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IN THIS ISSUE

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Educating staff on tracer methodology is a must: Survey results depend on it

This time around, surveyors will be asking unit staff the questions

Are staff at your facility skeptical that surveyors from the Joint Commission on Accreditation of Healthcare Organizations really will be asking *them* the questions during your next survey?

You'll need to prepare staff for major changes in the survey process, including the new tracer methodology, which will be a key part of the 2004 surveys when Shared Visions — New Pathways goes live. In addition, the performance of organizations accredited after Jan. 1, 2004, will be reported in the new Quality Report format, and all regular accreditation surveys will be unannounced as of January 2006.

"For several years now, we have told everyone that surveyors are going to be talking more to staff," says **Catherine M. Fay**, RN, director of performance improvement at Paradise Valley Hospital in National City, CA. "But in actuality, the numbers of staff who surveyors talked to in previous surveys were very small. So I don't think they really believe us this time."

But the Joint Commission's claims aren't just idle talk or empty promises, according to **Angie King**, BSN, CPHQ, quality management director at Tift Regional Medical Center in Tifton, GA. "Unit staff are definitely the ones surveyors are going to be talking to," she reports.

King's facility participated in the pilot survey process for the Joint Commission's Shared Visions — New Pathways initiative. "We chose to participate because we wanted to have the opportunity to put our 2 cents in. Since we heard there were going to be sweeping changes, we wanted to have some live interaction to say what was good and what wasn't."

Overall, the new survey process is a definite improvement, King says. "It is, by far, a much more educational process," she says, adding that the process is a "real silo-buster," breaking down walls between departments and services within the facility.

"Hospitals are comprised of many silos, even within the nursing department itself," she notes. "With this type of methodology, staff get to see the whole continuum of care."

Here are key aspects of the pilot survey at Tift Regional:

- **You'll have less control during the survey**.

Due to the new tracer methodology's unpredictable nature, there is a loss of control for both the organization and the surveyors, King says. "You cannot start out with a plan for where they are going."

This means that it will be more difficult to ensure key individuals participate in the survey process, she notes. "Our chief of surgery certainly did not put any patient at risk, but he chose to delay his start time because he wanted to spend time with the surveyors. Had he known when they were coming to the OR, he could have changed his schedule accordingly, because he wanted to participate."

Similarly, if you have one nurse manager who is responsible for two different departments, it could be difficult to ensure that individual is present, King adds. "If two different surveyors are there at the same time, and they are tracing back and forth, it's kind of difficult to coordinate schedules."

Since you can't predict exactly who will be in a given department when surveyors arrive, it's even more important that every staff member is ready to answer questions if needed, King says.

It also is tougher to ensure that you are present to step in if needed, she explains. "Obviously, I've never been able to be in every single place they had to go even before the new survey process, but there were certain areas I wanted to be."

It may be difficult to get used to the idea that you can't control where the surveyor is going next, King says. "As quality managers, we want to know where the surveyors are. For one thing, we want to be sure they're going to be nice to our staff, and we want to be able to interpret if they start talking Joint Commission-ese. We like to be around, but we have to recognize that we can't always be."

- **Surveyors may not cover every area during the survey**.

Since surveyors are tracing a patient's path through the facility, some departments or ancillary services may not come up during the survey itself, such as pharmacy, King notes. "They may not be able to see everything they need to in the hospital, so unless that is scheduled for a separate site visit, they will have to come back and do that after hours,."

- **Surveyors made good choices when selecting patients to trace.**

The surveyors asked for a list of all patients, where they are, what their diagnoses are, and how long they have been there. "Based on that, they made their patient selections," she says. "I think that they made good choices. Those were also the patients they interviewed."

One of the chosen patients was a child who had come in through the emergency department (ED), spent time in critical care, and was on the pediatric unit. "They looked at the competency of staff, since we had ICU [intensive care unit] nurses taking care of pediatric patients, but we don't have a pediatric ICU," King says. The questions asked of patients were focused on continuum of care, she states. "For example, they would say, 'Your care started in the ED; did you feel like that continued when you came up here? Was it explained to you? What happened when you got up here?'"

The pediatric patient had been given a nebulizer treatment, so surveyors asked the respiratory therapist who was responsible for teaching

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Editorial Questions

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this to the patient. "The therapist said it was their function. So the surveyor asked, 'Can you show me how that's communicated so nursing knows you've done it?'" King adds. "The surveyor then asked the nurse the same question, 'How do you look to see that they have been successful in teaching it?' and asked to see where they would look for this in the record."

- **Staff got more educational benefit from the survey**.

King gives the example of a surveyor discussing a patient's care with a nurse on the pediatric unit. "There was a question that came up about the patient's care in the emergency department, and the surveyor asked, 'Is the ED nurse here today, and if so, can she come up here?" she recalls. "That was great, because that ED nurse sat there with the pediatric nurse and together they answered the surveyor's questions. Afterward, she said it gave her a much greater understanding of what happens outside the walls of the ED."

One of your top priorities to prepare for the new survey process is ensuring that every staff member understands how to answer surveyor questions based on the new tracer methodology; but many quality managers feel they're flying blind.

"We have struggled with this. Since no one has actual experience with the tracer methodology, preparing the staff is difficult," Fays says.

In the past, getting ready for surveys centered around three things: standards considered to be hot button issues with surveyors that year, new standards, and previous survey findings, she says. "That won't work this time because this year, we anticipate a process unfamiliar to any of the hospital staff," she says. "So we had to come up with a new way of preparing for our May 2004 survey." The fact that the surveyors' whereabouts are unpredictable is another major change — a somewhat unsettling one for most quality managers. "Previously, a director or administrator would do their best to make sure a surveyor stays in one spot according to the schedule and doesn't go anywhere else." Fay points out.

As a result, many of the surveyor's questions typically were answered by the director, but that no longer will be the case, she acknowledges. "We are giving more and more information directly to the staff, because they are the ones the surveyors are going to be talking to."

Here are some effective strategies to educate staff about the new tracer methodology:

- **Ask staff questions to reflect the new survey process.**

At Tift Regional, staff were prepared by "walking ambassador" rounds and asked questions such as, "If you have a patient who complains of pain, what do you do?" and "Can you show me how you communicate with other departments?"

"My focus was to familiarize them with the type of questions that would be asked so they wouldn't be scared," King says. "If you can eliminate fear, staff will be able to answer the questions, because they know what they are doing. They might not know one way to answer it, but they will know another."

- **Explain that staff should focus on processes.**

Previously, survey preparation revolved around policies, procedures, and documentation, Fay says. However, with the new tracer methodology, processes have become very important, and surveyors will expect to hear staff talk about patient care in those terms, she explains.

"The intent of JCAHO is to determine what are our processes, how well they are implemented consistently, and how we measure the success of the process," she explains.

"With this survey, they will look at how we actually apply the functional processes to the patient, dependent upon their needs," Fay says.

Education for the new survey process is directed at the staff-level employees, Fay emphasizes. "They are the ones JCAHO tells us they will be talking with during the survey." She says the goal is that staff understand the following:

— processes they use in carrying out the responsibilities of their positions;

— how those processes are linked to other positions or departments;

— matching policies and procedures for the processes;

— how the department measures the effectiveness of the processes.

For all the above, staff must address hospital-wide processes that apply to all departments, such as the National Patient Safety Goals, infection control practices, and emergency preparedness, Fay says.

Surveyors are not going to come to a department and say, "This is Mr. Smith — what did you do for him?" she says. "If a study is done on a particular person, they will ask, 'How do you go about doing it, how do you inform them about it, how do you document it, and how do you determine who is qualified to do it?' What they are looking for is consistent application of a process."

This means that staff no longer can use the excuse "I didn't take care of that patient," Fay

says. "The Joint Commission isn't buying that anymore. What they are saying is if you have these kind of patients, you need to know how to take care of them."

- **Select your own patients to trace through the system.**

Each month, department directors are choosing a patient to trace, just as surveyors will be doing as of January 2004, Fay says. The staff are walked through a "process identification exercise" to determine their level of understanding. Each director or manager pulls a patient's chart or a given procedure, based on the type of care or service provided in the department.

For example, on the surgical unit, staff must be ready to discuss the process for any surgical procedure, she says. Radiology staff may be asked to discuss how they do a computerized tomography scan with contrast, and dietary staff may be asked to talk about the process of nutritional intervention for a patient who has been NPO ("nothing by mouth") for four days.

Staff are asked the following questions:

— What do we do for this patient first? "Staff then go through each process, including nutritional assessment or informed consent if they need it, and everything that is linked to whatever the diagnosis is," Fay says.

Use tool to prepare staff for new survey process

Shown here is a case presentation developed by **Catherine M. Fay**, RN, director of performance improvement at Paradise Valley Hospital in National City, CA, to help managers prepare staff for the Shared Visions — New Pathways survey process, including the new tracer methodology:

1. During the opening conference, the surveyor may select a patient with a diagnosis of cerebral vascular accident (CVA).
2. After determining the location of the patient, the surveyor will go to the unit.
3. Upon arriving on the unit, the surveyor will approach a staff member and start to question him or her about the patient:
   - "How long has this patient been in the hospital?"
   - "When he/she was admitted, how was the plan of care for this patient determined?"

Depending on the answer, the surveyor may ask:

- "What is the plan of care?"
- "Who contributed to the plan of care?"
- "How are components of the plan prioritized?"

Or the surveyor may ask:

- "How is the patient assessed?"
- "What is the hospital policy for assessment?"
- "Where is the assessment documented?"
- "Can we see the documented assessment and a copy of the policy on assessment?"

After looking at the assessment, the surveyor may say:

- "I see the patient is having difficulty swallowing. Do you do swallow studies here?"
- "Who does swallowing studies?"
- "How are swallowing studies ordered?"
- "Did this patient have a swallowing study?" If the answer is yes, the surveyor may ask to be taken to the department of the personnel who do the swallow studies.

4. When there are linkages in care that the surveyor wants to follow, and those linkages direct him or her to another department, the questions will be about a patient "with" a procedure, diagnosis etc. The questions won't necessarily ask about a specific patient who was provided care or services by the staff member. The surveyors are looking for knowledge of and consistent application of processes. It is expected that staff know the processes.
5. Upon arriving in the department, the surveyor may ask to speak to the staff person who does the swallowing study. Questions he or she may ask include:
   - "How do you get referrals for swallowing studies?"
   - "What is the process for the study?"
   - "How were you trained to do the study?" (The surveyor then may ask to see that person's file to confirm competency.)
   - "How do you communicate the results of the study to other members of the care team?"
   - "Is there any follow-up to the original study?" (The surveyor is looking to see if there is a reassessment after recommendations are implemented or there is improvement in the patient's condition.)
   - "How is the dietician involved in the management of a patient with swallowing difficulty?"
6. The answers to this question could direct the surveyor to the dietary department to ask about referrals, assessment, and criteria for nutrition management.
7. When finished in the dietary department, the surveyor could return to the location of the patient for a thorough review of the medical record to verify that everything was documented to reflect the process answers that were given.
8. After review of the patient's medical record, the surveyor could ask from where the patient was admitted. If the answer is the emergency department (ED), the surveyor probably will go to the ED and review the processes as they apply to this patient (or any patient with a CVA). ■

— What is the policy for that process?

— Can you get me a copy of the policy?

"Those are the steps that the Joint Commission is going to address," she adds.

- **Identify problem areas.**

Based on the results of the process identification exercise, managers identify areas where staff need improvement due to lack of knowledge or inconsistent answers, and these are addressed at the next staff meeting, Fay explains.

In addition, randomly selected department directors will report problem areas from their departments at the biweekly leadership team meetings, so that other directors can learn from their findings.

"We'll be asking managers and directors to share what they did on their unit, what their findings were, and how they addressed the findings," she says. "They may come up with problems that we may have to address with hospitalwide education. For example, if there are problems with staff knowledge about patient identification processes, then we know they are not getting the message."

- **Assess which types of patients are likely to be selected**.

For the patient tracer exercises, Fay suggests departments select patients who are representative of the core measures the facility is collecting data on. "We believe that is where the surveyors will be going," she says. "We don't have the performance improvement overview, and we don't have the opportunity to talk about core measures. Congestive heart failure and community-acquired pneumonia are our top DRGs, and the surveyors will know that. So there is a pretty good chance that they will be asking about these patients."

Surveyors likely will base the patient selections on your services, census, and core measures, Fay says. "They will probably look at patients with whatever your average length of stay is and may pull some patients so they can look at discharge planning. They may select a patient with a long length of stay, so they can see reassessments and revisions of treatment plans, and see that everything is carried out through long stays."

Surveyors also will consider patient populations at your facility, Fay says. "We have a very small pediatric population, so they might look at that," she says. "The more you do things, the more you take shortcuts, and the less you do things, [the more] you tend to forget, so those are the two ranges of risk."

No matter what type of patient is chosen, all the processes should be the same, Fay emphasizes. "People get admitted, have an assessment and treatment plan, nutritional status, medications, IVs, and may have some invasive procedures. Staff might not realize it, but it's pretty standard."

In the intensive care unit, you may have different competency levels depending on medications you are administering, and different procedures that you do, but the basic processes should be similar to other areas, she says. "So, I'm not as concerned about the diagnosis or how they select the patient. What is important is that the staff actually pick a patient and go through the process of learning — that they know the processes they use to care for the patient."

[For more information on preparing staff for the new tracer methodology, contact:

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Comparative performance data now ready for use

First round of hospital performance data released

Whether or not your hospital currently is participating in the National Voluntary Reporting Initiative, you can make good use of the just-released first round of hospital performance data. The data for 400 hospitals were posted on the Centers for Medicare & Medicaid Services (CMS) web site, and another 600 hospitals are expected to have data posted by February 2004.

As a quality manager, you should take a close look at these data, advises **Kathleen Catalano**, director of regulatory compliance at Addison, TX-based Provider HealthNet Services. "I looked at the data for one of the Texas hospitals, and they tell you exactly what the Joint Commission [on Accreditation of Healthcare Organizations] found when it performed the last triennial survey," she says.

The public can access this information as well, she notes. "You should know what's out there

about you facility," Catalano says. "It's amazing how many patients and their families review all of this information from here." She suggests comparing what is on the site for your specific hospital with the information you receive from ORYX core measures if you are doing the same indicators. "I'd certainly print out the information by indicator and share it with the relevant medical staff committees and medical executive committee."

Here are ways to utilize the comparative performance data:

- **Apply a similar model to your own internal comparative performance reports**.

For example, you can determine the following for each measure, says **Patrice L. Spath**, BA, RHIT, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates:

— Top 10% of JCAHO-accredited hospitals scored equal to or higher than: _____

— Top 50% of JCAHO-accredited hospitals scored equal to or higher than: _____

— Our hospital scored: _____

When reviewing the comparative data on the CMS web site, Spath recommends evaluating the following three factors:

1. The difference between your performance rate and the comparison groups and whether it is statistically significant.

2. Whether your performance results represent a multiyear trend or just a one-time occurrence.

3. The gap between your performance rate and the goals your organization has established for your performance.

- **Have a plan for action if your organization's performance is not satisfactory.**

The publicly available information won't be able to answer all of the questions that need answering to determine the best course of action, she says.

The data often are not risk-adjusted, Spath explains, nor are the unique attributes of the comparative organizations clearly defined, such as rural vs. urban facilities, or specialty vs. general hospitals. "It's impossible to control for all risk factors or consider all facility characteristics. But knowing *what* risk factors or characteristics have been accounted for in the data comparisons can help people interpret performance comparisons across organizations."

You may need to gather additional data that allow practitioners to look at other dimensions of risk, or facility characteristics that are not adequately addressed in the comparative database, she explains. "It will also be necessary for you to review the data definitions that were used to create the measures to appreciate what the performance numbers are telling you." These definitions can be found in the Technical Appendix on the CMS hospital quality web site (www.cms.gov/quality/hospital).

- **Be ready to encounter resistance.**

"When you discover performance improvement opportunities, you need to get people's attention around the organization," Spath says.

However, she cautions that individuals may react to significant variation on comparative reports in many ways. Even if the variation is statistically significant, they may choose to ignore the findings, according to Spath. "Don't be surprised if you encounter resistance when you present unfavorable performance measurement results. It's common for people to challenge the data's validity when faced with such findings."

You can't just print out the reports on the CMS site and expect people to respond to obvious performance improvement opportunities, Spath cautions. "Quality managers must present the data in a way that answers the common questions that may arise when practitioners review the comparative data results."

Here are two common questions:

1. ***Does our organization have sicker patients than those in the organizations we are being compared to?***

Quality managers should acquaint people with the data definitions for each performance measure, Spath says. She gives the following example: For the measure "beta-blocker on arrival for patients presenting with heart attack," patients with potential contraindications or reasons for not prescribing a beta-blocker on arrival are excluded from the performance rate. "Thus, only those patients who are considered candidates for a beta-blocker on arrival are included in the denominator. The issue of 'Our patients are sicker' is not applicable to this measure."

The severity of a patient's illness doesn't significantly affect the performance rates for the measures being reported by CMS, according to Spath. For the most part, the denominators exclude patients who would not be candidates for the intervention being evaluated because of illness severity, she explains.

2. ***What are the performance rates for hospitals like ours, a rural hospital with only 50 beds?***

The CMS data do not break down results by hospital size, Spath acknowledges. However, she

(Continued on page 171)

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Technology brings care directly to the patient

From testing to telemetry, patient care is being brought to the bedside of a growing number of patients across the country. Engendered by constantly evolving and improving technology, patient-focused care is demonstrating a significant potential for improving patient safety while bolstering satisfaction.

"Rather than having the patient go through the pain and suffering of being moved around, we now bring the treatment or testing to them through patient-focused care," says **Patrice L. Spath**, a consultant with Brown-Spath & Associates in Forest Grove, OR. "They become the center of the wheel."

The centerpiece of patient-focused care is a growing array of services known as point-of-care (POC) services. Among these is POC testing. "In general, [POC] has a number of advantages," says **James Nichols**, PhD, associate professor of pathology at Tufts University School of Medicine in Boston, and medical director of clinical chemistry for Baystate Health System in Springfield, MA, where he supervises POC testing. "It requires a smaller amount of blood and is minimally invasive, which is very useful for neonates, who do not have much blood. And you can do the test right there and go on with the treatment, which maintains continuity of care."

Marc T. Zubrow, MD, director of critical care for Christiana Care Health System in Newark, DE, says he is reaping benefits in both patient safety and satisfaction from his recently installed Flexible Monitoring system (manufactured by Welch Allyn Inc, Skaneateles Falls, NY), which uses wireless telemetry to monitor patient heart rhythms.

"Patients can literally go anywhere, and people will know what's going on [with them]; and they can be easily found in case of emergency," he notes. "Also, I had observed that in regular step-down units, the monitor watchers really weren't watching; nurses had many other duties and were often called away. Plus, the cacophony of alarms in traditional step-down units is disturbing, especially when a patient is trying to sleep."

Spath agrees that patient-focused care can enhance patient safety. "There's a significant patient safety aspect, in that any time a patient is handed off from one caregiver to another, there is a chance for an event. Not only does the patient have to be handed off, but information relevant to that patient has to be handed off as well."

In addition, POC enhances patient safety through improved identification technology, she adds. "If you are right at the bedside and get a drop of blood to test, you don't have to worry about the vial being mislabeled, getting mixed up, and having the wrong report coming back," Spath notes. "It definitely does minimize the patient ID problem."

The number of applications for POC services is nearly as wide as the applications a health care professional can envision. In testing alone, for example, it can include: blood gases; electrolytes; Ca++; Na+; K; Mg++; hematocrit; glucose; creatinine; and blood urea nitrogen.

"There is an advantage to performing the top 10 most popular tests at the patient bedside since it is expensive to package, transport, unpackage, relabel, and rack the specimens for analysis. Furthermore, bottlenecks are created in the central lab when large numbers of specimens queue up for labeling, aliquoting, and centrifugation,"[1] wrote **Robin A. Felder**, PhD, of the University of Virginia in Charlottesville.

Radiology is another area where POC applications are numerous, including picture archiving and communications systems; medical imaging displays and display controllers; and POC workstations. Interventional radiology, fluoroscopy, digitized X-rays, and ultrasound are just a few of the specific areas of application.

"Primarily, the major benefit [of POC radiology] is having images directly at the patient's bedside for referral or consultation," says **David Hebert**, marketing manager in the medical business unit for Planar Systems of Beaverton, OR, a major manufacturer of flat display panels and other POC products.

"Under the old model, you had to print the exam results in radiology, then walk over to the patient's bedside and then use it in conjunction

with whatever procedure was planned. This affords a tremendous time savings."

Planar produces a wide range of diagnostic or referral quality displays for radiology, including the recently introduced Invitium POC workstation. This involves either a "normal" CPU or a thin-client CPU that actually is embedded into the display panel on a card, so it is mobile and available to any clinical informatic.

What is the future of POC radiology? "In an ideal world, as we advance, we will be integratable into CPOE [computerized physician order entry], drug administration programs — ideally, any and all patient data that can be accessed at the bedside," Hebert says. "This will allow the opportunity for increases in quality of care, but distributing critical information as widely and as quickly as possible."

Zubrow initiated his project in response to the constant challenge of finding enough step-down beds for patients coming out of intensive care. "I noted that most patients being observed in the step-down environment could be monitored from a remote site, and in that way, multiple areas of a hospital could all be monitored from the same site," he recalls. "The same thing is true in upgrading; if a patient requires monitoring, you can do that remotely rather than having the domino of bed transfers to make beds available."

The system being used by Christiana, which was developed by Welch Allyn, "is a superior system," Zubrow says. "It was the first on the market that had a screening ion, which enabled us to visualize the patient's heart rhythm on their body." In other systems, he explains, when a patient has an acute problem, the health care professional usually has to push a button to get more specific information. "With this system, you walk in, and if you think you hear something you're not used to hearing in the rhythm, you have instant information."

Patients who are being monitored have leads on their bodies, which send information to a small box that also is on their person. The box, in turn, sends information to an antenna on the ceiling, which then sends the data through a land line to the monitoring room, staffed by monitor technicians, who are responsible for arrhythmia detection of all patients being monitored by the system.

"Before, we had to move patients to specific [hard-wired] rooms," Zubrow says. "This also meant a new set of nurses. This was a huge patient dissatisfaction issue." At the same time, Christiana implemented a STAT (stabilization-transport-administration-teaching) nurse program to support the changes of added monitoring to multiple nursing units. The STAT nurse is a medical intensive care nurse available 24/7 to help provide critical care for patients. "The STAT nurse responds to changing status," he explains. "If a patient's condition changes, there is immediate response."

There are two hospitals in the Christiana system. At Christiana, where the system has been in use since 2001, there are three central stations in use, each monitoring 44 patients. At Wilmington, there are four such stations.

"I think this has been a huge advance; I believe we are on the cutting edge, and the rest of the country will be doing this in short order," he says. "We've had a number of wonderful resuscitated patients who might not have been found that easily. Our survival rate for cardiac arrest is just as good [as for patients monitored in the more traditional fashion]. One of the concerns had been that we would not find these patients in time, but our data on in-hospital codes show we're doing every bit as well as step-down patients. This is a safety net we *know* is saving lives."

This is just the beginning for Christiana when it comes to remote monitoring, Zubrow says. "Pretty soon, we will be monitoring 'pulse-ox' [pulse oximetry] — perhaps within the next six months — and we will also be doing noninvasive monitoring of vital signs," he says. "Now, for example, if a patient on the floor requires medications through an intravenous drip, the pharmacy rules require they be in a certain location. In the future, we may not have to move the patient; this will improve patient care without increasing the need for personnel. In view of the current nursing shortage, this improvement in nurse productivity is very important."

As director of all clinical chemistry and responsible for POC testing, Nichols has many opportunities to employ such technology in the three-hospital Baystate system, which includes outpatient clinics, several nursing homes, and a Visiting Nurse Association. A number of simple tests are performed regularly, including urine dip strips, glucose, occult blood, pH, pregnancy, rapid "strep" tests, blood gases, electrolytes, and creatinine at POC. "A sample is taken, usually by finger stick or via the urine, then put onto either a dip strip or onto a kit," he adds.

There is a computer inside the hand-held device.

Before the test is performed, the operator is asked for the patient's ID number. "This way, the computer knows the patient and the lot number and links them to the result," Nichols explains. "Then we put the device into a docking station linked to our intranet, and it automatically sends it to our lab information system, then refers it back to the patient care system."

The time savings are significant; the whole blood does not have to be processed, spun, and separated. "You just put the whole blood on the device — it's faster; you don't have to draw it, wait for it to clot, spin it in the centrifuge, and then get the result to the clinician," he says.

Nichols sees several advantages to POC testing. Moving these tests to the bedside improves patient satisfaction and makes the care more patient-focused, he says. "I think it's more convenient. It brings analysis to the bedside, where the physician is as well, so it all works within the flow of patient care." This is not to say that the impact is totally positive, however. For example, staff sometimes may complain about the additional responsibility. "There is a general feeling that nursing is being dumped on, but we are all doing more," Nichols explains. "It's narrow-minded to not think of this as part of patient care — as much as taking a temperature, weighing the patient, taking vital signs, or giving drugs."

Still, there can be drawbacks to POC testing, he says. "You take lab testing, which is a well-defined, structured process. With point-of-care testing, you are outside of an environment you can control. That leads to problems. In a lab, you have controlled temperature and highly trained people whose sole function is to analyze specimens. They are just focused on turning out results. If you take this outside the lab, you can start to get errors and problems."

For Nichols, the issue of whether to use POC is not cut and dried; rather, it is a question of weighing pros and cons. "You really have to balance everything," he advises. "In the patient care setting, is this effective and is it going to lead to a better outcome? Does the work of keeping quality up outweigh the benefit of the increase in quality? What am I doing for that patient, and am I doing it frequently enough? Do I have well-trained people who do this on a daily basis so I can trust the results?"

If the results you get are "just numbers," that can be dangerous, Nichols explains. "Make sure you pick devices that have foolproof checks and balances, so you get a number that is meaningful. Plus, a lot of what you do is manual, so the documentation is not always there. Without a computerized system in all POC devices, we lose much of its potential."

Assuming you determine the benefits will outweigh any potential problems, just how difficult is it to do, for example, what Christiana did?

"There is a substantial financial outlay on the front end," Zubrow concedes. "But you can cost justify it if you extrapolate the cost of a nurse reader vs. a monitor reader, then the cost of transferring a patient — say, $200 or so. And who can put a cost on the reduced medical legal risk?"

In the final analysis, Nichols appears to agree. "In many instances, I see this as a wonderful technology for patient care and for improving what we do," he says.

Reference

1. Feder RA. "The Distributed Laboratory: Point-of-Care Services With Core Laboratory Management." In: Price CP, Hicks J, eds. *Point of Care Testing.* Washington, DC: The American Association for Clinical Chemistry; 1999. ■

New program helps breast cancer patients

Successful pilot becomes full-time program

A case management program for newly diagnosed breast cancer patients at MeritCare Health System in Fargo, ND, helps women smoothly navigate through the health care maze as they make treatment decisions.

The program started out as a pilot project in January 2002. The response from patients and staff has been so good the health system has made the job a full-time position.

"They have realized what it has done in the way of patient satisfaction and in helping to streamline the care," says **Linda Sveningson**, RN, MS, AOCN, breast cancer case manager at MeritCare.

At MeritCare, the breast cancer case manager is one full-time equivalent position shared by two master's-prepared nurses. The nurses have an active caseload of about 45 patients, 20 of whom are new patients and the rest going through surgical treatment.

In a typical month, Sveningson actively works with about 45 patients. About 20 are new patients who have just gotten a breast cancer diagnosis. The

rest are those she is following through surgery. "I'm the person they can call to point them along the way and give them any information they need," she says.

Sveningson is based in the radiology portion of the breast clinic, where many patients get the first information about their diagnosis. She calls patients within a few minutes after the radiologist calls to tell them their breast biopsy is positive. "I am there to provide support and education and to coordinate the appointments they will need. These patients are in an absolute state of shock. On the first day, I answer their most urgent questions and call them again the next day to talk further. The next day, they want to know what it means. On the first day, they're just blown out of the water by the diagnosis," Sveningson says.

She reviews the pathology report with patients and sends them packets of information about breast cancer and treatment options. "I can meet with them in person, but since so many live a distance away, I do a lot of work on the telephone."

The health system serves a large rural community in parts of North Dakota, South Dakota, and Minnesota, and some of the women who come to the clinic live as far as 200 miles away.

Sveningson does an initial intake assessment and enters the information into the health system's computerized charting system. The assessment includes their concerns and goals and any barriers to appointments.

"The surgeon can look at the information and know what we know about the patient," she says.

Depending on the diagnosis, patients may need a surgical consultation or a medical oncologist consultation. Sveningson helps set up an appointment and coordinates, whenever necessary, with the patient's primary care physician.

Before the program started, patients would get the initial diagnosis and then have to wait seven to 10 days to see a physician for follow-up.

"They would get information from friends or go onto the computer and search for themselves. We were concerned about whether they were going to get reliable information from a reputable web site," she says.

Sveningson helps patients navigate through the complexities of the health care system. She explains the treatment options and gives the patient the information that will help them choose the option that's best for them. "A lot of it is knowing that what they are feeling is normal and that it's not unusual for people in their position to have problems sleeping or eating." She prepares the patients for the surgical consultation, educates them about what to expect from the appointment, and gathers the information a surgeon may need when seeing the patient.

She often accompanies the patients when they see the surgeon and follows up later to clarify any information they don't understand and answer questions. "We are available to be their second set of ears when they see the surgeon. Some people don't want us there, but we try to touch base and make sure the surgeon is aware of their story."

She encourages the patients to call her with questions and concerns, but she also calls them at regular intervals.

"Women are very overwhelmed by the diagnosis of breast cancer. We have this culture of stoicism that says you handle whatever is thrown your way. They won't always call and say they need help. When I call them, they appreciate it greatly," adds Sveningson.

A lot of patients are afraid to bother someone by calling with questions, or they may call and the surgeon isn't available to talk. The breast cancer case managers often can answer the questions, she adds.

Once the patient has had surgery, Sveningson starts preparing them regarding what to expect for their consultations to medical oncology and radiation oncology. After patients receive a treatment plan, she follows up to help them understand the complexities of the cancer treatment.

"Patients often don't understand the treatment plan, and they are fearful of having chemotherapy and radiation. I'm able to re-emphasize how cancer is staged and how a treatment plan is determined. I give them the message that breast cancer can be cured," she adds.

Contact with the breast cancer case manager tapers off when the patients' postsurgical treatment begins. "By the time they start chemotherapy, they have gotten through the major complexity of navigating the system and they need to be followed closely by medical oncology. At that point, most of their questions are related to their treatment," Sveningson reports.

Since the position was established, the health center has not received any complaints or negative feedback from breast cancer patients. A patient satisfaction survey showed high satisfaction with the program.

"We know that if one person has a negative experience or feels like they fell through the cracks that they are going to tell 10 people. We are here to make sure that doesn't happen," she says. ■

(Continued from page 166)

suggests that you provide this information by creating a report that lists the hospital size and urban or rural designation next to each of the hospitals reporting data in their state or region.

Or create a report that only compares your hospital to similar-size hospitals in similar rural locations, Spath suggests. If you do this, it will be necessary to find out the size and location of other hospitals in the state or region. This information can be obtained from the American Hospital Association or state hospital associations.

"Remember, however, that quality medical care should not vary significantly based on hospital size or location," Spath cautions. If the measure represents appropriate care, such as "pneumonia inpatients who receive an oxygenation assessment, arterial blood gas, or pulse oximetry within 24 hours of hospital arrival," then your goal should be 100%, she says.

- **Use comparative data to provide information to others**.

The ultimate success of your organization's performance measurement system hinges on the ability to fairly assess important aspects of patient care, Spath says. "It should be simple so that everyone in the organization understands how performance is being evaluated."

An effective measurement system that includes comparative data should allow practitioners and administrative leaders to make objective and valid assessments of patient care quality, she says. In addition, the measures should provide people with an accurate source of information that enables them to oversee and improve patient care services on a continual basis.

- **Encourage your facility to participate in the initiative voluntarily**.

Otherwise, participation most likely will become mandatory per CMS, Spath adds. "It's best if hospitals can show support for comparative performance measurement initiatives and public reporting of results through a voluntary effort."

Curiosity and professional pride are the most common reasons practitioners want to see what their performance looks like compared to other organizations, she says. Quality managers should use these motivators when discussing the hospital's participation in the reporting initiative. "These are 'carrots' for practitioners," Spath says. "Of course, we can always resort to the argument, 'If we don't do it voluntarily, the regulators will force us to share performance data with the public.'"

Using "sticks" such as that is less likely to create an environment that embraces the opportunity to compare performance, and people will be less likely to initiate actions when performance is found to be undesirable, according to Spath. "Whenever possible, use carrots instead of sticks. The quality manager's job will be much easier if everyone agrees on the value of comparing performance across organizations."

[For more information about comparative performance data, contact:

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- ***Patrice L. Spath**, BA, RHIT, Health Care Quality Specialist, Brown-Spath & Associates, P.O. Box 721, Forest Grove, OR 97116. Telephone: (503) 357-9185. E-mail: patrice@brownspath.com. Web: www.brownspath.com.*
- **From Quality to Excellence: Using Comparative Data to Improve Health Care Performance** *is a 2002 book published by Brown-Spath & Associates. The cost is $40 plus $6 shipping. To order, go to www.brownspath.com.*
- ***The National Voluntary Reporting Initiative**, a joint effort led by the American Hospital Association, the Federation of American Hospitals, and the Association of American Medical Colleges, is available on the CMS web site: www.cms.gov/quality/hospital.]* ■

ACCREDITATION
Field Report

Quality control is major theme during survey

Open chart review significant survey component

If Joint Commission on Accreditation of Healthcare Organizations surveyors noted a potential problem area in one department at Hurley Medical Center in Flint, MI, they didn't stop there. Instead, they zealously looked for evidence of the same problem throughout the facility.

"It was a moving target," says **Michael Boucree**, MD, the facility's vice president for medical affairs.

"It seemed as if they would look for anything out of whack and then focus on that issue on each subsequent unit to see if there was a pattern, or if it was a unique occurrence."

If a problem was seen twice, it became a recurring theme on a daily basis, he adds. "With regard to one issue regarding multidose vial labeling and test solutions used on the units, the surveyor commented at the Wednesday morning conference, 'You apparently got the message out after Monday, because I didn't find this issue again.'"

Here are key aspects of the July 2003 survey:

- **There was an overall focus on keeping patients and workers safe**.

Surveyors continually addressed quality control issues in addition to the National Patient Safety Goals, Boucree says. "They looked at how we assure employee and patient safety and then tested our responses by comparing what we say in documents to what we actually do," he says.

For example, surveyors checked that rooms were adequately ventilated where cleaning solutions were used and that the solution was being used according to manufacturer's guidelines. On a pediatric unit, surveyors wanted to know how the organization got information about recalls for unsafe devices and how the particular unit would be notified of these changes.

For each of these areas, the surveyor checked the unit's policies against the actual practice observed by the surveyor. "If what the surveyor saw did not match up to what we said, we tried to clarify the issue," says Boucree. The surveyor then would "test" this on another unit or area to be sure that the facility was not misrepresenting actual practice, he says.

The new tracer methodology was evident, with surveyors following a patient who went into the OR to see that a complete history and physical was done, then looking at postoperative orders, and finally, going up to that unit to check that the orders actually were being carried out in a timely manner.

- **Surveyors were asked for input on the spot**.

If problem areas were identified, quality leaders frequently asked the surveyor to document their point of reference so they could read the full context to ensure understanding of what they were being told, Boucree says. When possible, problems were fixed on the spot or by the end of the day, and a memo of correction was immediately provided to the surveyor, he reports.

- **Open chart review was a significant component of the survey.**

One of the first things surveyors did upon arrival to a unit was to pick a chart and visit with that patient, or to visit a patient and then review that chart, Boucree says. "The surveyors might say that they were coming back to the particular unit or area to see something specific, which obviously gave us a heads-up," he says. "If any issues were identified on one unit, we quickly spot-checked other units for this same vulnerability."

The surveyors commented that the facility had done a good job of implementing the National Patient Safety Goals, and it was one of the few organizations that didn't get the Special Type 1 Recommendations. Boucree attributes this to creating a task force to implement policies and procedures to comply with the goals, and setting up monitoring activities to demonstrate compliance.

"The staff's ability to discuss the goals also was evident," he says. "We were a bit shy on the data relative to this, but there was ready evidence of our efforts of compliance."

- **The facility's plan of care was scrutinized.**

Boucree explains that there had been significant staff turnover due to retirements, resignations, and layoffs in the previous year. In addition, the facility posted a $24 million dollar loss in the prior fiscal year. "Thus, the year prior to our survey was riddled with corrective action plans and intense staffing and budget monitoring," he says.

As a result, there were inadvertent inaccuracies in the plan of care, which caused surveyors concern. "The department in question, which was a nonclinical area, was besieged by absenteeism," Boucree says. "There were many adjustments in this department from a staffing, managerial, and process improvement perspective."

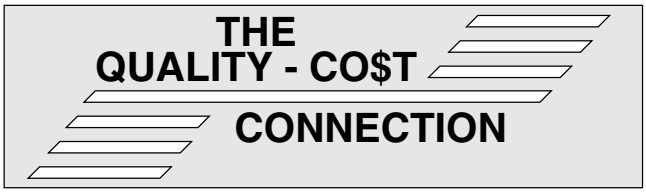
Since the survey occurred just after the beginning of the new fiscal year, the plan of care did not reflect all the monitoring systems and other changes that had been put into place, he explains. In addition, the new manager of the area had not had an opportunity to critically review the document. These findings caused the surveyors to dig further into other areas and processes, with stringent review of other plan of care summaries and budget documents, Boucree adds. "It was particularly uncomfortable since this occurred on the first day of the survey after the document review."

The surveyors accepted the explanation and the supplemental documentation which demonstrated compliance, but the seemingly simple inaccuracies could have caused a significant problem, he says. This was a critical lesson that was learned, says Boucree. "As we do last-minute preparations and

changes of the guard, senior administrative oversight becomes even *more* imperative, to ensure that there is document accuracy so as not to provide misinformation which has to be corrected and backtracked."

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

- ***Michael Boucree**, MD, Vice President for Medical Affairs, Hurley Medical Center, Flint, MI 48503. E-mail: mboucre1@hurleymc.com.)* ■



Gathering and reporting CPR performance data

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

Trending of resuscitation survival rates and other cardiopulmonary resuscitation (CPR) measures of performance can help caregivers pinpoint potential problem areas. The Joint Commission's standards are somewhat vague with regard to what CPR factors should be monitored regularly. At a minimum, hospitals should be evaluating CPR survival rates; however, to ensure high-quality patient care and reduce liability concerns, all of the key issues affecting in-hospital resuscitations should be evaluated regularly. In part 1 of this 2-part series, the important aspects of resuscitation were described. This column details techniques for gathering CPR performance data and what should be reported to the committee responsible for evaluating resuscitation and its outcomes.

Much of the information related to compliance with hospital policies on CPR training, code cart checks, and maintenance already is being documented. It is merely a matter of gathering the data from logs, checklists, and staff education files. It may take a little more work to gather information about the code event itself and post-resuscitation patient management.

Pre-designed CPR or code sheets help to make documentation easier and more consistent.

Documentation should begin at the time the code is called. Usually one person is designated to document on a code sheet that ultimately becomes part of the patient's record. A separate code critique form can be used to gather additional information for post-code evaluations. This form is not part of the patient's record. Both of these documents serve as the primary source of information for CPR performance data.

To enable complete documentation of the CPR event and allow for collection of information that will be used to create event-related performance measures, the code sheet should contain the following minimum data elements:

- Patient identification information
- Status of the patient, *e.g.*, inpatient, outpatient, ED, volunteer, visitor
- Where the code was called
- Who called the code
- Whether or not the code was witnessed
- Date and time the code was called
- Date and time resuscitation was started
- Time and watt seconds used for each electrical defibrillation
- Cardiac rhythm at time of defibrillation
- Tube size, time, name, and title of the person who intubated the patient
- Dosage and time medications were given
- Patient's level of consciousness throughout the code with changes in the patient's condition clearly documented and timed
- Site of each IV fluid, amount, rate, and time administered
- Equipment used during the code
- Names of staff who assisted at the resuscitation
- Patient outcome and disposition

The hospital should have policies about where blank code sheet are kept (*e.g.*, on every patient unit, on crash cart). The policy also should state who is responsible for recording the information during the code. The recorder is responsible for documenting the events as they happen. Since the events of resuscitation happen quickly, someone should assume the role of recorder as soon as safely possible.

Copies of the code sheet can be distributed to various departments or groups in the hospital. Be sure to remove patient identifiers before sharing copies with people who don't need patient-specific information. The pharmacy department may want a copy for purposes of restocking code cart medications and charging. A copy to central processing may help them determine what code cart equipment needs replacing. Risk management may receive a copy to investigate areas of potential

liability. The quality department can use a copy of the code sheet to collect performance data. If the team completes a code critique form or documents debriefing notes, the original should be forwarded to the risk management or quality department. Critique forms or notes should not be kept as a permanent part of the patient's record.

Several types of CPR performance measures can be used to evaluate patient resuscitation events. Examples include:

- Complication rates
- Average length of time from initiation of the code until the start of resuscitation
- Average length of time from the start of resuscitation until the end of the code
- Appropriateness of the code, *e.g.*, Did patient have "do-not-resuscitate" orders? Had patient actually arrested when the code was called?
- Average length of time for specific disciplines to respond to the code
- Percent of codes with reported equipment problems
- Percent of codes in which medications or supplies were not available when needed
- Percent of codes in which code cart items specific to the needs of the patient were not available, *e.g.*, pediatric medication doses or equipment necessary for newborn resuscitations
- Percent of codes in which staff or physician reported problems
- Percent of codes in which endotracheal intubation could not be accomplished
- Percent of defibrillations in which paddles were properly placed
- Percent of defibrillations in which no shock was delivered on first attempt
- CPR survival rates

CPR survival rate is the most common performance measure used by hospitals to evaluate resuscitation efforts. However, survival rates are difficult to benchmark without a good understanding of patient variables. Studies of CPR outcomes show wide disparity in survival rates. The worldwide average CPR survival-to-discharge rate has been reported to be 15.2%, with rates ranging from 3% to 27%. Researchers in Canada studied all records of adult cardiopulmonary arrests that occurred at three main teaching hospitals in Edmonton between Jan. 1, 1997, and Jan. 31, 1999. Medical staff witnessed 58% of the 247 arrests that occurred during the study period. Of these arrests, 48% of patients were resuscitated successfully. But only 22% of them lived long enough to be discharged from hospital.

CE *questions*

21. Which is true regarding the new tracer methodology from the Joint Commission?
    A. Patients will be selected based on core measures alone.
    B. Questions about patient care processes will be directed to managers instead of unit.
    C. Staff only will be expected to answer questions about patients they cared for.
    D. Surveyors will expect unit staff to explain patient care processes for any patient.
22. Which is true about the Joint Commission's new survey process?
    A. Surveyors whereabouts are dependent on a patient's path through the facility.
    B. Quality managers will have more control over where surveyors go in the facility.
    C. Scheduling of key department heads will become easier.
    D. Tracer methodology will enable surveyors to assess every service and department throughout the facility during the survey.
23. Which is accurate regarding comparative performance data released from the National Reporting Initiative?
    A. Severity of a patient's illness significantly affects performance rates for the measures reported by CMS.
    B. You should expect care to vary significantly based on hospital size or location.
    C. The data can be used to apply a similar model to your own internal comparative performance reports.
    D. The CMS data gives results broken down according to hospital size.
24. Which reflects actions of surveyors from the Joint Commission during a survey at Hurley Medical Center in Flint, MI?
    A. Surveyors were only interested in actual practice, not policies and procedures.
    B. If problems were identified in one area, surveyors looked for evidence of that problem in other departments.
    C. Each problem that was identified was treated as an isolated incident.
    D. Surveyors did not review the facility's plan of care.

For answers, see Answer Key, p. 176.

To more accurately evaluate your hospital's CPR survival rate, it's important to stratify the results into meaningful categories. For example, studies have shown that patients with ventricular tachycardia or fibrillation are more likely to survive resuscitation than those with asystole or pulseless electrical activity. Thus, it may be worthwhile to report CPR survival rates for patients having each type of condition. Researchers also have found that emergency department and coronary care unit

patients are more likely to survive a code than intensive care unit and general ward patients. Other factors related to better survival rates are respiratory arrest, witnessed arrest, absence of comorbidity, and short duration of CPR. Survival rates can be correlated with any of these pre-arrest and intra-arrest factors to help caregivers judge the results. By monitoring survival trends for different categories of patients, caregivers can identify improvement opportunities. For example, if CPR survival rates appear to be high in relation to published study results, it may be an indication of inappropriate codes, *e.g.*, CPR initiated for nonarrest situations. If CPR rates appear low, it may be a quality-of-care issue or it may be that do-not-resuscitate orders are underutilized or advanced directives are not being considered prior to starting resuscitation.

The notes from debriefings done immediately post-resuscitation also can be valuable sources of information. Some of the things that can go wrong during a code often are not clearly identifiable on the resuscitation record. Often, errors relate to leadership, teamwork, or procedural skills. If several physicians were present at the code, was a lead physician clearly identified? Were team members reluctant to question the person in charge, even if that person's decision was in error (*e.g.*, failure to question an incorrect epinephrine dose)? Did the team have access to the patient's complete clinical history, or were there delays in obtaining the hospital chart? Were members of the team distracted or fatigued? Provide a brief synopsis of debriefing notes along with the results of performance measures.

The committee responsible for monitoring CPR survival rates also should receive information about related CPR performance data, *e.g.*, compliance with training and code cart checks, problems identified during code situations, etc. Those nonclinical aspects of resuscitation can affect survival rates.

One of the more serious and clinically important adverse events is unexpected cardiac arrest. That's the primary reason why the Joint Commission standards require that all resuscitations be reviewed for appropriateness of care and analysis of the events leading up to the arrest. Despite the availability of cardiac arrest teams and advances in cardiopulmonary resuscitation, the risk of death from such an event has remained largely static at 50% to 80%. By reviewing the clinical aspects of patient care in addition to CPR processes, hospitals can identify ways to prevent arrests as well as improve patient outcomes following an arrest. CPR reviews also can identify underutilization of "do not resuscitate" orders for patients receiving palliative care. ■

SARS audio program updates guidelines

Leading epidemiologists say a global return of severe acute respiratory syndrome (SARS) — which wreaked havoc on the health care systems that had to deal with it — is almost inevitable. The current overriding concern is that SARS will resurface as a seasonal illness along with influenza and other respiratory infections.

What would happen *today* if a patient with suspect or probable SARS was admitted to your hospital? To help you prepare, Thomson American Health Consultants offers the upcoming audio conference: **The Resurgence of SARS: Why your hospital may not be as prepared as you think**, Dec. 9, 2:30-3:30 p.m. EST. Let our experts help you answer that and many other critical questions with practical tips and solutions to detect first cases and protect other patients and health care workers.

Our speakers are **Allison McGeer**, MD, director of infection control at Mount Sinai and Princess Margaret Hospitals in Toronto. A veteran epidemiologist, McGeer dealt firsthand with SARS patients and occupationally infected workers during the prolonged outbreak in Toronto. Hear the lessons learned by somebody who has dealt with this novel emerging pathogen on the front lines.

If SARS returns, hospital emergency departments (EDs) certainly will be on those front lines. To provide valuable guidance and critical insight in that setting, **Susan E. Shapiro**, PhD, RN, MSN, CEN, will outline valuable tips and procedures, in addition to addressing and clarifying recently

updated CDC recommendations for SARS. Shapiro is a post-doctoral fellow in risk assessment and intervention research with individuals and families at Oregon Health & Science University School of Nursing in Portland. A career ED nurse and nurse manager before recently completing a doctoral program, she is the Emergency Nurses Association's representative to the CDC's SARS task force.

Educate your entire staff for one low fee including 1 hour of CE, CME, or Critical Care credits for all attendees. You may invite as many participants as you wish to listen for the low fee of $249. Information on obtaining audio conference instructions and continuing education forms will be in the confirmation notice, which will be mailed upon receipt of registration. Your fee also includes access to a 48-hour replay following the conference and a CD recording of the program. For information or to register, call customer service at (800) 688-2421 or contact us via e-mail at customerservice@ahcpub.com. When ordering, please refer to effort code **35281**. ■

CE objectives

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

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions.

This concludes the current CE semester. Please return the enclosed survey to receive CE credit. ■

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

Hospital Peer Review 2003 Index

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December 2003 — Vol. 28, Issue No. 12

Continuing Education Evaluation

To earn nursing contact hours for this activity, you must return this evaluation form. Place an "x" in the appropriate spaces and return this page in the envelope provided. Thank you.

For your reference, here is the stated overall purpose of *Hospital Peer Review*:
Hospital Peer Review is a news and how-to publication for quality professionals that covers quality-related issues from government mandates through quality improvement.

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yes ☐ no ☐ 1. Are you able to identify clinical, legal, or educational issues related to quality improvement and performance outcomes?

yes ☐ no ☐ 2. Are you able to describe how those issues affect nurses, health care workers, hospitals, or the health care industry in general?

yes ☐ no ☐ 3. Are you able to cite solutions to problems associated with those issues, based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions?

yes ☐ no ☐ 4. Were these objectives consistent with the overall goal of the newsletter?

5. How many minutes do you estimate it will take you to complete **this entire semester** (6 issues) activity? Please include time for reading, answering the questions, comparing your answers to the correct answers, and reviewing the material relevant to the missed questions. _____ minutes

yes ☐ no ☐ 6. Were the CE questions clear and appropriate?

yes ☐ no ☐ 7. Were you satisfied with the customer service for the CE program?

yes ☐ no ☐ 8. Did this activity change your clinical practice? If so, how? _____

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