, 'How do safe quality measures impact patient care?'" she says. "People in health care are concerned about the patients, and that is what they want feedback on."

The measures you write should affect patient care directly, says Homa-Lowry. "When you begin to do that, staff become more motivated, especially if data are specific to their unit or population, and get feedback on how they are doing, and you talk with them about how they are doing."

You also should make the effort to come in on off-shifts and weekends, Homa-Lowry advises. "The staff really appreciate it when you take time to sit and talk with them about how things work," she says. "Maybe a system works really well on the day shift, but how does it work at night? That is when you really start to make it a 24/7 systematic process."

Encourage networking to facilitate data collection on the units, Homa-Lowry recommends. "If somebody says, 'I don't know how to do this,' or asks, 'Where can I get this?' you can help them. If you know where all the data sources are, it can save people from having to collect all or part of it. That makes their lives easier."

Even within nursing, units may have very different issues, such as infection rates rising only on one or two units, she says. "Why involve all the units that are doing it OK, including everybody, if it's not applicable to their area?" asks Homa-Lowry.

"It takes more time to plan and develop programs that are specific to particular units, departments, and disciplines, but it is a good way to reinforce the culture change," she adds.

[For more information about motivating staff for continuous preparedness, contact:

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Are you complying with CMS' new PI standards?

How to make sure your bases are covered

You probably are keenly aware of the need to comply with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements for performance improvement.

But are you in compliance with new performance improvement standards from the Centers for Medicare & Medicaid Services (CMS)?

The standards, which took effect March 25, 2003, require that you collect and compare data to assess performance improvements in key areas, including adverse patient events, the reduction of medical errors, and hospital operations.

CMS does separate random surveys to validate that there are not vast inconsistencies with JCAHO findings, explains **Michelle H. Pelling**, MBA, RN, president of the Newberg, OR-based health care consulting firm The ProPell Group.

"This supports continuation of deemed status," she points out.

Or, a facility could also undergo a full separate CMS survey because follow-up on a complaint indicated that there may be significant other issues that would require investigation and correction, Pelling adds.

If your facility does have a separate CMS survey, you will be evaluated using the CMS requirements, she says. "Most of them are the same as JCAHO, but there are a few variances."

For example, the requirement for "the hospital to measure, analyze, and track quality indicators including adverse patient events, processes of care, and hospital service and operations" is not significantly different from what JCAHO requires. CMS uses the word "improved health outcomes" whereas JCAHO uses the words "processes and performance" to a greater extent.

Both CMS and JCAHO require the prevention, identification and reduction of medical errors, Pelling explains.

"However, there are some differences in the language of the requirements," she says. "They are more prescriptive in some sections, and there are some slight differences." Here are the key differences in the requirements:

- **CMS requires that the "frequency and detail of the data collection must be specified by the hospital's governing body."**

This is clearly greater involvement than most boards engage in, Pelling says. "Organizations should be careful not to pull the board into micromanaging their projects."

This requirement can be met by preparing the documents that specify the detail and frequency of data collection and putting them in front of the board for discussion and approval, with some explanation provided by the performance improvement coordinator, she says.

- **CMS requires that "the number and scope of distinct improvement projects annually must be proportional to the scope and complexity of the hospital's services and operations."**

No numbers will be quoted, but this is not that different from JCAHO's position, says Pelling, indicating that a 100-bed hospital with limited services would not be expected to engage in the same number or scope of projects conducted by a 500-bed tertiary hospital.

"The actual number and complexity is a judgment call to be made by hospital leaders and performance improvement professionals," she says.

- **CMS requires the hospital to determine "the number of distinct improvement projects annually," which is much more specific than JCAHO.**

However, this requirement is not without merit, Pelling argues. "It requires leaders to do better planning and think through how many projects are reasonable, in light of their resources," she says.

These include facilitators, clerical staff, and operational staff time to participate, considering other hospital initiatives, Pelling explains.

"Leaders should consider establishing a conservative number of projects," she says.

There always is the opportunity to add additional projects if leaders are presented with urgent or unexpected circumstances that require attention within the year, Pelling says.

CMS requires that "the hospital must document what quality improvement projects are being conducted, the reason for conducting these projects, and the measurable progress achieved on these projects."

Again, this is more specific than the JCAHO standards, Pelling says.

"However, it makes sense and holds the hospital leaders accountable — for both establishing projects based on sound rationale, and paying attention to how the projects are progressing," she says.

It is essentially a documentation requirement, and easily can be complied with using **a chart such as the one at left**, Pelling adds.

[For more information on the CMS performance improvement standards, contact:

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QI Project	Rationale	Progress to Date

Foolproof ways to improve physician handwriting

Process at medical center impresses JCAHO

During a recent Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey at Regional Medical Center of Orangeburg (SC) and Calhoun Counties, surveyors were very impressed with the process developed to assess and improve physician handwriting, reports **Indun Whetsell**, the facility's director of quality management.

"We have done a lot in this area," she says. "Some physicians were very unhappy about the changes we made, but the Joint Commission was very pleased. It's not an easy thing to do, and we did incur some wrath, but it's very much worth it."

Here are some effective ways to improve physician handwriting:

- **Perform random audits**.

"We are addressing physician legibility full force," says **Larry Dunham**, RHIA, director of health information management at Baylor University Medical Center in Dallas. He explains that physicians are subject to "legibility audits," which are done by random selection.

"Our goal is to review each of our active medical staff members within the year, which is aggressive based on our size," says Dunham.

Pharmacy has teamed up with health information management to screen 100% of all orders for legibility, he adds.

Illegible orders are clarified with the physician prior to any order being carried out related to medication administration, Dunham says. "All cases that they deem illegible are routed to us for further review and investigation."

The following criteria for medication orders are used:

1. Name, dose, route, frequency included?
2. Order legible?
3. Order signed?
4. Signature legible and/or transcription (physician) number included?
5. Date included?
6. Are abbreviations used? And if so, are they approved?

Health information management pulls the records, and the facility's Center for Quality Care Coordination reviews them clinically to determine the impact on patient care, if any, Dunham says.

Regardless of whether the review is positive or negative, each physician receives a letter from the hospital's chief of staff, he says. Physicians who have met all the criteria are alerted that their records were reviewed and found to be in good order. If a physician doesn't meet the criteria, he or she receives a letter stating the findings and that the findings will result in further review.

- **Have physicians use ID numbers with their signatures.**

Physicians are encouraged to use their hospital-assigned identification numbers alongside their signatures for written orders, says Whetsell.

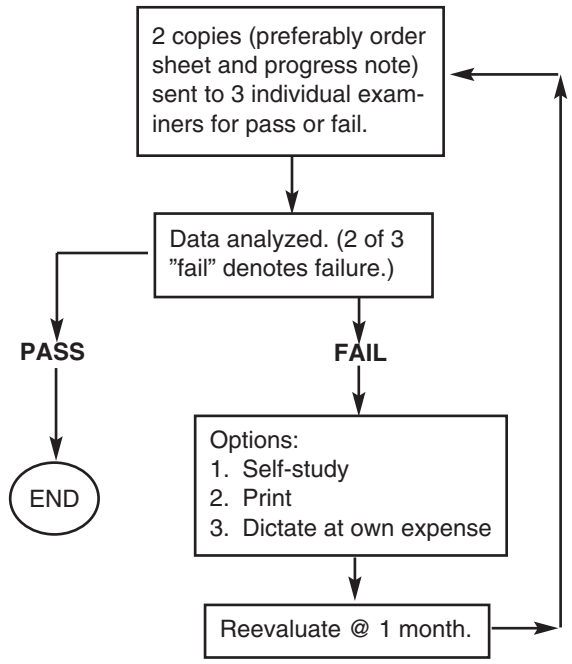
"We made copies of many doctor's signatures and handed them out at the medical staff meeting — where they couldn't read the names either!" she says. "This was a great visual aid."

- **Send samples to be graded by anonymous reviewers**.

At Regional Medical Center, handwriting samples were taken for all members of the medical staff, and copies were sent to three anonymous reviewers, consisting of a physician, nurse, and medical records director, to be graded on a "pass" or "fail" basis. **(See Handwriting Analysis Flowchart, below.)**

If the physician is failed by two or more reviewers, they are given the options of taking a remedial course, printing all orders, or dictating at their own expense, says Whetsell, who adds that handwriting

Handwriting Analysis Flowchart



Source: The Regional Medical Center of Orangeburg (SC) & Calhoun Counties.

is reevaluated every six months for all physicians. "This has made a huge difference in some physicians' handwriting," she says.

- **Routinely monitor compliance with the medical staff's handwriting policies.**

The monitoring of medical records is completed quarterly as part of the hospital's multidisciplinary chart reviews, Dunham adds.

Retrospective review also is done and is trended by physician to monitor any ongoing issues, he says. Physicians are notified to let them know that their documentation was screened and was secondarily reviewed for quality issues. If no problems are identified, the physicians are notified of this and informed that review will continue, along with ongoing education on legibility requirements.

- **Take action when a physician repeatedly fails to comply with the legibility requirements.**

If the physician fails, he or she is notified that further review will take place, Dunham says. "We also educate them on what we are looking for, and what the penalties may be if they do not show marked improvement."

If no improvement is, penalties include:

— Physician must pay for transcription of all notation.

— Physician must take handwriting course work.

— Physician must pay for scribes to make readable notations.

"If marked improvements are not seen through these means, the physician will be removed from the medical staff and will lose all privileges to care for patients at this facility," Dunham says. ■

THE QUALITY - CO$T CONNECTION

Review resuscitation and outcomes

Address data collection, improvement challenges

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

In response to recommendations from the American Heart Association (AHA), in 1999 the Joint Commission on Accreditation of Healthcare Organizations added a requirement for review of cardiopulmonary resuscitation (CPR) to the hospital performance improvement standard. In 2004, this requirement is found in Standard PI.1.10 — the organization collects data to monitor its performance. Although the requirement has been around for several years, hospitals still encounter data collection and improvement challenges. While the standards do not specify exact data collection and reporting requirements, the greatest benefit can be gained from reviewing all key aspects of CPR as well as the outcomes.

By analyzing resuscitation processes and outcomes, the health care team can identify improvement opportunities. In addition, areas of potential liability risk can be identified and corrected. For example, noncompliance with approved advanced cardiac life support (ACLS) protocols and/or failure to initiate early defibrillation could pose a liability risk to the facility. The International Liaison Com-mittee on Resuscitation recommends that resuscitation personnel be authorized, trained, equipped, and directed to operate an automated external defibrillator if their professional duties require them to respond to persons in cardiac arrest. This recommendation includes all first-responding medical personnel, whether physicians or nurses.

Several key clinical issues can be evaluated in the management of cardiopulmonary arrest. The first is airway management. Are intubations successful? How often is bag/mask ventilation required after failed intubations? If mask ventilation is not successful, are rescue procedures such as cricothyrotomy or laryngeal mask airway used? Once the airway is secure, is the adequacy of the patient's ventilation assessed? Be sure to regularly monitor how quickly defibrillation is initiated (delays are frequent allegations in liability claims). Evaluate whether the drugs and dosages used are consistent with AHA guidelines. Once the patient has been stabilized, appropriate post-resuscitation management should be provided. Disease-specific treatment should be started. Evaluating how patients are managed post-resuscitation can be a part of the medical staff CPR review process.

Evaluations of CPR events should include an analysis of the conditions that may have caused the patient to arrest. Myocardial infarction, pulmonary embolism, hypovolemic shock, drug overdose, metabolic acidosis, and hypothermia are common

causes of a cardiac arrest. Often, review of CPR cases primarily focuses on what happened when the patient was found to be in cardiac arrest; however, an important factor to consider is what precipitated the arrest and how it could have been prevented. A research team in England found that in-hospital unexpected cardiac arrests usually are preceded by signs of clinical instability characterized by deterioration in the patient's airway, circulation, or respiratory system for at least one hour before their cardiac arrest.[1] Clinicians at this hospital were able to decrease the incidence of cardiac arrests by creating a medical emergency team that intervenes when patients meet predefined clinical criteria such as:

- Respiratory rate > 30/minute
- Respiratory rate < 6/minute
- SaO_2 < 90% on oxygen
- Blood pressure < 90 mmHg despite treatment
- Pulse rate > 130/minute
- Repeated or prolonged seizures

The addition of the medical emergency team as a pre-emptive response team to manage these patients resulted in a 50% reduction in the incidence of unexpected cardiac arrests.

Hospitals should have established policies and procedures governing CPR. According to the AHA, recertification of basic life support (BLS) and advanced cardiac life support is recommended every two years. Be sure that employees in your facility have properly maintained certifications. Many hospitals have incorporate automated external defibrillator training into their BLS courses.

Caregivers should respond quickly to a cardiac arrest victim and assess the patient's status. The likelihood of survival to hospital discharge doubles if CPR is administered within four minutes of collapse. Every person who provides direct patient care must be familiar with the cardiac arrest procedure and how to initiate the code team. Nurses and technicians should know where emergency equipment (*e.g.*, oxygen, suction, defibrillator/ECG unit, and code cart) is located in their department. Review of CPR cases could include an evaluation of the timeliness of switchboard operator contact, initiation of CPR, and arrival of the code team.

All hospitals have a designated code team of specially trained nurses, respiratory therapists, anesthesia personnel, and physicians who are expected to respond to codes immediately. A crash cart may be brought to the scene of the code if one is not already available. The crash cart contains emergency equipment, medications, and intravenous supplies and solutions. CPR evaluation should include an assessment of the response time by the code team and any issues involving the crash cart that may have created problems for the code team (*e.g.*, missing supplies, outdated drugs, delay in arrival of cart).

In emergency situations, the outcome can depend on the cooperative actions of the code team and on quick decision making and actions. One factor that should be evaluated is the number of people at the scene. Too many people responding to the code can often lead to disorder and diffusion of responsibility. Researchers recommend that one physician, knowledgeable about cardiac resuscitation, should take the lead and assign tasks related to the resuscitation to team members. The lead physician should direct the resuscitation process and make the clinical decisions without directly performing procedures whenever possible. The

CE *questions*

17. Which of the following is recommended to comply with JCAHO's universal protocol?
    A. giving staff a one-time inservice
    B. discussing media stories and published studies about real incidents
    C. using chart review alone to monitor compliance with surgical timeout
    D. having only nurses mark the surgical site
18. What is true regarding preparation for the switch to unannounced surveys?
    A. Organizational policies for restraint only need to address nursing, not medical staff or radiology.
    B. Staff nurses do not require training in data collection or quality measures.
    C. Conducting weekly patient tracer rounds is effective staff education.
    D. If infection rates increase for a particular nursing unit, you should involve all nursing units.
19. Which is accurate regarding the new performance improvement standards from the CMS?
    A. No random surveys are ever conducted.
    B. Joint Commission performance improvement standards are more lenient.
    C. The required number and scope of performance improvement projects is the same for every facility.
    D. Facilities are required to determine the number of annual performance improvement projects.
20. Which of the following is recommended to improve legibility of physician handwriting?
    A. Legibility should be assessed only after a complaint occurs.
    B. Audits should be conducted by random selection.
    C. Compliance should be optional for members of the medical staff.
    D. If there is a problem with legibility, the facility should pay for scribes or transcription.

Answer Key: 17. B; 18. C; 19. D; 20. B

leader should involve team members in decision making by soliciting suggestions from team members and ensuring everyone is in agreement about a decision to stop the resuscitation attempt. The leader should facilitate a debriefing once resuscitation is completed/terminated so that everyone can learn from the experience. This debriefing should occur even though a multidisciplinary committee will review the event later. Insights gained during the immediate post-resuscitation discussion should be communicated to the committee respond for overseeing resuscitation practices in the hospital.

In most hospitals, crash carts are available on all nursing units and in specialized departments such as radiology, minor procedure, and outpatient respiratory and cardiac treatment centers. The crash cart should be checked routinely according to policy and restocked following a code. A nurse usually is responsible for making routine crash cart checks. If this responsibility is rotated among staff, people can stay familiar with what supplies are available on the crash cart. The cart check should include ensuring appropriate supplies are available, sterile, and within the expiration dates. All equipment is examined and tested for proper functioning. Staff should complete a checklist as they review the crash cart. The checklist helps to ensure that items won't be overlooked and provides documentation that the check was completed. In addition to the regular crash cart checks, clinical or bioengineering personnel should make periodic rounds to make sure the defibrillator/AED/pacer equipment is functioning properly. Compliance with these maintenance checks should be monitored.

Most hospitals have a committee that is responsible for developing policies and procedures for CPR training and equipment maintenance and conducting post-arrest evaluations. The committee includes physicians, anesthesiologists, critical care nurses, and respiratory therapists. To fulfill their responsibilities, the committee should receive regular performance reports covering the key aspects of resuscitation, including compliance with policies and procedures and CPR survival rates. In some hospitals, this committee also is responsible for evaluating the physician aspects of care. In other hospitals, these issues are identified by the multidisciplinary committee and referred to one of the medical staff peer review committees for more in-depth evaluation.

The second part of this article covers the data-collection aspects of CPR evaluation and performance measures that routinely can be assessed by the committee responsible for resuscitation review.

Reference

1. Buist MD, Moore GE, Bernard SA, et al. Effects of a medical emergency team on reduction of incidence of and mortality from unexpected cardiac arrests in hospital: Preliminary study. *BMJ* 2002; 324:387-390. ■

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h. Copies Not Distributed			211	136
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Patient safety offers new opportunities in quality field

You may need skills enhancement to advance

Long hours and steady salaries are current trends for health care quality managers, according to the latest *Hospital Peer Review* Salary Survey. Although opportunities abound for today's quality professionals, you may need additional skills to reap the benefits, say leaders in the field.

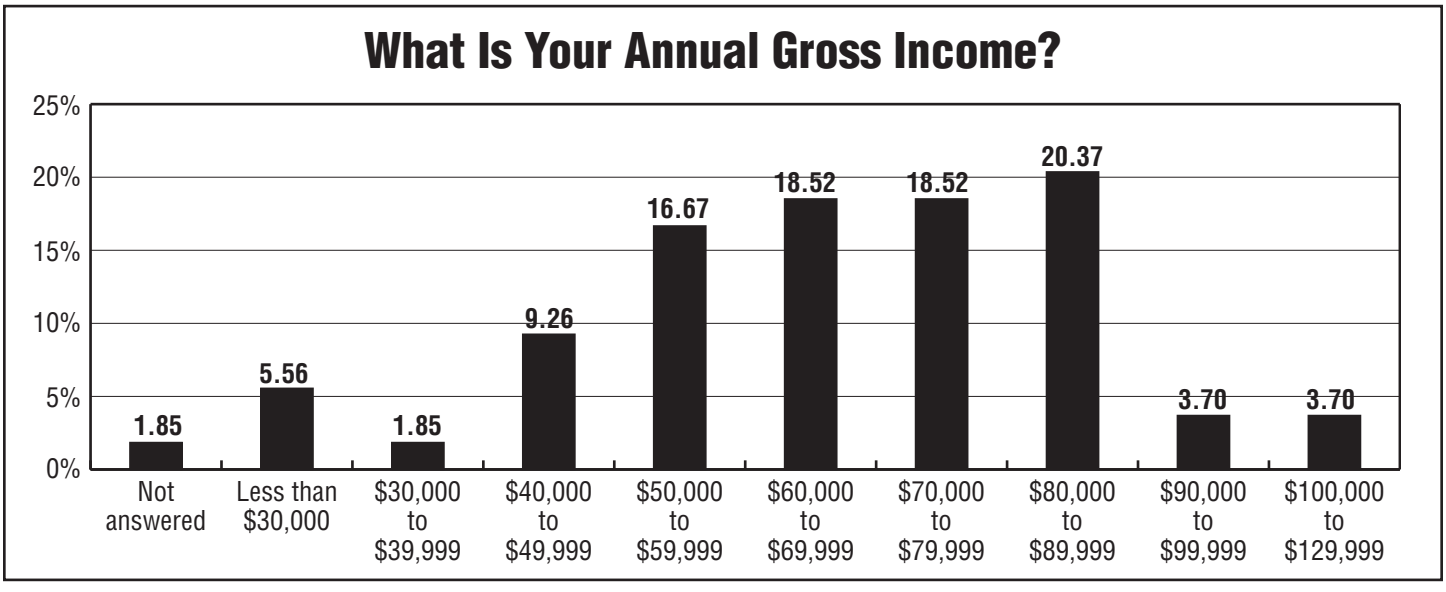
The 2003 *Hospital Peer Review* Salary Survey was mailed to readers in the June 2003 issue.

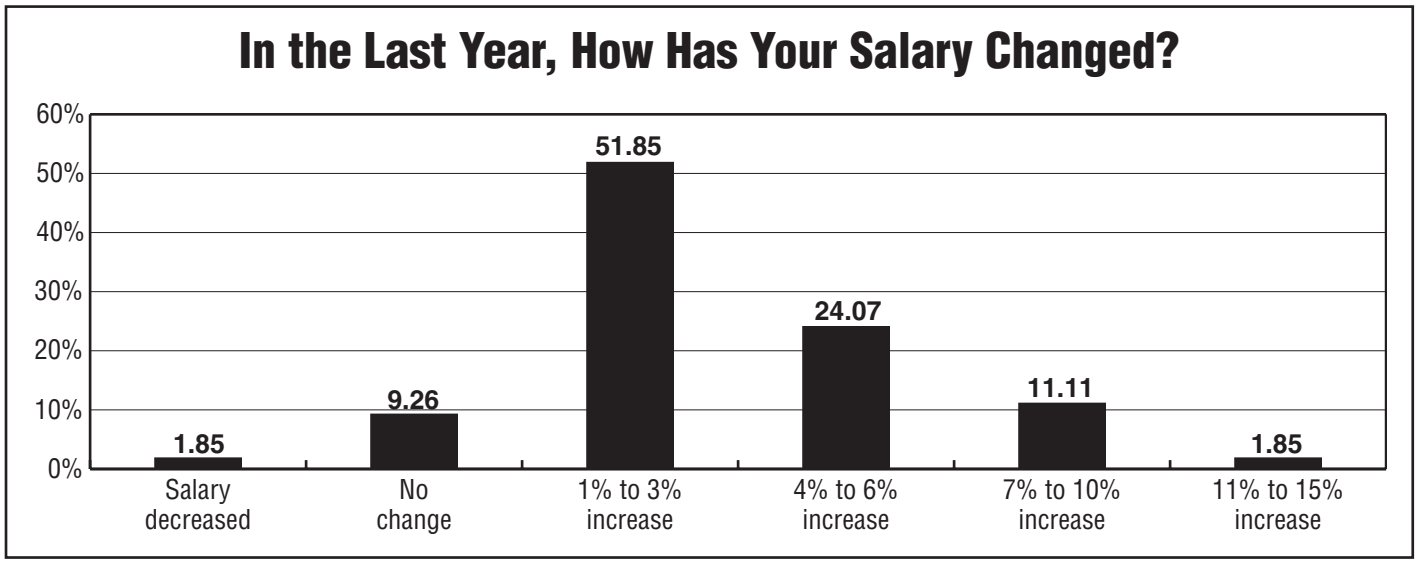
This year's results suggest that quality managers are making about the same as last year, with 17% reporting an annual gross income of $50,000 to $59,000, and 19% reporting an annual gross income of $60,000 to $69,000. Slightly more than half reported that their salary increased by 1% to 3%, 24% reported an increase of 4% to 6%, and 11% received a 7% to 10% increase.

Quality managers still are putting in long hours, with the vast majority of respondents (81%) working more than 40 hours a week. Twenty-two percent report that they work 41-45 hours a week, and 37% report that they work 46-50 hour a week. Another 22% report working more than 50 hours a week.

Patient safety is key role

More quality professionals are becoming organization vice presidents, and more organizations see the role as a key leader, regardless of title, says **Janet A. Brown**, RN, BSN, BA, CPHQ, FNAHQ,





president of JB Quality Solutions Inc., based in Pasadena, CA.

Since patient safety remains the key focus, Brown recommends fine-tuning skills involving prevention activities. These include use of proactive methodologies such as Failure Mode and Effects Analysis, developing facilitywide incident identification tools, and having close links with risk management, physicians, and infection control.

Your key goal is to foster a culture that informs patients of what they should expect of their care, such as hand washing, and of adverse events should they occur, Brown says. "However, safety is only one dimension of quality for which the professional may assume leadership, training, and/or organizing responsibility," she says.

The quality professional is the organization's advocate for continuing the quality focus, even though quality is everyone's job, Brown says.

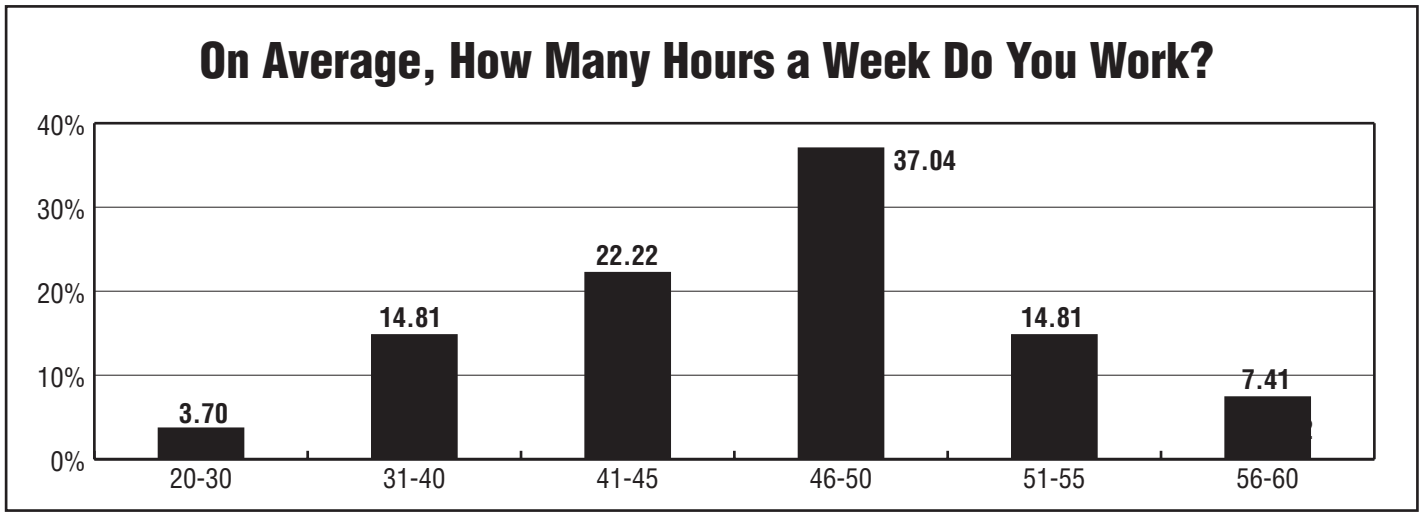
Quality remains in the forefront of the minds of consumer organizations such as the Leapfrog Group in Washington, DC and the Foundation for Accountability Portland, OR, she explains.

"It is the primary reason we tend to become responsible for assuring regulatory and accreditation compliance," says Brown.

As the field of knowledge and the need for that knowledge increases, quality professionals are moving from being "doers" to resources, says Brown. This means knowing where the information is, how to find and organize it, how to help interpret it for decision making, how to build and train teams, how to teach performance improvement processes, how to motivate, and how to market, she says.

Certification increasingly is an advantage, in both position and salary, adds Brown. "More employers prefer or require certification, and salaries are approximately $10,000 higher for quality professionals with the Certified Professional in Healthcare Quality [CPHQ]," she says.

The patient safety movement and the growing interest in Six Sigma offer quality managers new employment and advancement opportunities,



says **Fay A. Rozovsky**, JD, president of the Richmond, VA-based Rozovsky Group.

Both career paths demand a strong understanding of statistical control methods, Rozovsky says. Although you may understand the fundamentals, the tools found in Six Sigma and in epidemiology may take some skill enhancement, she says. "Course work in this area will be useful, especially course work with a focus on health care."

Another must is a thorough understanding of regulatory and accreditation requirements and clinical risk management related to creating a culture of safe patient care, Rozovsky says. She recommends using the Chicago-based American Society for Healthcare Risk Management as a resource.

The Glenview, IL-based National Association for Healthcare Quality is another good resource on the accreditation requirements, says Rozovsky.

Some quality managers are getting involved in organizationwide performance improvement initiatives, such as Six Sigma and rapid cycle improvement, says **Patrice L. Spath**, BA, RHIT, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates.

"This knowledge and experience raises the importance of the quality position within the organization, which is reflected in higher salaries and greater responsibilities," she says.

However, quality managers wishing to advance into these roles must gain additional skills, Spath says. She suggests taking "Black Belt" training in order to lead Six Sigma projects, or volunteering as reviewers for the Malcolm Baldrige National Quality Award or for state quality award programs.

"Whatever you can do to gain additional skills will pay off in career advancements and increased value to your organization," she says.

Spath suggests utilizing these resources:

- The National Association for Healthcare Quality and other organizations sponsor educational programs for individuals who are new to health care quality management.
- Community colleges and universities may offer relevant coursework. "For example, students in health information management training programs are required to learn the fundamentals of health care quality management," Spath says.
- Many educational institutions offer an associate or degree program in health information management with on-line educational classes.
- The Chicago-based American Health Information Management Association offers a complete list of schools offering programs in health information management.

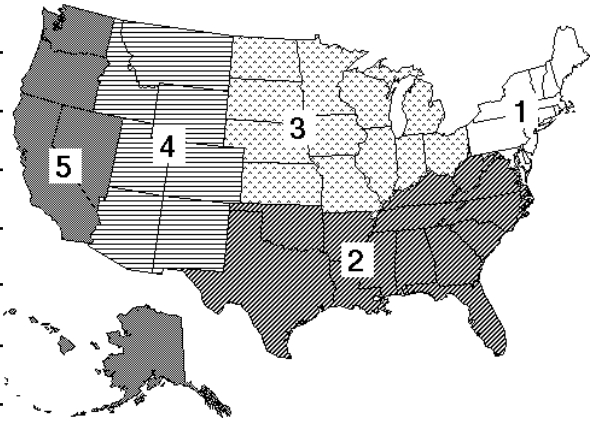
"In many cases, it is possible for the new quality manager to take one or two classes without enrolling in the complete program," she says.

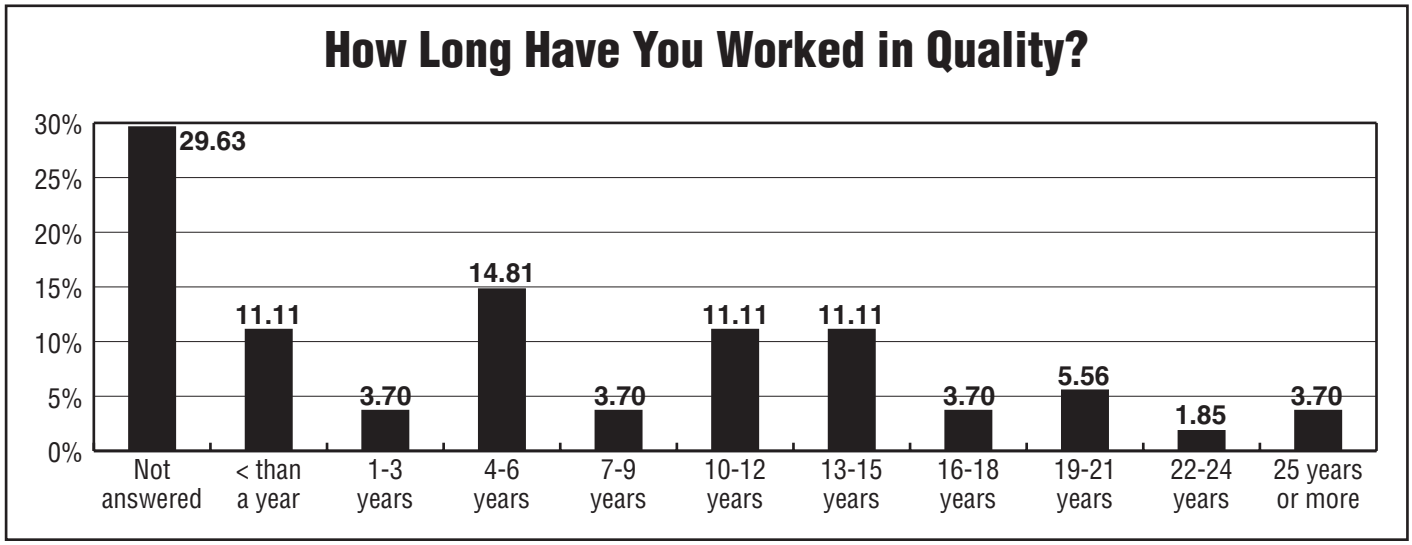
- A list of state quality organizations is posted on the web site of Quality Digest (www.qualitydigest.com/html/qlinks.html).

"People should directly contact the award program in their state to learn more about the

Salary by Region

Income	Region 1	Region 2	Region 3	Region 4	Region 5
Less than $30,000	0%	5.26%	11.11%	0%	0%
$30,000 to $39,999	0%	5.26%	0%	0%	0%
$40,000 to $49,999	0%	10.53%	16.67%	0%	0%
$50,000 to $59,999	33.33%	10.53%	16.67%	0%	20%
$60,000 to $69,999	22.22%	31.58%	11.11%	0%	0%
$70,000 to $79,999	33.33%	15.79%	22.22%	0%	0%
$80,000 to $89,999	11.11%	15.79%	22.22%	0%	60%
$90,000 to $99,999	0%	0%	0%	50%	20%
$100,000 to $129,999	0%	5.26%	0%	50%	0%





award and what volunteer opportunities may exist," Spath says.

Many of these award programs also offer low-cost training sessions, such as the Baldrige program (web: www.quality.nist.gov), Spath adds.

- To learn more about Six Sigma in health care, several organizations offer on-line learning opportunities, including the Milwaukee-based American Society for Quality (www.asq.org).

"A Google search will find lots of companies and organizations with Six Sigma training," says Spath. "It's best if quality managers take courses that are specific to health care."

The survey found that almost half (48%) of respondents are between 46 and 55. "The quality profession is aging faster than there are younger professionals being added," says Brown. "Some have actually been in the field since its inception in the mid-1970s."

In addition, nurses and other health care professionals may change career directions and enter the quality field after years in another area, she says.

"Experienced quality professionals need to identify, train, and mentor younger, qualified people to be ready to essentially replace themselves in their workplace, whether that comes through retirement or a change of employment," she says.

Although a significant number of survey respondents (29%) have six years or less experience in quality management, a large percentage (61%) have worked in health care for 25 years or more, says Spath.

This appears to indicate that many of the new quality managers are moving into that position either as a promotion within their own organization or from other health care settings, she adds.

"People with a health care background have a distinct advantage, but they may not have the data management skills needed to support today's information-driven performance improvement efforts," says Spath.

This has training and orientation implications, Spath says, since people new to health care quality management must gain new skills either through on-the-job training or a formal education program.

Quality managers typically work long hours, which is an indication of the commitment necessary to support an organization's quality program, Spath says.

"In my experience, the quality profession attracts those who attend to detail well, who strive to do all the right things right, who have a very hard time saying 'no,' often at the cost of their own time, energy, and even health," Brown points out.

"In humor, I say we are the 'Type A' personalities of health care, but I have seen and learned myself that we must also have a quality life and a healthy body — a balanced perspective," she says.

While a job in the quality management department might look inviting to a staff nurse or other staff member tired of the hectic environment of direct patient care, the pace of the job is not likely to slow down in the quality department, adds Spath.

Also, quality managers often are "exempt" employees who don't qualify for overtime pay, which is a consideration for those people who have come to rely on this as a source of additional income.

"Quality management is a calling, and not necessarily a 9-to-5 job," says Spath. "Commitment is important." ■