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2 children's deaths after surgery raise concerns about safe medication use

Likely morphine overdoses put spotlight on drug policies

At an Oklahoma hospital, two children died within a few days of each other after having routine outpatient surgical procedures. One child died from toxic effects of morphine with a probable primary myopathy as a contributing cause,[1] and the other child died from probable codeine and morphine toxicity, along with acute and chronic bronchitis with evolving pneumonia, according to the autopsy reports.[2]

One child had undergone surgery on his toenails, and the other had undergone tonsillectomy with adenoidectomy and bilateral myringotomy. The post-anesthesia standing orders form at SouthCrest Hospital in Tulsa had space for the physician to choose morphine, Demerol, or Tylenol for pain control. In both cases, a physician had not indicated which medication was to be administered, according to the investigation by the state health department.

That investigation indicated that the facility failed to follow accepted standards of practice for administering drugs, including a requirement that a physician's order specify the drug, the dosage, and the route of administration.[3] The facility also failed to administer drugs in accordance with state and federal laws, according to the investigation.[3]

The investigators reviewed the medical staff bylaws and regulation, the pharmacy policies and procedures, and the ambulatory surgery policies and procedures and found the hospital didn't have any written policy or regulation on the use of standing orders. Also, the hospital failed to ensure post-anesthesia evaluations were performed, the investigation reported.[3] The hospital, when contacted for comment, released a statement that the hospital has been conducting an ongoing internal review.

SouthCrest Hospital isn't alone in its difficulty. Many facilities, even accredited ones, have problems meeting the standard of care for medication administration. In 2003, 41% of hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations received the worst possible score, a 1, for standards related to prescribing, preparing,

dispensing, and administering drugs, according to the Joint Commission web site (www.jcaho.org). **(For more information on the Joint Commission's requirements, see story, p. 39.)**

For its part, SouthCrest Hospital has revised the standing orders for pediatric outpatient surgeries to clarify drug dosage and route, according to the investigation report.[3] Also, the hospital has added to its post-anesthesia care unit policy that nurses will calculate and document the maximum dose for each medication ordered on the standing orders. In addition, the facility, which did not self-report the deaths, is conducting a root-cause analysis that will be reviewed by the Joint Commission, explains **Mark Forstneger**, spokesman for the Joint Commission.

"Most people don't come into an organization saying, 'What can I mess up today?'" says **Michael Jarema**, associate project director of the Division of Standards and Survey Methods at the Joint Commission. "When you have an error, while individuals are still accountable, we want organizations to go beyond the individual and ask, 'What underlying processes led to the error occurring? Was this a process issue?'"

This concept is labeled "proactive risk assessment," Jarema says. For example, in the Oklahoma cases, "the point is that the nurse, or physician, or organization didn't deliberately or willfully or by design intend for an error to occur, but an error did occur. What can they do to make sure the next 1,000 patients that come through door are safer?"

To avoid medication errors, adapt a medication safety protocol, urges **Dorothy Fogg**, RN, BSN, MA, perioperative nursing specialist at the Center for Nursing Practice at the Association of periOperative Registered Nurses in Denver. **(For information, see source box, p. 40. Also see "Recommended Practice: Potential Hazards Associated with Medication Use in the Practice Setting" at www.same-daysurgery.com in the "toolbox." Look under the "safety" heading.)**

In addition, there are systems available to help same-day surgery providers reduce the likelihood of medication errors. They include:

- **Unit dosing systems.**

Highland Hospital in Shreveport, LA, uses unit dosing through the Pyxus system (Cardinal Health, San Diego). The system provides acceptable unit doses if a physician orders the wrong dosage, says **F. Dean Griffen**, MD, FACS, surgeon at the Highland Clinic, also in Shreveport.

"For the nurse to alter that dosage would prompt a query," such as a question about why the nurse has ordered a dose that is 10 times as much as the default dose, he says. In that case, the physician's order might have had the decimal in the wrong place, Griffen says.

"This is a fairly inexpensive way to provide safe dosing," he says. However, this technology only addresses some of the medication safety problems, Griffen acknowledges. For example, it doesn't address issues such as writing orders

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illegibly, giving medications to the wrong patient, failing to recognize allergic reactions in a timely manner, and administering medications subcutaneously instead of intravenously when an intravenous line is misplaced, he says.

• Computerized physician order entry (CPOE). About 15% of hospitals in the United States have at least partial CPOE systems, Griffen points out. With CPOEs, a physician enters a drug, dose, and administration into a computer, which eliminates the problem of legibility, he says. The CPOE lists acceptable dose ranges, frequencies, and routes, he notes. There are many advantages, Griffen states. "CPOEs can provide default doses, which is helpful when a physician thinks he knows the doses, but he doesn't," he says.

Also, physicians can provide a patient's background information, such as allergies and other medications, to the CPOE, Griffen explains. If a physician subsequently tries to prescribe a medication to which a patient is allergic or which is incompatible with medications the patient already is taking, the computer alerts the physician.

The system also can provide default doses to meet patient's specific needs; for example, if a dosage is toxic for a patient with kidney failure,

New JCAHO survey process addresses medication errors

In light of so many providers having difficulty meeting the standard of care for medication administration, the Joint Commission on Accreditation of Healthcare Organizations is taking action.

One its 2004 national patient safety goals is to improve the safety of using high-alert medication. **(For more information, see *Same-Day Surgery*, September 2003, p. 104.)** In addition, newly organized medication standards from the Joint Commission put more focus on medication processes as a system, rather than individual standards, says **Michael Jarema**, associate project director of the Division of Standards and Survey Methods at the Joint Commission. For all surveys three days or longer, surveyors will walk through the six steps of medication processes:

- **Selection and procurement:** This is the process by which the organization decides what medication to have available and the process by which it obtains medications, including what to do if there is a shortage of a medication.
- **Storage:** The provider addresses issues of medications that sound alike and look alike, as included in the national patient safety goals, including control of medications.
- **Ordering and transcribing:** This area includes consideration of computerized physician order entry (CPOE), verbal orders, written orders, etc. It covers approved abbreviations, use of generics, indications for use, precautions, and 13 orders that require special attention, including an incomplete or illegible order.
- **Preparing and dispensing:** This area covers the preparation, issuance, and accountability for doses of a prescribed medication by a pharmacist or authorized individual. It includes review of medication orders for appropriateness, safe preparation, labeling, dispensing practices, and medication recalls.
- **Administering:** The standards addressing this process cover giving a prescribed dose of a medication to a patient and describes safe administration processes such as verifying the medication, dose, route, time, and patient.
- **Monitoring:** The standards addressing this process within an organization's medication management system focus on the responsibility for monitoring effects of medications and the organization's response to actual or potential adverse drug events and medication errors.

The surveyors might pinpoint a specific medication and "walk it through" the organization, Jarema says. They may ask, "How would you determine how you're going to use this drug in your facility? What are storage issues? How do you train staff?" For new medications, they might ask, "Does this medication require anything unique?" Surveyors might pull a patient's chart and ask about any medications the patient is taking that are considered high risk, such as warfarin. They might ask staff, "How is the medication approved for use in your organization? How did you decide to use it? How frequently do you review the medication you're using? How do you know providers are competent to use them?" If surveyors see a drug is administered in a specific area, such as the pre-op area, they may go to that area and talk to staff about storage and other safety issues, he explains.

Also, facilities are required by the Joint Commission to have a regulation that provides a system for a nurse to contact a physician when an order isn't legible or it's the wrong dose, adds **F. Dean Griffen**, MD, FACS, surgeon at the Highland Clinic at Shreveport, LA. ■

SOURCE AND RESOURCES

For information on medication safety, contact:
- **F. Dean Griffen**, MD, FACS, Surgeon, Highland Clinic, 1455 E. Bert Kouns, Shreveport, LA 71105.

For a sample protocol on medication safety, go to the Association of periOperative Registered Nurses web page (www.aorn.org). At the bottom of the page, click on "patient safety first," then "information resources," then "AORN Guidance Statements," then "Safe Medication Practices in Perioperative Practice Settings."

the system will provide default doses for those patients. The system also provides information on lower-cost medications that are clinically equivalent, he continues. On the downside, CPOEs must be integrated into facilities' current computerized system, he says. Also, the systems are expensive, Griffen acknowledges.

Brigham and Women's Hospital in Boston spent $1.9 million setting up a CPOE in the early 1990s, says **David Bates**, MD, MSC, chief of the division of the general internal medicine at Brigham and Women's. Ongoing costs for a CPOE are approximately $500,000 a year, he says. However, in 1994, the cost of an adverse drug event was estimated to be about $5.6 million, he explains. CPOE allowed Brigham and Women's to reduce adverse events, over a three-year period, from 14.7 per 1,000 hospitals days to 9.6 per 1,000 hospitals days, Bates says.

While the CPOE doesn't eliminate adverse events, it is cost-effective, Griffen maintains. "And who cares about cost if you save one life?" he asks. About 14% of adverse drug events end in the death of a patient, he says.

More help is one the way. The Food and Drug Administration (FDA) is issuing a final rule requiring bar codes on the labels of medications. The bar-code rule will encourage widespread adoption of advanced information systems that, in some hospitals, have reduced medication error rates by as much as 85%, according to the Department of Health and Human Services.[4] With these systems, patients are provided with identification bracelets that bear a bar code. The health care provider scans the patient's bar code and scans the medication's bar code. The information system verifies that the right patient is getting the right medication at the right time, the right dose, and via the right route of administration.

In a study conducted at a Veterans Affairs Medical Center, using such a bar-code scanning system, 5.7 million doses of medication were administered to patients with no medication errors.[4] The FDA estimates that the bar-code rule, when fully implemented, will help prevent nearly 500,000 adverse events and transfusion errors over 20 years.

"We have to make systems that are foolproof so human error can be mollified," Griffen says.

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Three credentialing steps help ensure competency

[In this second part of a two-part series on new technology, we discuss how to handle credentialing in this story and how to respond to errors. ***(See story, p. 41.)*** *Last month, we discussed training and informed consent issues regarding new technology.]*

How do you credential physicians who want to perform procedures with new technology? If they are credentialed elsewhere or appear to have their documentation in order, do you wave your magic wand and rubber stamp their credentials? If so, you may want to rethink that policy.

"The facility is expected to perform its own credentialing and privileging for every physician on

(Continued on page 42)

EXECUTIVE SUMMARY

A thorough credentialing process can help your program ensure physicians are prepared to perform procedures involving new technology.
- Involve one or more committees to review the physician's expertise and experience.
- If the physician underwent a training course, determine whether there was an assessment to evaluate the skills and judgment.
- At least every two years, revisit the physician's credentials, some sources suggest.

When an accident occurs, don't make these mistakes

Sometimes, despite your best efforts, an accident occurs with new technology and a patient is injured or dies. Above all, you don't want it to happen again. Surprisingly, one of the most common mistakes that providers make is "insufficient investigation or lack of response to an error so that it is repeated," says **Bruce C. Hansel**, PhD, executive director of forensic services at ECRI, a Plymouth Meeting, PA-based nonprofit health services research agency that focuses on technology, risk and quality management, and environmental management.

Stephen Trosty, JD, MHA, CPHRM, director of risk management and CME for American Physicians Assurance Corp. in East Lansing, MI, says that "ultimately, there should be a policy in place after the initial discussion [with the family] so that a group including physicians, nursing, risk management, perhaps engineering, and probably someone from communications/PR can actually get information as it comes in and see what occurred as the investigation occurs."

Avoid these other common mistakes made by same-day surgery providers when an accident happens:

• Don't point fingers, and don't delay having staff talk to risk management.

Providers' first instinct may be to immediately point a finger at someone else, Trosty says. However, the information they have may be inaccurate, he adds.

"Information may come back to haunt you or others. Don't make assumptions for what occurred before you have information and facts." Contact the risk manager immediately, Trosty says. Have a policy that staff can talk to the risk manager, pastoral care/social services, or the head of their department, who can coordinate the discussion with risk management, Trosty suggests. If the physician or staff members talk to others, they subconsciously may be swayed by what others are saying; in a lawsuit, those discussions may be discoverable, he says. "People are going to be very upset, and they may talk about what they assume occurred," Trosty says. "It may not be accurate, but it may assist plaintiffs in making what is not a legitimate case."

Also consider calling the risk manager at your insurance company, say some sources interviewed by *Same-Day Surgery.* That person may be able to steer you during the process, they say.

• Don't ignore the patient and the family.

"It's not easy [to talk to the patient or family], but you don't want the patient or family to get the sense they're being ignored, that people are hiding things, or that they're not being upfront and honest," Trosty says. "They increase frustrations and can increase the potential for a lawsuit." The physician should explain to the family that there was a negative outcome and express sympathy and concern. "You don't want people initially admitting liability," he says. Keep the discussion limited and simple, Trosty emphasizes. "What might appear to be the cause of the incident may not end up being the cause." Avoid making any promises about the future, and don't offer any assurances regarding money or payment issues, Trosty says. Inform the patient and/or the family that an investigation will be conducted and, as information is obtained, it will be shared with them. "The family ought to be provided the name and number of someone they can contact if they have questions or concerns," he adds. The physician is a good contact for any clinically related questions, and social workers, chaplains, or others trained in counseling are good contacts.

As the investigation progresses, you may determine that someone else is the best person to talk to the patient and/or family. "But there should be determination who the spokesperson is so there are not multiple persons working at cross purposes," Trosty says.

• Don't ignore equipment that was involved.

The most common mistake that providers make following an accident is that they fail to save or sequester all of the medical devices that potentially were involved in the incident, Hansel adds.

Arrange for a knowledgeable independent source to check the functioning of the equipment, Trosty suggests. "Sometimes, the manufacturer will try to get in and get its hands on the equipment. I strongly recommend that not occur. That's not an independent source," he notes. You only have one opportunity to perform an assessment of the equipment in the actual condition it was in when the incident occurred, Trosty points out.

However, do notify the manufacturer, say sources interviewed by *SDS.*

• Don't forget public relations.

Have mechanisms in place ahead of time regarding how you will deal publicly with an accident, Trosty adds. "Get your PR people working on how best to put out information and minimize damage, particularly before all the facts are known," he says.

Issue a written statement prepared by administration, risk management, and your legal counsel, Hansel suggests. It can be read publicly if necessary, preferably by a person experienced in dealing with the media, he says. "Impromptu conferences, extemporaneous speeches, and Q&A sessions should be avoided," says Hansel.

• Don't ignore needs of physicians and staff.

If a patient has died, the impact can be dramatic on physicians and staff, Trosty stresses. Consider having pastoral care and/or social services available, he says. However, physicians and staff should limit discussions to emotional issues, rather than specifics of the case, with people such as social workers whose discussions may be discoverable in a lawsuit, Trosty says. "Leave the clinical/medical discussions for the peer-review process or investigation process," he advises. ■

SOURCES

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staff," says **Stephen Trosty**, JD, MHA, CPHRM, director of risk management and continuing medical education for American Physicians Assurance Corp. in East Lansing, MI. "If they do not do so, then they can be held liable for negligent credentialing. The courts have made it abundantly clear, as has [the Joint Commission on Accreditation of Healthcare Organizations], that it is not acceptable to accept the credentialing from another facility."

There has been an increase in the number of malpractice actions in which negligent credentialing is one of the allegations, Trosty warns. "There also has been an increase in the number of these legal actions being won by plaintiffs," he says.

Consider these suggestions to reduce liability and ensure patient safety when credentialing for new technology:

• Involve one or more committees.

At Ingham Regional Medical Center, a credentialing committee is chaired by the co-leaders of the professional staff and includes representatives from the hospital specialties, some administrative staff, and **Michelle Kelly**, CPMSM, supervisor of medical staff services. **[See hospital's policy on privileging for new techniques/procedures at www.same-daysurgery.com. Click on toolbox. Your user name is your subscriber number from your mailing label. Your password is sds (lowercase) plus your subscriber number (no spaces). The policy is listed under "policies and procedures."]**

Physicians requesting credentials give the committee an overview of the technology and are quizzed on their proficiency and experience, their interpretation of the outcomes with the technology, potential complications and how they are addressed, the basic science on which the technology is based, and needs for staff training and equipment. The physician also usually addresses any reimbursement for the procedure. The committee determines if the physician is qualified to use the new technology.

The next step is for the physician to submit a formal request for privileges accompanied by a proctor's recommendations. The request is reviewed by the appropriate department chairman.

At The Surgery Center of Nacogdoches (TX), the physician requesting credentials submits information to a medical executive committee including an outline of the procedure, training, costs, reimbursement, and an anticipated number of procedures, says **Jeanie Suhor**, RN, director. Five physicians are on the medical executive committee, including the medical director and the vice medical director, and the administrator.

"Once the medical executive committee gives its approval, the physician submits a request for privileges to the credentials committee, which determines competency by training and/or certification," Suhor says. The credentials committee is made up of five physicians.

The request then goes back to the medical executive committee and then the governing board for its approval.

"This does sound like a lengthy process, but requiring approval of several committees is a better assurance of competency, management of equipment purchases, and patient safety," Suhor says.

• Assess the training and proctoring.

Just because someone performs surgery doesn't mean they're competent to use new technology to perform surgery, Trosty points out.

"Make sure they have gotten adequate and sufficient training from verifiable and legitimate sources," he says.

At Ingham Regional Medical Center, physicians have these options:

— attend a program accredited by the Accreditation Council for Graduate Medical Education or attend an American Osteopathic Association-accredited residence program;

— attend continuing medication education programs in one of these accredited institutions;

— complete testing or certification by a certifying board;

— provide documentation of training or practice under direct supervision of a recognized authority in the field.

Find out more information about the course, such as whether there was an assessment to evaluate the physician's skills and judgment, suggests

Richard J. Croteau, MD, executive director for strategic initiatives at the Joint Commission.

Ensure the physician understands the principles behind the technology and how the technology works, advises **Bruce C. Hansel**, PhD, executive director of forensic services at ECRI, a Plymouth Meeting, PA-based nonprofit health services research agency that focuses on technology, risk and quality management, and environmental management. "Too often, the training focuses on how to use the device, he continues. "As long as nothing goes wrong, knowing how to use it is enough. But when things go wrong, having a good understanding of the technology and how it works vastly improves the user's ability reason through what is happening and troubleshoot the situation," Hansel explains.

Use proctoring or monitoring the first few times physicians use new equipment to make sure they're competent in what they're doing, Trosty advises.

• Recognize credentialing is an ongoing process.

Credentialing is not something you do once and the physician is credentialed forever, Croteau emphasizes.

"That position doesn't recognize that skills change over time," he says.

Regularly revisit the physician's credentials as required by law or facility rules, say sources interviewed by *Same-Day Surgery.*

"Look at the individual's experience with particular types of procedure, what their results have been, and get input from others who have first-hand knowledge of the individual's practice, ultimately to make recommendations on whether privileges should be continued or not," Croteau says.

When an accident does happen, you want to ensure that nothing has happened that could anger a jury, says **Lori G. Cohen**, Esq., partner at Alston & Bird in Atlanta. "The last thing you want a jury to believe is that the new technology is being trotted out as a means of testing or experimenting," she says. "You never want a jury to feel like anyone is being treated as a human guinea pig." ■

Same-Day Surgery Manager

Improve your relationship with anesthesia services

By **Stephen W. Earnhart**, MS
President and CEO
Earnhart & Associates
Austin, TX

I have had several individuals contact me regarding a past article in which I mentioned that the service that administrators find the most difficult to work with is anesthesia. **(See "SDS managers share their biggest headaches," *Same-Day Surgery,* July 2003, p. 78.)**

Since I wrote that article, I have tried to understand from where the problems arise. After further conversations with the original group and others, especially anesthesia personnel, it appears that many of the problems same-day surgery programs are having result from poor communication.

Most of the problems arise from three areas in the initial setup of the outpatient surgery program:

1. Anesthesia personnel tell me that they didn't know they were going to be expected to stay in the center until the last patient of the day's ride finally showed up.

2. They didn't know that they must have a contract with every carrier (provider) with which the outpatient surgery program has a contract. Many anesthesia groups across the country are boycotting certain insurance providers because of what they think are poor rates. You have to be sympathetic to their cause, but you also have to understand the role of the outpatient surgery program in providing coverage for their patients.

3. Another area of dispute between anesthesia coverage and ongoing same-day surgery management is identifying, by name, those individuals within an anesthesia group that the surgeons wish to not rotate through the facility. Can that be done? Actually, it can be and is done in many same-day surgery programs. Being sympathetic to the chief of the anesthesia group, you can imagine what that type of request must do internally to their cohesiveness. Yet you also can appreciate a new program that knows that "Dr. Brown" does not adopt the same philosophy of marketing to the surgeons, staff, or patients of the new facility. He may be considered too slow, constantly late, or abusive to the staff, and the surgeons do not want to deal with his personality.

It's hard to blame them if they have a history with that individual.

Other ongoing issues that are a result of anesthesia include:

• Anesthesia staff not wanting to open another OR to accommodate another case.

• Anesthesia staff not wanting a large gap in time between the end of one case and the start of another.

This situation is especially true of new programs that are trying to accommodate the surgical staff and be available to meet their needs.

• Anesthesia staff's desire to "run the board" or control the "back of the house" functions of the same-day surgery program. Since anesthesia staff members are compensated only for the time they are with a patient, they want to compress that time as much as possible. It's hard to blame them.

• Anesthesia staff's lack of willingness to assist in room turnover. That situation goes against what was stated in the last item, but the fact is that some staff members do not have the same incentives to be time efficient. Unless they were told that their contract depended upon help with turnover times, what can you do?

• Anesthesia staff's lack of willingness to clean up after themselves. This is the old "Your mother doesn't work here" issue in that the staff of the same-day surgery program don't feel that they need to clean up and put away anesthesia equipment and supplies after the case. Often anesthesia personnel forget how much the nurses assist them during induction and transfer.

So what can be done? You need to deal with these issues yourself, but these are my ideas that historically have worked in other facilities:

• Clearly define the role of anesthesia up front. We recommend that you come up with a list of your expectations for the anesthesia group of what you expect from them so there are no questions later. Clearly, there is always room for negotiations, but that needs to occur before the contract is signed, not after the fact.

• Work with the anesthesia group if there is a contract dispute. Often just giving them time to work out the details of their contract will suffice. You are in a long-term relationship with them. If you have to give them two or three months of room to negotiate a better carrier contract, it won't effect you significantly. You might need them to help you someday on a similar issue.

• If you definitely do not want Dr. Brown in your center, state it and stick by it. But often a better way to start the relationship is to allow all members of the department to rotate through the center until there is a problem with a particular individual.

We all act differently in new surroundings.

• Anesthesia staff need to understand that you are going to have to be accommodating to the surgeons. If they repeatedly refuse to work with the center by not accommodating late bookings, then you need to address it and let them know that the same-day surgery program will consider those refusals when it is time to renew their contract.

• A good anesthesia group can make or break a surgery center. You want them on your side (without compromising your mission statement). If they want to assist in running the board, make sure that it is not your pride that is getting in the way of the potential new efficiency they can bring.

• Room turnover contributes to the well-being of every member of the organization. If a member of the anesthesia department is too good to help you, then refer back to the item above on accommodating the surgeons.

• This is a give-and-take issue. There might be a very good reason they are not helping you. Sit down and discuss it. I have never seen a situation in which this type of problem cannot be fixed.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management.

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Advice on turning your OR into a sharps safety zone

No-hands passing, sharps holders decrease injuries

Major advances in reducing sharps injuries have not yet pervaded the OR, where one out of four sharps injuries takes place,[1] but there are some simple steps that same-day surgery managers can take to promote safety, sharps safety experts say.

"I think it's a rare exception to find a surgeon who doesn't care about the safety of his coworkers," says **Mark Davis**, MD, FACOG, an Atlanta surgeon who has become a major proponent for sharps safety in the OR. "The problem is just getting their attention."

EXECUTIVE SUMMARY

While percutaneous injuries from needles, syringes, and lancets dropped by at least 55% from 1993 to 2001, injuries from suture needles declined by only 5%. To improve safety:

- Develop a "no-hands passing" protocol.
- Use sharps holders to pick up and pass sharps.
- Choose items such as blunt sutures, blunt retractors, and safety scalpels to reduce opportunity for injury.
- Use data to support the changes when presenting new protocols or supplies to physicians.

The overall data are convincing. While percutaneous injuries from needles, syringes, and lancets dropped by at least 55% from 1993 to 2001, injuries from suture needles declined by only 5%, according to data from the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville.

It's important that sharps injury data be shared with all OR staff, says **Joan Blanchard**, RN, MSS, CNOR, CIC, perioperative nursing specialist in the Center for Nursing Practice at the Association of periOperative Registered Nurses in Denver. Quality improvement projects focused on specific practices such as use of safety items and safer techniques for passing can bring improvement, she says. When you introduce new processes through QI project, staff are more likely to comply with safety requirements, Blanchard adds.

Gaining support from administration and physician leaders also is crucial, Davis notes. "The same-day surgery manager can't do it alone," he says. "Physicians typically want to speak with physicians if they're being asked to do something. If the top levels of administration don't support the change, then it's really a tough job."

Ultimately, change must come from within the OR itself. So the first step in any injury reduction program should involve building a team of OR safety champions, says Davis, who works as a consultant and wrote the book *Advanced Precautions for Today's OR.* **(For ordering information, see resource box, p. 46.)**

Surgical programs often begin addressing sharps injuries by implementing safer practices, such as no-hands passing. At Rose Medical Center in Denver, **Pat Koehmstedt**, RN, CNOR, operating room educator, met with staff and helped them design a neutral zone and select a sharps holder.

To back up the new process, she made and put posters above the scrub sinks to remind everyone to use the neutral zone and sharps holders and educated surgical technicians and nurses at the monthly staff meetings. The chief of surgery discussed the new practice with surgeons.

"For a week when we started it, I went from room to room, talked to the surgeon, talked to staff," Koehmstedt notes. "It was quite difficult to start off with it, but the approach was for their benefit."

Sharps injuries related to passing declined from about four a month to two or fewer. Some months there are none. Over time, the surgeons stopped using the special plastic device because of the extra time and motions required, but the neutral zone, with no-hands passing, has remained, she says.

"The whole theory was to decrease [sharps injuries], which we have accomplished," adds Koehmstedt. "Even though they're not using an instrument, the technique is improved."

Techniques such as the no-hands passing for transfer of sharps are a key step to take in a sharps safety program, Davis says. Hand-to-hand passing is the cause of 25% of scalpel injuries and 50% of suture injuries, he points out.

Convincing surgeons to use other safety devices, such as blunt suture needles, is more difficult. But as new products are developed, they may become more acceptable, Blanchard explains. "You really have to look at what's being offered and work with the companies by providing feedback to help them improve the product," she says.

Other safety devices that can be used include safety scalpels, blunt retractors, and safety syringe needles, Davis says.

Some devices may interfere with access to the incision or may not be appropriate for a particular procedure, he points out. "Surgeons may need to make the decision to use certain safety devices on a case-by-case basis," Davis adds.

Surgeons are data-driven, so show them the numbers, he says. The surgeon and the scrub tech don't know how many people got stuck last year, Davis continues. "If they weren't the ones stuck, they don't know anyone got stuck," he adds. "You've got to get the data so people will be motivated to accept change."

Awareness of the risks — medical and regulatory — can have an impact. An estimated 2.7 million Americans have chronic hepatitis C. Many of them don't know it, and that situation creates a risk of infection from bloodborne exposures.

OR blood exposure rates from your facility should be posted in the lounge at least on a quarterly basis, Davis says. This posting increases the

SOURCES

For more about OR sharps safety, contact:

- **Mark Davis**, MD, FACOG, Atlanta. Phone: (404) 233-3359. Fax: (404) 233-5662. E-mail: msdavismd@aol.com.
- *Advanced Precautions for Today's OR* is $14.95 plus $5 shipping and handling for one to three books. Contact Sweinbinder Publications, P.O. Box 11988, Atlanta, GA 30355. Phone: (404) 261-4595. Fax: (404) 233-5662. E-mail: sweinpub@aol.com. To see other sharps safety educational materials, go to www.orprecautions.com.
- To obtain a checklist for sharps injury prevention, go the International Healthcare Worker Safety Center at the University of Virginia web site. Go to www.virginia.edu and choose "research and centers" on the right navigational bar. Under "Individual UVA Centers by Area" and "Health System," select "International Healthcare Worker Safety Center."
- The Centers for Disease Control and Prevention has launched an on-line workbook to help health care organizations design, implement, and evaluate sharps injury prevention programs or enhance an existing program. Go to: www.cdc.gov/sharpssafety/index.html.

level of education for the staff and motivates everyone to look for ways to reduce sharps injuries, he adds.

Hospitals and surgeons may come under scrutiny from the Occupational Safety and Health Administration through its stronger enforcement of the bloodborne pathogen standard. Standard 1910.1030 says employers with employees that can be exposed to bloodborne pathogens in the course of their job responsibilities must have a plan to reduce exposure.

The employer also must document ongoing efforts to evaluate and implement new technology that reduces the risk of exposure for employees. That standard is the most frequently cited as not being met in hospitals.

Surgeons also can receive citations and fines for noncompliance, Blanchard says. "[Inspectors] want to see that you are using safety devices wherever they're available," she adds.

Surgeons often are described as resistant to change, Davis notes. "They can actually be quite adaptable to change as long as they can be shown that the new ways of doing things, when done correctly, are not harmful to patients," he says.

And even if surgeons initially don't embrace some of the changes that are necessary for sharps safety, they will adapt, Davis says. "To say that surgeons are resistant to change and stubborn is throwing in the towel," he adds.

Reference

1. Perry J, Parker G, Jagger J. 2001 percutaneous injury rates. *Advances in Exposure Prevention* 2003; 6:32-36. ■

After 8 patient deaths, FL moratorium announced

14-day interval required between procedures

Florida surgeons cannot perform liposuction and abdominoplasty procedures on the same patient within 14 days of each other as a result of a 90-day moratorium imposed by the Florida Board of Medicine on Feb. 11, 2004.

The board acted upon information from adverse incident reports, which included eight deaths reported between August 2002 and January 2004. Four of the deaths involved patients who had liposuction and abdominoplasty procedures on the same day in the office surgery setting.

"The current office surgery limitations may not be enough to protect patients," says **Lisa Tucker**, MD, chair of the board. "We must investigate this combination of procedures to determine whether or not the process is safe and take appropriate, long-term steps to ensure safe procedures for all patients." The board members' concern is that the combination of procedures in a short period of time may increase abdominal pressure, which affects blood flow and increases the risk of pulmonary emboli.

A survey on lipoplasty safety that covered 94,000 lipoplasty procedures performed by board-certified plastic surgeons in 2001 showed the estimated risk of death from lipoplasty performed as an isolated procedure to be one per 47,415 procedures. When combined with abdominoplasty, the risk was significantly higher at one per 3,281 procedures.[1]

The rule that imposed the moratorium also requires physicians performing Level II and Level III office surgery to submit copies of their office surgery logs from June 1, 2002, through Jan. 31, 2004, to the state health department no later than May 10, 2004.

The Florida Board of Medicine members will use data from the logs to determine if the rule preventing both procedures within 14 days of

each other will become a permanent rule.

This is the second time in recent years that the board has issued a moratorium on office-based surgery as a result of patient safety concerns. **(See "What led Florida board to pass moratorium?" *Same-Day Surgery*, November 2000, p. 137.)**

The American Society for Aesthetic Plastic Surgery (ASAPS), in Los Alamitos, CA, supports the board's investigation because the society's members support the continued study of the safety of office-based surgery, says **Robert Bernard**, MD, a plastic surgeon and president of ASAPS.

"Our concern is that it is easy to jump to a conclusion based on limited information," he says. "We want the board to do its due diligence before enacting far-reaching restrictions impacting patient care."

For more information about the rule and the requirements for submission of office surgery logs, go to www.doh.state.fl.us. Look under "health notices" for the section titled "Attention Level II and III office surgery physicians." The link will take you to a detailed description of the rule and instructions on how to submit office logs.

Reference

1. Hughes CE. Reduction of lipoplasty risks and mortality: An ASAPS survey. *Aesthetic Surgery Journal* 2001; 21:120-124. ■

Medicare announces new surgery center rates

The Centers for Medicare & Medicaid Services has announced these rates for ambulatory surgery center groups, effective April 1, 2004:

- Group 1, $333;
- Group 2, $446;
- Group 3, $510;
- Group 4, $630;
- Group 5, $717;
- Group 6, $826 [$676 + $150 for intraocular lenses (IOLs)];
- Group 7, $995;
- Group 8, $973 ($823 + $150 for IOLs);
- Group 9, $1,339.

The update is a result of changes included in the Medicare prescription drug bill. The rates will be frozen at this rate through 2009. **(For more information, see, "ASCs must brace for possible 1% reduction and no increase until 2010," *Same-Day Surgery*, January 2004, p. 1.)**

Although the national payment rates are reverting back to the Oct. 1, 2002 rates, centers' local wage indexes will remain unchanged. ■

COMING IN FUTURE MONTHS

- Controversial procedure might not be covered
- Tips for reducing PONV
- Mastectomies undergo reconstruction
- Tips from pediatric surgery programs
- Tips from programs that score high in patient satisfaction

CE/CME objectives

After reading this issue of *Same-Day Surgery*, the CE/CME participant will be able to:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. (See *"2 children's deaths after surgery raise concerns about safe medication use"* in this issue.)
- Describe how those issues affect clinical service delivery or management of a facility. (See *"New JCAHO survey process addresses medication errors" and "Three credentialing steps help ensure competency."*)
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See *"You're writing more as abbreviations disappear."*)

CE/CME answers

13. A; 14. D; 15. A; 16. D

CE/CME *questions*

13. What technology is described as a "fairly inexpensive way to provide safe dosing" by F. Dean Griffen, MD, FACS, surgeon at the Highland Clinic at Shreveport, LA.
    A. unit dosing systems
    B. computerized physician order entry
    C. bar coding on medications
    D. none of the above

14. For all surveys by the Joint Commission that are three days or longer, surveyors will walk through how many steps of the medication process?
    A. 1: selectment and procurement
    B. 2: selectment and procurement, and storage
    C. 3: selectment and procurement, storage, and ordering and transcribing
    D. 6: selectment and procurement, storage, ordering and transcribing, preparing and dispensing, administering, and monitoring

15. When a physician wants to be credentialed in new technology, what type of information should managers determine about the course, according to Richard J. Croteau, MD, executive director for strategic initiatives at the Joint Commission?
    A. whether there was an assessment to evaluate the physician's skills and judgment
    B. how long the course was
    C. who the instructors were
    D. what written materials were reviewed

16. What is one reason surgeons might not to choose to use certain items such as blunt retractors or safety scalpels during a procedure, according to surgeon Mark Davis, MD, FACOG?
    A. The expense is too great.
    B. Insurance doesn't reimburse safety items.
    C. Surgeons don't like to try new things.
    D. The safety instrument's design might impede access to the incision.

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the June 2004 issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

You're writing more as abbreviations disappear

No more d/c, u, Q.D., or Q.O.D., according to Joint Commission list

Old habits are hard to break, and the Joint Commission on Accreditation of Healthcare Organizations is asking same-day surgery staff members to break some habits they've had since nursing and medical school.

National Patient Safety Goal No. 2 requires health care organizations to standardize abbreviations, acronyms, and symbols and to develop a list of do-not-use abbreviations.

The list includes abbreviations that are most commonly misinterpreted and most likely to cause an adverse outcome. All Joint Commission-accredited organizations were required to have a minimum list of do-not-use abbreviations in place by Jan. 1, 2004, and they were to have added at least three other abbreviations pertinent to the organization to the list by April 1, 2004. **(See list of abbreviations, p. 2.)**

The requirement that every organization accredited by the Joint Commission develop a do-not-use abbreviation list was in place throughout all of 2003, but the requirements needed to comply with the patient safety goal addressed by the list become more specific in 2004.

The list is designed to clarify communications and avoid interpretation mistakes as different people read the patient's chart, explains **Richard J. Croteau**, MD, executive director for strategic initiatives for the Joint Commission.

"Although we don't believe the list should be lengthy, our surveyors found that some organizations' lists were so short that they didn't address abbreviations that have been proven to cause confusion," he says. "Some organizations had only one item identified, and one item does not make a list."

The do-not-use minimum requirements and the additional abbreviations to consider were identified after review of root-cause analyses of adverse events included in a variety of databases, including the Joint Commission's database of sentinel events, Croteau says.

Because several of the abbreviations are medication-related, the Joint Commission worked with the Institute for Safe Medication Practice (ISMP) in Huntingdon Valley, PA. In addition to the lists recommended by the Joint Commission, organizations also are encouraged to review a list developed by ISMP to see if your same-day surgery program is using risky abbreviations related to medication, he suggests. **(For information on how to access that list, see resource box, p. 3.)**

Another way that the staff at Nacogdoches (TX)

(Continued on page 3)

EXECUTIVE SUMMARY

A do-not-use abbreviation list is required to meet Joint Commission on Accreditation of Healthcare Organizations' National Patient Safety Goal on communications. The Joint Commission has specified minimum requirements for the list. As of April 1, organizations should have added at least three more abbreviations that are pertinent to their operations to the list.

- Abbreviations that are easily misinterpreted should be on list. Include abbreviations that can cause patient harm if misinterpreted.
- Monitor adherence to do-not-use list with chart audits.
- Educate physician office staffs as well as same-day surgery staff and physicians.

Joint Commission's List of Do-Not-Use Abbreviations

The Joint Commission on the Accreditation of Healthcare Organizations issued the following list of five abbreviations that should not be used in patient-specific documentation, including discharge or medication instructions.

Set	Item	Abbreviation	Potential Problem	Preferred Term
1	1	U (for unit)	Mistaken as zero. four or cc.	Write "unit."
2	2	IU (for international unit)	Mistaken as IV (intravenous) or 10 (ten).	Write "international unit."
3	3 4	Q.D. Q.O.D. (Latin abbreviation for once daily and every other day)	Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for "I."	Write "daily" and "every other day."
4	5 6	Trailing zero (X.0 mg) Lack of leading zero (.X mg)	Decimal point is missed.	Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg).
5	7 8 9	MS MSO_4 $MgSO_4$	Confused for one another. Can mean morphine sulfate or magnesium sulfate.	Write "morphine sulfate" or "magnesium sulfate."

Each Joint Commission-accredited organization also should have added at least three other do-not-use abbreviations that apply to the organization as of April 1, 2004. The list below includes several items that should be considered. **(Also, see source box, p. 3.)**

Abbreviation	Potential Problem	Preferred Term
µg (for microgram)	Mistaken for mg (milligrams) resulting in one thousandfold dosing overdose.	Write "mcg."
H.S. (for half-strength or Latin abbreviation for bedtime)	Mistaken for either half-strength or hour of sleep (at bedtime). q.H.S. mistaken for every hour. All can result in a dosing error.	Write out "half-strength" or "at bedtime."
T.I.W. (for three times a week)	Mistaken for three times a day or twice weekly resulting in an overdose.	Write "3 times weekly" or "three times weekly."
D/C (for discharge)	Interpreted as discontinue whatever medications follow (typically discharge meds).	Write "discharge."
c.c. (for cubic centimeter)	Mistaken for U (units) when poorly written.	Write "ml" for milliliters.
A.S., A.D., A.U. (Latin abbreviation for left, right, or both ears)	Mistaken for OS, OD, and OU, etc.	Write: "left ear," "right ear," or "both ears"; "left eye," "right eye," or "both eyes."

Source: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

Medical Center Surgery Center identifies abbreviations that might cause problems is through chart audits, says **Janice S. Williams**, RN, BSN, regulatory manager for the surgery center. "We were surveyed in 2003 and had our do-not-use list in place, but we have added some abbreviations to meet the minimum requirements for 2004," she says.

In addition to using chart audits to identify which of the additional abbreviations are used most often and present the greatest risk for misinterpretation, the audit tool also is used to measure compliance with the do-not-use standard, Williams explains.

Compliance with this requirement is not as high as compliance with other Joint Commission standards, Croteau admits.

"In 2003, we saw an overall compliance rate of 70% for the do-not-use abbreviation list as compared to a compliance rate of 90% or better for other patient safety goal requirements and standards," he says. "This is a tough standard to meet because we are not just changing processes, we are changing behavior."

Introduction of the list required inservice education, posters in all areas of the same-day surgery program, fliers in the physician's in-house mailboxes, and presentations to the medical staff, Williams explains. The posters and fliers, which listed the banned abbreviations, were created in-house and reminded everyone not to use the abbreviations in order to increase patient safety, she says.

Don't forget to include the physicians' office staffs in your education efforts, Williams notes. "Any handwritten paperwork that relates to patient care must comply with the standard, even if it is generated by the physician's own staff," she says.

Repetition throughout the year was necessary because staff members and physicians are being asked to stop using abbreviations they've used since nursing or medical school, Williams adds. "With some of us, we are changing 30 years of learned behavior. We are adding 'd/c' to our list, but we've all been accustomed to using it for discharge."

She obtained medical staff buy-in by having the medical staff review and approve each variation of the do-not-use list as it is introduced. The approval process not only gave Williams a chance to explain the reasons for including different abbreviations, but also gave her an opportunity to point out how elimination of confusing abbreviations will increase patient safety, she adds.

SOURCES AND RESOURCES

For more on use of abbreviations, contact:

- **Richard J. Croteau**, MD, Executive Director for Strategic Initiatives, Joint Commission on the Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5000. Fax: (630) 792-5005. E-mail: rcroteau@jcaho.org.
- **Barbara Ann Harmer**, RN, MS, Senior Consultant, Healthcare Consultants International. Phone: (407) 709-7209. E-mail: HCIhelp@aol.com.
- **Janice S. Williams**, RN, BSN, Regulatory Manager, Nacogdoches Medical Center Surgery Center, 4948 N.E. Stallings Drive, Nacogdoches, TX 75965. Phone: (936) 568-3595. E-mail: Janice-NMC.Williams@tenethealth.com.

William's organization still has an "approved abbreviations" list that staff members use, but Croteau points out that this list is not required. "We require that organizations standardize their terminology so that the chart can be easily read and understood by others, and many organizations do this with an approved abbreviation list," he explains. "We would prefer that no abbreviations be used, but if there is a list, we will check to make sure it is used consistently."

The Wilmette, IL-based Accreditation Association for Ambulatory Health Care (AAAHC) does not take the same approach to clear communications as the Joint Commission, says **Barbara Ann Harmer**, RN, MS, a health care consultant and AAAHC surveyor. "AAAHC is not a prescriptive as Joint Commission," she explains.

"In our standards, we require that the clinical record be kept in a consistent and standard format that is predetermined. Also, throughout all of the standards that relate to records, AAAHC emphasizes the need for legibility and accurate communication, Harmer adds.

If a same-day surgery program chooses to meet the standard with a list of abbreviations that are approved or that cannot be used, be sure that all staff members use the list consistently, she explains. "One of the biggest problems is a cumbersome list that no one uses." For this reason, review any list you use on a regular basis to make sure it is appropriate for your organization, Harmer says.

"If you state that a list is how you are meeting a standard, the surveyor will be looking in your charts for proof that staff members use the list," she notes. ■

AAAASF changes its anesthesia requirements

Reports of adverse events, including the death of a cosmetic surgery patient, after administration of propofol by RNs have resulted in a change in anesthesia standards for some organizations accredited by the Gurnee, IL-based American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF).

Facilities that want to use propofol must meet standards set for "Class C" facilities. AAAASF accreditation recognizes three types of same-day surgery programs:

• Class A at which all procedures are performed in the facility under local or topical anesthesia only.

• Class B at which procedures are performed under local or topical anesthesia, intravenous or parenteral sedation, regional anesthesia, analgesia, or dissociative drugs without the use of endotracheal or laryngeal mask intubation. Inhalation general anesthesia nitrous oxide is not permitted at Class B facilities.

• Class C at which all types of anesthesia are used, including endotracheal or laryngeal mask intubation and inhalation anesthesia administered by an anesthesiologist or certified registered nurse anesthetist (CRNA).

Class B facilities that want to continue to use propofol, even for conscious sedation, but will not use other general anesthesia, can comply with the new standard by completing a form that certifies that there is an anesthesiologist or CRNA administering the propofol. The facility also must have neuromuscular blocking agents on-site, according to AAAASF standards.

For details of the changes, go to www.aaaasf.org and click on "Standards" on the left navigation bar, then choose "Standards change for B facilities." A list of rules and requirements for B facilities that need to move to C facility status is included, as well as a copy of the certification form for B facilities that will not be using any other general anesthesia. **(For more information about propofol administration, see "Should RNs administer propofol? Providers stand on both sides of issue," *Same-Day Surgery*, October 2003, p. 109.)** ■

Joint Commission OKs third PPR option

A third option to the Periodic Performance Review (PPR) has been approved by the Joint Commission on the Accreditation of Healthcare Organizations.

Earlier this year, Joint Commission created two options to the self-conducted midcycle review for organizations that may be concerned about the discoverability of PPR information shared with the Joint Commission.

In Option 3, a midcycle, on-site survey is conducted by Joint Commission surveyors rather than by the organization itself. No written documentation or report of the survey is left with the organization, and findings are conveyed orally to management.

At the subsequent full survey, surveyors will be aware of the findings of the midcycle survey, but will not discuss with the organization, unless asked to do so, the fact that any particular standard had been found out of compliance at the midcycle assessment. Instead, the surveyors will focus on compliance with those standards at the time of the full survey.

The electronic PPR tool provides a screen in which an organization indicates the PPR option of its choosing; the tool also includes a "users guide" with instructions on how to complete the on-line form. ■

Unannounced surveys will focus on these areas

The 2004 fixed performance areas that will be addressed in random unannounced surveys conducted by the Joint Commission on the Accreditation of Health Organizations will be organized by critical focus areas instead of performance categories as in the past.

The critical focus areas for 2004 are staffing, infection control, medication management, and National Patient Safety Goals that are relevant to the organization. About 5% of all organizations accredited by the Joint Commission are randomly selected for unannounced surveys. Random unannounced surveys will end in January 2006 when the Joint Commission begins conducting all accreditation surveys on an unannounced basis. ■

PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Beaumont makes patients partners in safety efforts

Facility defined patients' role in safety

In its recent initiative to minimize medical errors, William Beaumont Hospital in Royal Oak, MI, has made its patients "Partners in Safety." That's the name of the new program, which was launched in 2002.

"We knew it was the right thing to do," says **Kay Beauregard**, RN, MSA, director of hospital accreditation and nursing quality.

"It's not unusual to open a paper or a journal that tells patients what they should do to prevent medical errors. The community was seeing it in the lay press — 'Protect yourself from infection when you go to the hospital!' 'Save yourself from medical error!' We wanted our patients to know that we firmly supported their active role, that we appreciated their questions, and that we felt it was of value in preventing errors," she says.

Before Beaumont could 'put the *patient* in patient safety,' it first needed to change the overall culture of the organization. That effort began in 2000. "This involved the creation of a learning environment, so we could learn from our medical errors, and the creation of a nonpunitive environment, so people would, in fact, report errors or potential errors," Beauregard notes.

It was in 2002 that the Beaumont staff seriously addressed the question, "How can our patients be partners with us? First, we had to define what we felt the patient's role was in safety," she says. The facility put together a brochure for patients, *You and Your Caregivers: Partners in Safety.* "It tells the patient that safety is a top priority and that they play an important role in safety efforts. Basically, it says, 'Please help your caregivers give you the care you expect.'"

The brochure provides an itemized list of things patients can do to enable the staff to provide safe care. The list was developed from a number of sources, including the Joint Commission on Accreditation of Healthcare Organizations and the National Patient Safety Foundation, as well as a review of the literature. "We took what was out there and put it in a format that was comfortable to our culture," Beauregard says.

The brochure is divided into several key areas:

- **Patients are encouraged to ask questions and share their concerns.**

To facilitate this process, patients are told to bring a family member or friend with them whenever possible. Patients should feel free to ask questions about what a medication is for, what test is going to be performed, or why something is being done. Customer hotlines also are provided.

- **Patients are told to pay attention to the care they are receiving.**

Patients are informed about the wristband ID they received and told to make sure their nurse or physician checks the band before administering any medication or treatment. Surgical patients should be sure the physician marks the area to be operated on and to ask questions about it.

Health care workers should introduce themselves when they enter the room; patients should look for their name badges. It's OK to ask anyone who touches you whether they have washed their hands. Patients should tell the nurse or physician if something doesn't seem quite right.

- **Patients should know what meds they are taking and why.**

Patients are told to carry a list of *all* meds they are taking, including herbals and over-the-counter drugs. They should tell physicians and nurses about any allergies or side effects. They are told

staff expect them to ask questions about meds.

- **Patients should educate themselves about their diagnosis, treatment plan, and medical tests.**

Patients are encouraged to ask their physician or nurse for information about their condition; they should make sure all the information they need is written down. Patients should be sure they know how to use any equipment needed for home care.

- **Patients should be part of all decisions about their treatment.**

Patients should share all information about their condition, including special needs, with their caregivers. They should provide details about their medical history, as well as the symptoms they are having. Patients should be sure to understand the information they receive and ask questions as often as needed.

Implementation involved distribution of the brochure through several different venues. "We put it into all patients' information packets they received when admitted," Beauregard adds. "Also, our chief of medical staff sent it out to all our physicians with the message, 'This is our approach; we support it; we encourage our patients to ask questions.'"

The brochures also were distributed via community education programs, which reach 15,000 to 25,000 community members a year. "We felt this was a good opportunity to give them a brochure, so when they do have to interact with our facility or another facility, they can be safer," she explains. The brochures also were stocked in the waiting rooms.

Of course, seeing that the nursing staff were on board was critical. "We left it to the nursing departmental leaders to deliver the message — to make sure every employee received the brochure and discussed it at their various meetings," Beauregard says. During these meetings, nurses were asked questions such as, "How will you react if a patient questions the meds you are giving them, or if you are asked if you washed your hands?"

"What we want them to do is say thank you, and then answer the question," she notes. "They need to understand *why* patients are our partners."

Another vehicle for disseminating the key messages at Beaumont is the executive patient safety rounds, which include a hospital administrator, a medical administrator, and department directors, who talk to staff about patient safety issues. "During those rounds, they also talk to patients, so here we again demonstrate how to involve patients in safety," Beauregard observes.

Surveys conducted by Beaumont indicate that progress has been made, but she asserts, "We still have a way to go with it."

The number of patients and family members who say they received the written materials has gone up from 50% to 70% during the past two years. "Even though we provide a packet for *all* patients, the managers feel some of those brochures are not being actively read, so we are continually looking for new strategies," Beauregard observes.

What might those strategies be? "We're looking at more and better ways to provide information to patients, considering options such as putting it on a closed-circuit TV system," she says.

"We're also looking at translating the brochure into different languages. This is *very* important; one of the biggest obstacles to patient questions and learning properly about their diagnoses are cultural barriers." Currently, Beauregard is considering translating the brochure into Arabic, Spanish, Russian, and Ukrainian.

[For more information, contact:

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OSHA delays enforcement of TB standard to July

The Occupational Safety and Health Administration (OSHA) will delay until July 1, 2004, enforcement of the general industry respiratory standard for health care providers and other employers required to protect workers from potential exposure to tuberculosis.

Employers required to protect against TB were subject to a separate standard while a 1997 proposed rule for TB protection was being considered; however, OSHA recently decided to withdraw its proposed rule and begin applying the general industry standard.

The delay will allow affected employers six months to make the changes necessary to comply with the general industry standard, which includes more stringent requirements, including mandatory annual fit-testing.

The OSHA announcement can be found at www.osha.gov/ under "OSHA News." ■