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Are you aggressively addressing ED crowding? JCAHO says you must

Poor patient flow is dangerous, and no longer just an ED problem

Is your hospital's emergency department (ED) reporting record diversion hours, with patient volume and acuity higher than ever? Is the practice of holding admitted patients for long periods in the ED becoming the rule rather than the exception?

If so, this can have a profoundly negative effect on quality of care in your organization. "Poorly managing patient flow can impact vulnerable areas, such as the emergency department, where overcrowding can occur and create an environment with patient safety issues," warns **Robert Wise, MD**, vice president for standards at the Joint Commission on Accreditation of Healthcare Organizations.

Now a new leadership standard from the Joint Commission calls for you to implement strategies to address ED overcrowding by managing patient flow throughout your organization. The new standard takes effect Jan. 1, 2005.

As a quality manager, you now must incorporate ED overcrowding into your performance improvement activities. That means using performance indicators to predict and monitor the capacity of areas that receive emergency patients and planning for the care of patients placed in temporary beds.

It's not just the ED

Many quality managers still consider overcrowding, diversion, and boarding of admitted patients an "ED problem," says **Kim Shields, RN**, clinical systems safety specialist at Abington (PA) Memorial Hospital. "Often, there is a disconnect between the ED and hospital inpatient side," Shields adds. "We need to stop thinking of ourselves as silos, and recognize we are one entity, not two separate entities."

The Joint Commission standard initially was referred to as the "Emergency Department Overcrowding" standard, but as a result of comments after a June 2003 field review, the standard's name was changed to "Managing Patient Flow" to more accurately characterize the problem.

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"While the emergency department is a vulnerable area when patient flow issues occur, the improvements needed lie in organizationwide changes rather than changes solely in the emergency department," Wise underscores.

In addition, a 2003 report from the Washington, DC-based General Accounting Office found the inability to move patients out of the ED into hospital beds was a key factor contributing to overcrowding.¹

To effectively address ED overcrowding, use these effective strategies:

- **Look outside the ED.**

At Scottsdale (AZ) Healthcare, a "Patient Throughput Project" has achieved dramatic results by addressing overall capacity in the hospital. "We could improve all we wanted to in the ED; but if you don't have any place to move patients, they are going to sit in the ED," says **Sylvia Bushell**, consultant for organizational effectiveness. "We saw that we needed to improve overall capacity."

Project leaders identified three key areas to improve capacity: discharging inpatients earlier in the day; streamlining the process of getting a patient admitted from the ED; and improving management of bed control.

Here is a partial listing of some of the changes that were made:

- Mobile phones are used to give reports. While the process to admit patients to the hospital used to require as many as nine separate phone calls, now only a single call is made, Bushell reports. "Fewer calls are made because the ED and floor supervisors have mobile phones to communicate and give reports on," she says.

- Guidelines were developed for admission to each floor or unit.

- Discharge alerts were put on patient charts to give priority to patients about to be discharged.

- Carpets were removed to make room cleaning faster.

- Transporters now alert housekeeping that a room is ready for cleaning when they move a discharged patient out of the room.

During the organization's 2003 survey, Joint Commission surveyors had good things to say about the changes being implemented. "They liked what we had done and thought we were headed in the right direction," Bushell adds.

- **Look at the process from the patient's point of view.**

All process changes were made with patients' viewpoints in mind. "We asked ourselves, 'How can we only ask for information one time instead of four or five times?' We documented all the times patients were asked the same questions repeatedly and designed our processes so we ask as few times as possible," she says.

- **Use trigger points to avoid diversion.**

A tool was created to standardize the decision to go on ED diversion. "Before we created this tool, going on diversion depended on individual preferences and perceptions," Bushell explains.

Despite significant improvements in managing capacity, there still are times when patients can't be moved into the hospital because of lack of beds, she says. To address this, an action plan

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Editor: **Staci Kusterbeck**, (631) 425-9760.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).

Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).

Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@thomson.com).

Senior Production Editor: **Ann Duncan**.

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Editorial Questions

For questions or comments, call **Staci Kusterbeck** at (631) 425-9760.

was put into place for when bed availability does become scarce. "We set up a process for what specific people need to do when we get down to X number of intensive care, telemetry, or med/surg beds, and when we get down to Y number of beds," Bushell adds.

The action plan identifies trigger points, which call for specific actions to avoid ED diversion or holding of patients.

The Trigger Point Tool is as follows:

Green = All beds are open. No triggers are in place. Beds are assigned as usual.

Yellow = 10 to 20 beds remain in the hospital. The bed control manager implements discharge holding areas, assesses potential ED admits, stops accepting transfers from other facilities, and starts a standby list of direct admits. Nurse managers and supervisors, ancillary departments, and on-call staff are notified that this trigger point has been reached.

Red = 0-5 beds are available. Nursing directors implement the following as needed: Floors accept a boarder patient, lists are created of stand-by direct admits and elective surgeries, and a case manager is contacted to evaluate these cases.

The nurse directors also notify the administrator on call, chief of surgery, chief of medicine, community physicians, and ancillary departments so they will increase staffing and service levels.

The trigger points are guidelines and not hard-and-fast rules, Bushell adds.

"Everyone involved in their development agreed that lots of judgment is needed for when each of the trigger points will be implemented," she says. "By outlining the people responsible during each trigger, the actions to be taken, and who needs to be notified, a plan exists for the most frequent capacity situations."

- **Use real-time communication to monitor capacity.**

"Bed control huddles" are held four times a day during peak times and three times a day on a regular basis. All unit and floor supervisors, ED and surgery supervisors, and bed control staff attend the huddles, which last only five or 10 minutes, to share discharge status for each floor and the number of beds needed for the ED and surgery. "Establishing this communication process has been one of the essential success factors for managing capacity," Bushell says.

In addition, stoplights are posted at every interior doorway entrance in the hospital with red, yellow, and green color codes used to indicate the number of beds currently available. Each light

consists of three bands of color about 4 x 6 inches in size situated high on the wall. "They are unobtrusive unless one knows to look for them," says Bushell. "But physicians and staff can look up and know immediately that if it's red, we are very low or have no beds; if it's yellow, we are getting close to red; and if it's green, there are beds open and there is no problem."

If the light is red, floors are asked to board a patient while waiting for a patient to be discharged. "The goal is always to keep patients flowing from the ED into the hospital," says Bushell. "It is now an exception for us to hold patients for long periods in the ED, and our length of stay is pretty short compared to many EDs."

- **Educate all staff about ED crowding.**

Often, inpatient staff do not have a true understanding of what goes on down in the ED, adds Shields. "We are not working as a true team, and we have to break down those walls," she says.

To address this, Shields is developing a three-minute video for all staff to watch during orientation, depicting the entire process of a patient being admitted from the ED. "You'll find that the inpatient side does have the ability to tighten up and get patients in a little faster, if they understand the impact this has on the backflow and overcrowding in the ED," she says.

- **Ensure the same level of care is given to admitted patients in the ED.**

When the decision is made to admit an ED patient, the Joint Commission requires that the patient receives the same level of care as he or she would as an inpatient. For example, an interdisciplinary admission assessment has to be done within a certain number of hours, and an interdisciplinary plan of care must be documented. In addition, the same staffing ratio should be provided as if the patient were upstairs, as you should not have two different standards of care.

At Scottsdale Healthcare's EDs, if patients are going to be held for more than four hours, they are moved to a central area where an inpatient nurse provides the same level of care as if the patients were in a bed on the inpatient unit. If an inpatient nurse is not available, the ED may need to supply the nursing staff, but this would be in addition to the staff allocated for the ED, says **Mary Kopp**, ED service line manager. "We have been proactive to assure patient-to-nurse ratios and monitor staffing levels to assure quality care is delivered."

- **Address ED delays.**

Although patient flow is an organizationwide

problem, delays in the ED do have to be addressed, Kopp says.

According to new statistics from the Centers for Disease Control and Prevention (CDC), EDs are experiencing record volumes, with more than 110 million ED visits in 2002 — an increase of nearly 3 million over the previous year. Patients also are sicker, with a greater percentage of patients being classified as emergent and urgent, and they are spending more time in the ED. The CDC report found that two-thirds of patients spent one to six hours in the ED, with the average duration of a visit lasting 3.2 hours.²

After overall capacity was addressed, Scottsdale's project leaders turned their attention to the EDs in the two-hospital system, using a multidisciplinary approach.

"We involved all the stakeholders, including pharmacy, laboratory, radiology, transport, housekeeping, technicians, physicians, cardiovascular, nursing, and respiratory," says Bushell. "We had everyone involved, anytime we met."

Three main areas were addressed in the two EDs: Improving lab turnaround time, radiology turnaround time, and overall patient flow. The following changes were made:

— The laboratory initiative focused on the period of time from obtaining specimens until they are on an instrument. "The flow into and through the lab to the instruments was streamlined," Bushell says. "A new central processing area will enable the lab to know where specimens are in the lab at all times." In addition, several instruments will be moved for more efficient flow of specimens through the lab.

— The radiology initiative addressed communication, prioritization of orders, root causes of delays, and turnaround times. "The volumes require radiology techs dedicated to the ED. Ongoing problem-solving meetings are being held between radiology and the ED," she notes.

During the process for both lab and radiology improvement, work environments were organized using 5S quality principles — originally developed in Japan.

The ED has its own trigger points used to monitor bed availability and determine which actions are needed by other departments. "This process assures everyone is on the same page and working for the same goal — to assess bed capacity and decompress the ED," Kopp says.

There are three trigger points for the ED:

1. **Green** indicates that more than six beds are open in the treatment areas.

2. **Yellow** means that six beds are available.

3. **Red** signals that no beds are available.

"Each trigger has identified roles to assist movement of patients and staff allocation to an area to assist with admission, discharge, or treatments in flow of patients," she notes.

As a result of these and other changes, the average wait time for patients who were ready to leave the ED and be admitted decreased from 75 minutes to 23 minutes, and the ED's average length of stay has gone from six to eight hours to two to four hours.

"This has improved patient satisfaction at both campuses," Kopp concludes. "Our diversion hours remain one of the best in the area and decreased 42% with implementation of the trigger points."

[For more information about improving patient flow in your organization, contact:

- **Sylvia Bushell**, Consultant for Organizational Effectiveness, Scottsdale Healthcare, 3621 Wells Fargo Ave., Scottsdale, AZ 85251. Phone: (480) 675-4590. E-mail: sbushell@shc.org.
- **Mary Kopp**, ED Service Line Manager, Scottsdale Healthcare Shea, 9003 E. Shea, Scottsdale, AZ 85260. Phone: (602) 227-0510. E-mail: mkopp@SHC.org.
- **Kim Shields**, RN, Clinical Systems Safety Specialist, Abington Memorial Hospital, 1200 Old York Rd., Abington, PA 19001-3788. Phone: (215) 481-4378. Fax: (215) 572-9087. E-mail: KShields@amh.org.
- *The complete report Hospital Emergency Departments: Crowded Conditions Vary Among Hospitals and Communities is available free at the United States General Accounting Office web site at www.gao.gov. Click on "GAO Reports," "Find GAO Reports," "GAO Reports," and type in "GAO 03-460" without the quotation marks. Single printed copies of the report are available at no charge. To order, contact U.S. General Accounting Office, 441 G St. N.W., Room LM, Washington, DC 20548. Phone: (202) 512-6000. Fax: (202) 512-6061.]*

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Prevent infant abductions with FMEA processes

Identify key areas of concern

Do you think that a kidnapper could walk undetected through the halls of your hospital by using a fake ID badge and get away with a baby? That's exactly what happened at one Salt Lake City facility, when a woman wearing hospital scrubs and a makeshift badge managed to abduct a 3-day-old infant. The baby was returned to the mother within 30 minutes of the abduction, after a security guard found the kidnapper in a grocery store a block away.

This frightening incident puts a spotlight on the need for effective policies to prevent infant abductions. A total of 18 infant abductions have been reported since the Joint Commission on Accreditation of Healthcare Organizations began tracking sentinel events in January 1995.

Quality managers at Good Samaritan Hospital in Puyallup, WA, met for a brainstorming session of worst-case scenarios that could occur. "We looked at our hospital very carefully to determine the most dreadful things that could happen," says **Jann Robinson, RN, MA, CPHQ**, the organization's patient safety officer. "Infant abduction was at the top of the list."

The decision was made to do a failure mode and effect analysis (FMEA) on infant abduction. "We determined that this was an extreme patient safety risk and the most devastating thing that could happen at our facility," says Robinson. Here are steps being taken as part of the organization's FMEA, which currently is under way:

- **An infant abduction FMEA team was formed.**

First, the team created a flowchart to identify every possible failure mode. "The goal is to flow chart the system as it is working today in our hospital, then go through each one of those points and identify what could break down," Robinson says. For example, a receptionist giving access to a visitor without following procedure would constitute one type of failure mode.

As different categories are identified, smaller teams are being formed from appropriate areas, which will report to the FMEA team, she says.

For example, a team made up of facilities and security staff and a representative from the alarm company would address the alarm system itself, or a team with staff from education, patient safety,

nursing, and security would be asked to formulate an education plan.

The stakeholders currently included in the process are obstetrics, security, patient safety, and the nursery, reports **Karen Baker**, manager of the obstetrics unit. "Our plan is to bring in additional stakeholders as appropriate."

- **Key areas of concern were identified.**

These possible failure modes were identified:

- Access to the unit, including hospital personnel, visitors, and construction.

- Interface with door closure. "The current security system that we have interfaces with our door access system," says Baker. "We will address the mechanical interface integrity, global lockdown, and fire alarms/door egress."

- Alarm issues such as false alarms, response to alarms, consistency in staff response, and transmitter errors.

- Prevention, including drills, education, orientation, annual review, and patient/visitor education.

- The hospital's "Code Pink" response for infant abduction, including drills, policy review and update, and staff education.

- **Preliminary changes were identified.**

So far, a long list of possible changes have been identified, Baker says. These include implementing an improved system to control visitors; redirecting access to the unit through the service corridor; limiting the number of doors into the unit; requiring training for all construction workers; doing an education blitz for patients and staff; creating a structured preventive maintenance plan; and documenting and archiving all debriefings following drills.

"I know as we work through the FMEA, we will identify many other issues and processes that will need to be addressed," she adds.

- **Access is limited.**

It was discovered staff were taking a potentially risky shortcut using the main doorway instead of the service entrance. "They would get their cart through and keep going without checking to see that no one else came in behind them," Robinson adds. Staff now are required to use the mirrored service entrance, which enables staff to check that no one is following, at which point they enter the labor and delivery area through a second door. Although nurses and receptionists have been taught proper procedure for visitors, there has been inconsistent adherence to this process, she says.

The current procedure is to stop each visitor, ascertain who he or she is visiting requiring first

and last name, and identify support people who are wearing an identification wristband. At the point of entry to the unit, visitors are given a detailed explanation for the policy and requested not to hold the door for any other individuals, either staff or visitors. Once they are on the unit, the visitor is to proceed directly to the patient's room. "We don't know exactly what avenue we are going to be taking, but we are going to do something to have accountability for visitors," says Robinson. "We suspect we are going to badge people or give wrist bands such as "Dad" or "Significant Other," or give patients cards to hand out to a limited number of visitors."

- **A mock "infant abduction drill" is done at least twice a year.**

To test whether staff were searching bags appropriately, **Maureen Guzman**, RN, MHA, CPHQ, director of quality management, has begun conducting mock infant abduction drills. "I had a pretend baby in my bag, and I got completely out of the hospital. We found that people at our facility are so nice that they don't want to stop somebody and ask 'What is in your bag?'"

If a staff member manages to stop the mock abduction, a \$55 gourmet gift basket is given as a reward. However, with three drills to date, no one has ever stopped the abduction, reports Robinson. During one drill, she noticed staff were hesitant to stop anybody who had on a hospital badge. "We've done a lot of training around this; I don't care who they are, an employee or the president, you stop them."

- **Each unit was inserviced.**

Previously, the infant abduction policy was sent out and nurse managers explained it to staff, but this obviously was not effective since staff aren't consistently following procedures, adds Robinson. Now, each hospital employee attends orientation and an annual update where the infant abduction policy is reviewed. "However, we continue to have gaps in the responses by staff during infant abduction drills," she says.

The plan is to have an "infant abduction month" when posters will be hung throughout the facility, including the policy, profile of a typical kidnapper, and staff responsibilities. "Poster design will be attention grabbing but still project the severity of this issue," Robinson points out. Also, a team will go to each unit to educate staff about the policy. For example, when staff complained about wheeling carts the extra few steps to the service entrance door, quality managers pointed to real-life infant abduction cases to bring home the seriousness of

the problem. "Sometimes, people don't think of the reality of what could happen," she says. "A few cases have been very notorious in the media. We used these to give people a mental image of what could happen."

[For more on preventing infant abductions, contact:

- **Karen Baker**, Manager, Obstetrics Unit, Good Samaritan Hospital, 407 14th Ave. S.E., Puyallup, WA 98371-0192. E-mail: karenbaker@goodsamhealth.org.
- **Jann Robinson**, RN, MA, CPHQ, Patient Safety Officer, Good Samaritan Hospital, 407 14th Ave. S.E., Puyallup, WA 98371-0192. Phone: (253) 697-1962. Ext. 1962. E-mail: jannrobinson@goodsamhealth.org.
- A book and self-assessment tool are available on the National Center for Missing & Exploited Children's web site at www.ncmec.org. Click on "Media," "Publications," "For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions." The first 10 printed copies are free of charge for facilities. To order, contact: National Center for Missing & Exploited Children, Charles B. Wang International Children's Building, 699 Prince St., Alexandria, VA 22314-3175. Phone: (800) 843-5678 or (703) 274-3900. Fax: (703) 274-2200. ■

Complying with JCAHO's read-back requirement

Take steps to reduce communication errors

Do all staff at your organization know what constitutes a "critical test result?" If not, this could cause you problems during your next survey.

The Joint Commission on Accreditation of Healthcare Organization's 2004 National Patient Safety Goals include a requirement to eliminate communications errors, failures, and delays, with a recommendation that all critical test results be reported verbally or by telephone and read back.

"With the read-back requirement, the Joint Commission is trying to reduce or eliminate error caused by oral miscommunication of a medication to be administered and assure that critical test results have appropriate actions taken to protect the patient," says **Leisa Oglesby**, assistant hospital administrator of quality services at Louisiana State University Health Sciences Center in Shreveport.

Here are some effective ways to comply:

(continued on page 83)



PATIENT SATISFACTION PLANNER™

Key words, eye contact boost satisfaction scores

Staff education, involvement key to score increases

Making sure your patient satisfaction program is top-notch takes more than just sending out surveys, according to winners of a national patient satisfaction improvement award offered by Press Ganey Associates in South Bend, IN.

"I knew that the only way we could go was up when I looked at how our satisfaction scores compared to other ambulatory surgery programs," says **Marilyn Bergman**, RN, clinical manager of ambulatory surgery for Providence Alaska Medical Center in Anchorage.

"We were between the third and sixth percentile in rankings, so I knew we could put some programs in place to increase our scores," she says.

The first thing Bergman did was to educate her staff. "Staff members were shocked because we do provide excellent care, and they had no idea that our patient satisfaction scores were so low because they had never seen them before," she says.

In addition to sharing the data, Bergman also shared the questions on the survey and the meanings of the different rankings.

"After our initial sessions of education on the meaning of the patient satisfaction scores, we set goals for improvement," she explains. "We wanted to improve to the 25th percentile by the first year, and we actually ended up reaching that goal in six months, and we reached the 50th percentile at the end of the first year."

Recent results are close to the second year goal of 75%. "We don't always meet our goal every month or every quarter, but we are pleased with our efforts to improve," she adds.

Several activities contributed to Providence's success, Bergman notes. "We did some scripting to make sure that patients understood why we were doing some things a certain way," she says.

The scripting didn't require nurses to memorize speeches or specific sentences, but it did identify key words to include when explaining things to patients or their family members.

"For example, when we close the curtain on the patient's cubicle, we say 'I'm closing this curtain to give you some privacy,'" Bergman adds.

Staff members repeat the phrase "I am doing this to protect your privacy" or a version of that phrase throughout the patient's stay, she says.

"When the patient receives the survey in the mail several weeks later, he or she is more likely to answer the question related to our concern for the patient's privacy in a positive manner because we constantly described our reason for our actions," Bergman notes.

Identifying key words

Identification of key words and actions was also effective at the same-day surgery program at St. Edwards Mercy Health Network in Fort Smith, AR, which saw patient satisfaction scores climb almost 6 points in 15 months from a starting average of 86.05 to an average score of 91.65.

"We choose five areas that greatly affected patients' perception of our service and came up with ways to improve our attention to those areas," says **Michelle Gasaway**, RN, clinical nurse manager of the ambulatory surgery department at St. Edwards.

For example, acknowledgement of the patient is important, so employees know to make eye contact with people, even if they are coming up to a desk to ask for directions or for information that the employee may not have.

"It's very easy to avoid interruptions by avoiding eye contact, but we make the eye contact, even if it means going elsewhere or making phone calls to help the patient or family member," she says.

In addition to acknowledgement, her staff identified other key areas of customer service: introduction by name; explanation of time that the patient or family member can expect for each step of surgery and recovery; explanation of delays; and use of the words "thank you."

Gasaway's staff also uses phrases such as, "I'm raising this side rail for your safety," or "I'm doing this to increase your privacy." Staff

members who volunteered to serve on a patient satisfaction team developed the phrases and laminated cards that list the five fundamentals of good customer service for each employee.

One of the responsibilities of team members is to take time to observe the patient's experience. "Too often, we get caught up in doing our job, and we don't look objectively at what is happening to the patient," Gasaway explains.

Looking at waits through patients' eyes

Now, patient satisfaction team members take time to sit in waiting areas and go to different areas, such as lab, radiology, or business office, related to same-day surgery and observe the patient's experience, she says.

"This doesn't take a lot of time, and each staff member who observes a different area becomes more aware of his or her own area," Gasaway adds.

"This increased awareness enables all of us to be more proactive and take steps to correct long wait times before patients complain," she notes.

Because her program involves lab, radiology, and other areas of the hospital to which ambulatory patients go, staff members feel comfortable pointing out to other employees that they didn't hear an explanation of the long wait given to the patient, Gasaway says.

"Staff members also make suggestions about the way they handle scheduling of lab work and other tests to avoid long waits," she explains.

Have a process to immediately address patients' concerns, Bergman adds. Nurses in her program know to ask a patient if there is a problem if they notice behavior that suggests dissatisfaction, she points out.

"Many times it is a matter of apologizing for a delay and thanking the person for their patience, but nurses also can give coupons to the hospital coffee shop for family members to use or some other simple thing," Bergman continues. "If necessary, nurses contact a supervisor who immediately talks with the patient or family member to resolve the problem."

Bulletin boards in staff areas are used to post current patient satisfaction scores, Gasaway adds.

"The actual report is very complicated, so it is summarized so that staff members can easily see the areas of improvement and decline," she says.

"When we see that we are not doing as well in areas that are rated most important by patients, we take a look at what we are doing and add new

key words or emphasize the area such as concern about pain, delays, or privacy," Gasaway points out.

"Sometimes, we do see a drop in one area if we've been concentrating on other areas, so it is a constant process of review, evaluation, and changes to our approach," she says. ■

Program targets patient, physician satisfaction

Reducing LOS is another important goal

A new preadmission program at the University of California (UC) Davis Health System is building a stronger link between hospital and physician's office and identifying issues — much earlier in the process — issues that might affect length of stay (LOS).

In addition to reducing LOS, the initiative is aimed at increasing patient and physician satisfaction, as well as heightening physician awareness, says **Karen Warne**, RN, manager for patient services and transfer center.

As an academic medical center and regional referral center with a large proportion of its population either nonfunded or underfunded, she notes, UC Davis gets patients who are "the sickest of the sick and the most complex of the complex.

"If we are going to improve efficiency and use of resources, we have the best opportunity to do this with our scheduled admissions," Warne explains.

"We thought if we could move the energy spent once the patient is in bed, where nurses look at unidentified needs, to [a time in advance of] scheduled admissions, there would be some opportunity to work with patients proactively to identify the kinds of things they will need for a safe discharge," she adds.

"It can be as simple as understanding that the patient lives in a rural area that may be serviced in a limited way by home health," Warne adds, "or as complex as a patient who's homeless and normally lives under a bridge who will need intravenous antibiotics after discharge."

The patient in question might be, for example, an 80-year-old widow who lives alone, is independent, but is going to have surgery that will require not just a funding source, but family

support or resources, she says.

"Has the family been contacted? Has she been able to make arrangements [for care after discharge]? If not, what resources are available?" Contacted before admission, before she's in post-surgical pain, Warne points out, the patient is in a better position to be a participant in her own care plan.

Although no additional dollars were allocated for the program's startup in the fall of 2003, Warne says, she was allowed to designate **Kori Pilkington**, RN, one of the hospital's utilization review/discharge planning nurses, to take the new position of preadmission nurse.

"My goal is to demonstrate her value," Warne says. "A physician might be deciding to admit a patient for what really would [more appropriately] be an outpatient work-up, and Kori will be able to talk with the physician, have our physician reviewer look at the case, and a decision might be made to handle it in a more cost-effective way."

It won't take many cases of deferring elective procedures found not to be medically necessary in the acute setting, or where the patient avoided a prolonged hospital stay because discharge services were arranged in advance, to justify funds for the program, Warne suggests.

To identify patients who might be at risk for longer LOS, Pilkington telephones patients to ask about their post-discharge plans and their perception of what their post-discharge needs will be.

She also reviews available medical records, and may speak with the physician or clinic staff. When her assessment is complete, a copy of her notes goes to the discharge planner who will have the case, as well as into the medical record, Warne adds.

Questionnaire addresses care needs

Some of the clinics associated with UC Davis have collaborated with Pilkington to develop a questionnaire that patients, with a nurse's help if needed, can fill out in advance of their hospital stay, she says.

The questionnaire, which includes 10 questions designed to help determine if the patient will need assistance or another level of care after discharge, then is faxed to the preadmission nurse.

The questionnaire addresses issues as simple as whether the patient has transportation from the hospital or as potentially complicated as

whether the patient is a caregiver.

"It's not unusual to find there is a developmentally disabled adult child at home and now the patient, who is the caregiver, has to go to a lower level of care before going home," Warne notes.

In one case, she explains, clinic personnel assumed a patient would have help after discharge from the hospital because they knew she had a daughter. "It turned out the lady had told her daughter, 'Go ahead and take your vacation to Europe — it's a good time because I'm going to be laid up.'"

Another time, Warne says, a patient who lived in a trailer with no electricity asked about transportation and was told by a person at the clinic, "Oh, the discharge planner will take care of that."

"These are the kinds of things we're hoping to identify early on, shift some of the workload forward and improve communication between the outpatient and the inpatient settings," she adds. "It's my observation that we operate in silos. We are working to improve the transition of care across the continuum."

In the case of the latter patient, Warne explains, Pilkington's assessment revealed that while a church group had arranged to take the person to the hospital, nothing had been planned regarding post-discharge transportation.

She helped him contact the church to set up the return trip. Without that intervention, Warne notes, the discharge planner ultimately would have taken care of the problem, but the patient's discharge would have been delayed while transportation was arranged.

In the case of a patient coming from a psychiatric facility — for cancer treatment — Pilkington discovered that the person's family was making arrangements to move him closer to them, she says. As a result, the hospital was able to transfer care to the physician in that area who would be following the patient's long-term care.

"[The preadmission initiative] is making sure all the pieces are considered, breaking down silos by creating a flow of communication, and being able to offer expertise on some of the things the typical nurse or physician may not know," Warne adds.

Educating physicians

Part of increasing physician awareness, she notes, is educating physicians so they are considering "nonmedical things," such as funding issues and resource issues, that will affect the

use of medical resources.

Pilkington, meanwhile, says one of the most enjoyable parts of her job has been interacting with the mostly elderly patients as she tries to identify their needs.

“A lot of them are delightful to talk with,” she says, and appreciative of being contacted. “An orthopedic patient who was going to have a spinal fusion — a 79-year-old widow — was so thrilled. She said, ‘I am so happy you called — I didn’t realize UC Davis cares about me.’”

Tracking tool on the way

Although evidence of the new program’s success is anecdotal at present, UC Davis is developing a tracking tool that will determine outcomes more precisely, Warne says.

“[The tracking tool] is a mechanism to gather data to identify what educational initiatives we might need to consider with clinics or physicians, what the problem areas in the health system are regarding decision making in our use of resources, and hopefully, to identify patients who might benefit from having an assessment made prior to hospitalization,” she adds.

In using the tool, Warne explains, the preadmission nurse will fill out an intake form that documents the outcome of her interventions and fax it into a database. Except for the narrative information in the “comments” part of the form, she adds, the data will fall into the various fields of the database.

“This will provide data to support the outcomes of this new program, as well as identify areas that will benefit from process improvement,” she adds.

The preadmission nurse will indicate whether the patient has met InterQual criteria, used to determine the appropriateness of the admission, Warne notes.

However, that the InterQual outcome is used only as a screening guideline and is not the final decision. InterQual is a clinical decision support tool produced by McKesson Health Solutions in Newton, MA.

If the case doesn’t meet the standardized criteria, she says, it is bumped up to a physician reviewer, who makes the final decision.

“We’ll be collecting date of admission and medical record number and hope to match that with registration data to see if we’re noticing a difference in overall LOS, patient satisfaction, and reimbursement,” Warne says. ■

CE questions

This concludes the CE semester. Fill out the enclosed evaluation form and return in the envelope provided. When your form has been received, a certificate will be mailed to you.

21. Which of the following is recommended to address ED overcrowding?
 - A. The problem should be solved in the ED alone.
 - B. Since ED volumes are steadily decreasing, the problem will subside on its own.
 - C. Patients held in the ED may receive a lower level of care during the time they spend waiting for an inpatient bed.
 - D. Overall hospital capacity must be addressed, including the inability to move ED patients into inpatient beds.
22. Which is a part of the FMEA process for infant abduction at Good Samaritan Hospital in Puyallup, WA?
 - A. Staff are required to enter labor & delivery through a secure service entrance.
 - B. To save costs, only labor & delivery staff are included in educational efforts.
 - C. A decision was made not to limit visitor access.
 - D. Receptionists are instructed not to waste time stopping hospital employees.
23. Which is true regarding reporting of critical test results?
 - A. The read-back requirement only applies to laboratory tests.
 - B. Nurses must read back all critical results reported verbally or by telephone.
 - C. Nurses do not need to document “read back” unless a result is life-threatening.
 - D. Staff are required to read back all test results, not just critical results.
24. Which is a requirement of the Joint Commission’s proposed 2005 National Patient Safety Goals?
 - A. All facilities will be required to immediately implement bar-coding systems.
 - B. All organizations must work towards implementation of bar-coding systems.
 - C. Facilities should avoid use of bar-coding until further notice.
 - D. Only large urban facilities will be required to use bar-coding systems.

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

(Continued from page 78)

• **Define “critical” test results.** According to the Joint Commission, the term “critical test results” refers to all diagnostic tests including imaging studies, electrocardiograms, and laboratory tests. However, the Joint Commission expects each organization to define critical test results and will measure compliance as defined by the organization’s policy.

“Each organization will need to sort out what is life-threatening and requires immediate action from those results that are important but could be reported some time later,” says **James H. Nichols**, PhD, DABCC, FACB, director of clinical chemistry at Baystate Health System in Springfield, MA. The organization has a critical values policy approved by the chief of clinical pathology and the patient care policy and medical staff executive committees, he says. “Any changes have to go through this multilevel approval process.” The policy lists all the results that meet the criteria for critical values, based on the test, age, sex, and other conditions.

Each diagnostic department has defined criteria for which test results are considered “critical” within their area, says Oglesby. “For instance, an echocardiogram may be different from a lab, and a chest X-ray may be different from a gastrointestinal X-ray,” she says.

• **Decrease the number of handoffs.** At Baystate, a process is being piloted to decrease the number of handoffs in the procedure for critical test results. Previously, whoever answered the phone on the nursing unit would communicate with the nurse in charge of the patient, who in turn would talk to the clinician about the test results. Now, the lab communicates directly with the nurse caring for the patient, who either acts based on preexisting orders or contacts a clinician who can act on the result.

“This has led to significant improvements in the time to clinical action,” Nichols says. The time frame from the lab calling the result to when the physician takes clinical action was reduced by removing the middleman, he explains. “Previously, the ward clerk or secretary may have taken the result and then had to communicate it to the nurse or clinician, who could take medical action.”

• **Implement a read-back procedure.** Baystate Health System’s read-back procedure requires the person accepting the result to state his or her name or ID number and read the test, value, and units back with the patient’s name to the lab tech on the phone. The lab tech then documents that “the value was called to ____ by tech ____ @

time,” and that “the value and patient’s name were verified by read back” as a comment in the result field of the lab report in the medical record.

The read-back procedure for nursing units is for the nurse accepting the verbal order to record and then read back the order in its entirety to the prescribing physician at the time the order is given, documenting that the order was read back. “The physician or designee shall be notified of all critical, life-threatening results within one hour via telephone,” Oglesby explains.

The individual accepting the reporting of critical values must record and read back the critical value in its entirety to the reporting individual at the time the critical value is given and document that the critical value was read back.

The hospital’s clinics are notified by the diagnostic area of the critical value. The accepting staff must notify the physician within one hour and document in a clinic log and the medical record the date, time, staff member’s name receiving the result, the critical result, and actions taken as directed by the physician.

For diagnostic areas, technicians are required to keep a log documenting who the results were reported to and the time they were reported. For example, if a technician finds an abdominal aortic aneurysm on X-ray, the technician would notify the medical staff and document in a logbook that he or she talked with that physician, Oglesby says. “Also, the physicians in the diagnostic areas notify the patient’s attending physician to report the critical value. The diagnostic area physician documents in their dictated report the discussion with the attending physician,” she says.

• **Have a process to notify patients.** When a patient has a critical test result, not only does the technician who is doing the interpretation have an obligation to notify the physician, but the hospital has an obligation to notify that patient, Oglesby says. “That is the other piece, that when you have a critical test result, the patient is notified and appropriate action is taken.”

A policy is in place to notify patients of any test result that could result in a life-threatening risk to that patient. “We have an emergent procedure where the sheriff’s office is notified to go to the person’s home if it is potentially life-threatening, such as a potassium level indicating a severe electrolyte imbalance,” Oglesby explains.

• **Measure compliance.** Currently, compliance is measured by pulling all critical results called and reviewing manually, Nichols says. “We’re looking into a system that would require the technician to

enter the 'verified by read back' comment or the result cannot be verified," he reports.

The organization's laboratory information system could be programmed to remind the technician to make the call by requiring the comment to be completed. Then after the result is reported, the system would check to be sure that the comment was attached, Nichols explains. "This would mandate that the action takes place actively, rather than having the comment as a passive supplement to the result," he says.

He notes that there are newer "middleware" solutions, which are software data managers that sit between the analyzer and the laboratory information system. These can sort data, run statistics, and perform rules-based algorithms on data before sending it to the system. "For those laboratory information systems that can't mandate read-back comments, middleware could be an alternative means of reminding the tech by flagging the result if they attempt to finalize it without the comment," Nichols points out.

Compliance is measured through chart audits as well as observation and mock surveys, says Oglesby. "If we're up on the floor looking at environment-of-care issues and someone takes a verbal order or calls with a critical test result, we document that we observed that while on the floor, and whether they did it right or not."

If the proper procedure is not followed, the observers stop to educate staff. Recently, chart audits revealed that the read-back procedure was not always being done. "Staff were not calling the requested physicians with the critical lab or X-ray results," she says. "We have had to educate the staff involved, with inservices, staff meetings, and chart audits completed for physician peer review."

[For more information, contact:

- **James H. Nichols**, PhD, DABCC, FACB, Director, Clinical Chemistry, Baystate Health System, 759 Chestnut St., Springfield, MA 01199. Phone: (413) 794-1206. Fax: (413) 794-5893. E-mail: james.nichols@bhs.org.
- **Leisa Oglesby**, Assistant Hospital Administrator of Quality Services, Louisiana State University Health Sciences Center-Shreveport, 1541 Kings Highway, Shreveport, LA 71130. Phone: (318) 675-5030. Fax: (318) 675-4646. E-mail logles@lsuhsc.edu.
- VoiceLink is a universal messaging system allowing radiologists to communicate critical patient findings by calling an access number, stating the unexpected or urgent patient finding, and sending it to

the referring physician by pager, fax, e-mail, or mobile phone. The system continues to alert the referring physician until the message is retrieved. For more information, contact Vocada, 3626 N. Hall St., Suite 908, Dallas, TX 75219. Phone: (214) 219-5240. E-mail: sales@vocada.com.] ■

Joint Commission issues 2005 patient safety goals

Bar-coding proposal could stir controversy

Last year, quality managers who were expecting major changes from the Joint Commission on Accreditation of Healthcare Organization's 2004 National Patient Safety Goals got a bit of a surprise: The goals were largely the same as the previous year's. This time, however, that won't be the case.

The 2005 National Patient Safety Goals and Requirements have been released for public review and comment and will be finalized this summer. Two of the new proposed goals include reducing the risk of harm from patient falls and reducing the risk of surgical fires.

But it's another new goal that might stir up some controversy — the proposal that hospitals develop plans for implementing bar-code systems for patient identification and matching patients to their medications or other treatments by Jan. 1, 2007.

Most organizations have not yet implemented bar-coding systems, and this may be viewed as unduly burdensome, says **Kathleen Catalano**, director of regulatory compliance at Provider HealthNet Services in Addison, TX.

"People may be asking, 'Is it really doable by 2007? Will the cost be prohibitive?'" she says. "For those institutions that have never introduced bar-coding, a thorough and credible evaluation must be made of how the facility will move forward to meet this goal." She recommends considering this a performance improvement project. "Go through all of the steps outlined by the Joint Commission for designing a new process, including review of literature and budgets."

Still, it may be that the bar-coding goal will be accepted and eventually implemented by organizations, Catalano says. "I think we'll have to wait and see about who makes the most noise. It could be this will be viewed as necessary."

Catalano says she expects that the final goals

will be very similar to what was proposed.

"I don't believe there will be major changes in the finalized goals unless the outcry from the field review is really loud about the bar-coding," she says.

In general, the proposed goals are in line with the number and severity of sentinel events that have occurred in these particular areas, Catalano says. "Most of these patient safety issues have already been evaluated to some degree by many facilities," she adds.

For instance, most facilities have implemented a falls reduction program. "The question on the falls issue is whether or not facilities have the resources for the number of bed alarms and low beds they need, or will they come up with alternative safeguards," Catalano notes.

Reducing the risk of surgical fires may be a bit challenging, due to the requirement of educating staff, licensed independent practitioners, and anesthesiologists/anesthetists. "Most will listen

because it's not just a question of the patient's safety; it's the operating crew's safety as well," she says. "But there are usually some who feel they don't need the training."

Testing the OR staff for their response to surgical fires easily can be added into the facility's fire drill plan, Catalano notes. Since the goals are being adopted in the summer, they definitely will become effective Jan. 1, she says.

"This will still leave a little time to put the necessary pieces in place," Catalano adds. "Most of these will require interdepartmental collaboration and a work plan before rollout."

[For more information on complying with the 2005 National Patient Safety Goals, contact:

- **Kathleen Catalano**, Director of Regulatory Compliance, Provider HealthNet Services, 15851 Dallas Parkway, Suite 925, Addison, TX 75001. Phone: (972) 701-8042, ext. 216. Fax: (972) 385-2445. E-mail: Kathleen.Catalano@phns.com.] ■



**THE
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Telling the patient satisfaction story

Feedback should lead to service improvements

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

Many health care organizations are gathering feedback from patients to determine their satisfaction with health services. Armed with this information, senior leaders and managers can establish customer-driven process improvement priorities and make more informed process redesign decisions. Regular patient and family input on their needs, expectations, and experiences also enables the organization to measure whether it is increasing its ability to satisfy customers. The bottom line is that finding out what patients, families, and other stakeholders think about what the organization does and how it is done should lead to service improvements.

It is likely that your organization will be

overwhelmed with the amount of information it receives from satisfaction surveys and other feedback mechanisms. This is especially true if the survey tool is lengthy or if there are a large number of open-ended comments. It can be challenging to aggregate and report the results in a manner that helps senior leaders determine what improvements should be done first, where improvement actions should be focused, and what enhancements are worth making.

To make the best use of patient satisfaction data, the results must be presented in a way that allows for accurate analysis. Depending on the methodology used to gather the data, the results may be represented as an average score or rating for various service aspects. Chances are, however, that the information also can provide a wealth of insights about how patients and other stakeholders view the services they have received from your organization.

An analytical approach that is very useful for evaluating satisfaction survey results is driver analysis. Driver analysis identifies the service or services that most significantly affect respondents' satisfaction. Using multivariate analysis, the most important factors affecting satisfaction are identified. For example, the overall satisfaction rating is compared to levels of satisfaction for specific services to determine the degree to which variation in the overall level of satisfaction is explained by the variation in specific service ratings. Those individual factors or services that

most adequately explain the variation in overall patient satisfaction are considered the drivers. By identifying the drivers of satisfaction, the organization can initiate changes patients and their families will most likely notice and value.

Driver analysis provides decision makers with a tool to prioritize the satisfaction survey results. The results are prioritized because customer feedback efforts often yield more information than a health care organization can deal with. Also, the organization may not have sufficient resources to address all aspects of service that receive low patient/family satisfaction ratings. Driver analysis enables the organization to identify which functions or services deserve the highest levels of attention.

To tell the story in customer satisfaction data,

different techniques can be used. **In the table on p. 87** are descriptions of the statistical techniques that most likely will meet all the needs and expectations of the decision makers charged with analyzing patient satisfaction data.

The following is a simple example of how feedback from a satisfaction survey might be analyzed: Suppose your organization's patient satisfaction survey includes the question: "On a scale of 1 to 5, where 1 represents 'highly dissatisfied' and 5 represents 'highly satisfied,' how would you rate your satisfaction with discharge instructions?" Over a three month time period, 450 patients responded to this question.

If you were to tabulate all the scores, the average response would be the mean. Although the mean is a very important piece of information,

Patient Satisfaction with Discharge Instructions 1

(n = 450)

| Score | Number | Percent of Those Expressing an Opinion | |
|-------------------------|---------------|---|-------------------|
| | | Out of 393 | Out of 450 |
| 1 – Highly dissatisfied | 42 | 11% | 9% |
| 2 | 27 | 7% | 6% |
| 3 | 122 | 31% | 27% |
| 4 | 132 | 34% | 29% |
| 5 – Highly satisfied | 70 | 17% | 16% |
| Subtotal | 393 | 100% | 87% |
| Don't remember | 22 | - | 5% |
| Don't know | 35 | - | 8% |
| Total: | 450 | - | 100% |

Patient Satisfaction with Discharge Instructions 2

(n = 450)

| Score Category | Number | Percent of Those Expressing an Opinion |
|-----------------------|---------------|---|
| Dissatisfied | 69 | 18% |
| Neutral | 122 | 31% |
| Satisfied | 202 | 51% |
| Total: | 393 | 100% |

Don't remember seeing or receiving discharge instructions: 22 (5% of 450)

Don't know/no opinion: 35 (8% of 450)

COMING IN FUTURE MONTHS

■ Comply with 2005 National Patient Safety Goals

■ Tricks to regain control during unannounced surveys

■ How to reduce the risk of surgical fires

■ What to do before implementing bar-coding systems

■ Steps to decrease the risk of harm from patient falls

there is a lot more you can do with the data. It is often useful to begin with a frequency distribution where you determine the number and percentage of respondents who gave each score between 1 and 5. One way to present that distribution is **shown in the top box on p. 86.**

Of the 450 patients responding to the survey question, 22 did not remember receiving discharge instructions, and 35 said they had no opinion or did not know how they would rate their satisfaction with the instructions.

In the example provided, the information about those who do not remember or have no opinion is

presented separately to allow the decision makers to focus attention on those patients who did have an opinion to express. The percentage of those with opinions based on the 393 respondents is presented in column 3. However, if it is important to determine the percentage of patients who do not remember or have no opinion about the discharge instructions, the figures also are calculated using 450 — the total number of patients who were asked the question (column 4).

The information shown may be too detailed for some people in the organization. For instance, the difference between a 1 and a 2 rating may not be

Statistical Techniques for Analyzing Patient Satisfaction Data

| Statistical Technique | Purpose | Example |
|------------------------------|--|---|
| Mean | Determine the average response | The mean rating for overall satisfaction is 4.3. (Sum of all scores divided by # of respondents.) |
| Median | Identify the middle response | The median score for overall satisfaction is 4. (When responses are listed in numerical order, the middle response if odd number of respondents, or the average of the two middle responses if there is an even number of respondents.) |
| Mode | Determine frequency of response | If 50 people responded to the survey and 26 rated the service a 2 out of a possible 5, the mode would be 2. |
| Frequencies | Summarize distribution of responses | 67% of respondents rate overall satisfaction 4 or 5. |
| Cross-tabulations | Summarize distribution of responses by another variable | 78% of Medicare respondents rate overall satisfaction 4 or 5, compared to 60% of non-Medicare respondents. |
| T-Test | Test for statistically significant differences between 2 independent variables | Obstetrical service respondents are significantly more satisfied overall than orthopedic service respondents. |
| Analysis of Variance (ANOVA) | Test for statistically significant differences between 3 or more independent variables | Overall satisfaction differs significantly among obstetrical service respondents, orthopedic service respondents, and general medicine service respondents. |
| Correlation | Determine how responses to 1 question predict responses to another question (measures the strength of relationship between variables) | Of all aspects of the patient care experience, satisfaction with the cleanliness of the environment best predicts overall satisfaction. (Respondents who are satisfied with cleanliness tend to be satisfied overall, and respondents who are dissatisfied with cleanliness tend to be dissatisfied overall.) |
| Regression | Analyze the effects of a relationship among responses to 2 or more questions (measures the effects of 1 or more variables on another variable) | As satisfaction with cleanliness decreases, overall satisfaction decreases. |

meaningful for them. Thus, it is useful to collapse the information into a smaller number of categories. One possibility is to create three categories: dissatisfied, neutral, and satisfied. (See **bottom box, p. 86.**)

If the data are being analyzed by individual services in hopes of finding improvement opportunities, it may be inappropriate to collapse the data because the difference between satisfied and highly satisfied is important.

However, if the information is to be used for high-level trend analysis, collapsing categories often can help make the information easier to grasp. The responsibility for producing meaningful reports falls to the quality manager. It is the manager's task to identify sensible ways to collapse or expand categories according to the needs of the audience.

It is important to present patient satisfaction data as succinctly and clearly as possible.

Therefore, it may be best to present the survey results in a simple, straightforward manner to most audiences and save the mathematical details for an appendix or supplementary briefing. Graphic representations of data also are powerful ways to display findings. It is very easy for audiences to get the message when information is presented in bar graphs, pie charts, and similar data displays.

There is no reason to elicit patient feedback unless your organization plans to use the information to improve services. Patient and other customer feedback may suggest many potential improvements or enhancements to consider. Narrowing down the list to those that will have the most direct effects on overall customer satisfaction is the ideal.

Driver analysis can help senior leaders select those actions most likely to affect overall service satisfaction. While each organization must consider its own capacity for action, it is important to do something or patients may feel that their input was not valued or the effort they expended to respond was wasted.

To get leadership support for improvements, satisfaction results should be accurately reported and presented in a constructive way that emphasizes the positive.

Results, findings, and recommendations should be presented as opportunities for improvement — not for punitive purposes. If patient satisfaction surveys cannot be used to influence change or improvement, the feedback process did not meet its objective, no matter how carefully the survey was planned and carried out. ■

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