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Is it time to re-examine structure of your quality department?

It may be an appropriate reaction to shifting market realities

Doesn't it make sense that a commitment to continuously improving performance should include a periodic review of the organizational structure that governs your QI efforts?

Several quality professionals contacted by *Healthcare Benchmarks and Quality Improvement* recognize that, in fact, conducting such reviews from time to time is essential to efficient QI operations.

In some cases, they observe, the structure just becomes tired or too large and cumbersome to operate efficiently. At other times, significant shifts in industry trends call for a new approach to structure design, they add.

"We have a very active discussion board.0569 and recently had a posting asking, 'How do you structure the quality function, what is your committee made up of — who's on it?'" reports **Sharon Lau**, a consultant with Medical Management Planning, in Los Angeles, referring to her BENCHmarking Effort for Networking Children's Hospitals.

"A number of replies indicated that the quality departments or committees were in the middle of a major revision," Lau notes.

What reasons were given for these revisions? "It sounds like people are really looking at how the quality function can be structured for maximum efficiency and benefit," she says.

Key Points

- Periodically review the structure that governs your QI efforts.
- The search for maximum efficiency and benefit is one of the leading causes for re-examination.
- Make sure the right people are made accountable for key quality decisions.

"Which got us to thinking: It used to be that quality wasn't really a department but something that everyone was expected to do — a value, if you will," Lau points out.

"At that time, there was a person in charge of JCAHO issues, a corporate compliance officer, then a quality department. So you had all these different pieces being fragmented under different silos," she adds. Subsequently, Lau says, people began recognizing that all these different functions, including the medical staff, touched on quality.

Susan W. Adams, RN, CPHQ, director of quality resources/risk manager at Primary Children's Medical Center in Salt Lake City, has a similar viewpoint.

"In the late 1980s, the changes people tended to make were in response to regulatory issues and were more specific than they are now," she observes.

"We have more latitude to be creative and innovative than we did then. Then it was discipline-specific; you had medical staff functions and did quality specific to the disciplines. Nurses did their things — doctors did theirs — and so on," Adams says.

Streamlining the structure

With the scope of the quality function having become so broad, it is easy for the structure to become bloated, observers say. This, then, has become one of the predominant reasons for restructuring.

"I started at this position several weeks ago, and they hadn't had a quality director in quite a while," says **Gayle Bielanski**, RN, CPHQ, director of quality and patient safety at Phoenix Children's Hospital. "We are now thinking about restructuring."

The current quality council has a medical staff committee, composed of the vice chairs of several medical staff committees, nursing directors, representatives of clinical areas such as radiology and lab, and a patient care and quality enhancement committee — a board committee — that includes board members, an individual in charge of the quality council, and one or two directors, she explains.

"What happened was, they seemed to duplicate each other's work; it was not supposed to be that way, but it got that way," Bielanski says. "Our thinking was to combine the two."

The new structure she has in mind would consist of two nurse directors, two or three clinical directors, some physicians, and two or three board members. "This way, they could bring back to the board whatever they found," she explains.

In hospitals where Bielanski had previously worked, she says, the quality council was a hospital committee.0569 with an administrative function.

"It was not truly a medical staff committee, although there was medical staff in it," she says.

For additional input, she entered a posting on the aforementioned discussion board. What did her peers say?

"So far, all of them say they are a medical staff committee, and only one hospital said they had two separate committees," Bielanski adds.

"My guess is that it preserves the confidentiality of anything that comes out of it and protects it

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Editorial Questions

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from discoverability." That means, she notes, that neither attorneys nor the media can get a hold of the information.

"For example, if it was reported that you had a certain number of errors, or a patient sued over receiving the wrong information, that could be used against your hospital," Bielanski notes.

Another issue she had been curious about was how often each of the departments reported, and when. "None of our departments had been reporting their quality information; it had been very lax," she says.

The respondents to the posting said reporting took place either quarterly or yearly. "We're leaning toward having all clinical departments report on a quarterly basis and the others every six months or every year," Bielanski explains.

Freeing up staff for systems PI

At Primary Children's, Adams is now contemplating the latest in a number of changes that have been implemented in the quality function during her 24 years there. What has occasioned this change?

"We've been using the interdisciplinary model since 1991," Bielanski explains.

"At this time, the enterprise is so heavy with so many people trying to represent things that we need to free up resources to have more time to devote to solving and monitoring and evaluating the solutions we come up with. We want to make [the structure] leaner and meaner to free people to do systems process improvement," she adds.

The current quality function is "a cast of hundreds," Adams observes. "We have unit-based geographic functions, hospitalwide functions, leadership functions. There is also a group or body outside the quality council that oversees the hospitalwide and the unit-based functions."

There is another issue driving the redesign, she continues. "We were trained to hold people accountable who were technically filling volunteer positions, so we are really trying to engage our senior leaders and look at accountability kinds of issues," Adams notes.

"We think that maybe some improvements weren't happening because we were asking the wrong people to be held accountable, rather than connecting the dots with leadership," she says.

To come up with a new plan, Adams created a strategic team of six individuals — the medical director, Chief Operating Officer, patient care services administrator/Chief Nursing Officer, patient safety manager, process improvement director, and herself.

"Our corporate strategic planning folks conducted some focus groups with all the participants, all the nursing medical directors, senior leadership, and then people on the existing committees and processes and functions," she reports.

In addition, the quality department did an intense analysis of accountability of committees, resources, strengths, weaknesses, regulatory requirements, and other key areas.

"We just completed a two-day retreat, and I think we were blown away with the complexity of the process," Adams says. "Some people thought we could spend a day coming up with a model, but we really want to streamline the structure; and I think we've come up with some innovative ideas we need to flesh out."

While a true model has not yet been finalized, one of the key recognitions of the group is that "you can't get a committee of gigantic proportions to do real work productively," Adams points out. "So we're adopting a model of three — it's a SWAT team approach to real process improvement, and I think we've done the right process."

A change in the structure will require a change in board bylaws, Bielanski says, "But we haven't had a problem yet. We have gone to most of the medical executive committee meetings and will go to the quality council tomorrow and the board next week. I don't think we will have an issue, because all the docs realize there's a problem they need to fix."

Bielanski says she is hopeful the bylaws can be changed within 30 days or so.

Know when change is needed

To make such improvements in the quality structure, you need to be able to recognize when change is needed, Adams notes.

"When you feel like you're not making those incremental leaps, or it feels cumbersome or broken, or you do not have the right people talking, it may be time for change," she offers.

"You should ask yourself if you can find the root cause of a problem quickly; if you can, your structure is probably OK," Lau adds.

"But if things are not getting reported, or you're not able to find answers, maybe your structure isn't where it needs to be." That structure doesn't have to look the same in every hospital, she says.

"There's probably no one right answer, but you

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have to look at accountability in making sure quality happens. Depending on how your culture works and how people interact, you may have a different way of doing it, but your key question should always be, 'How do we assure accountability in quality?'"

Performance improvement, Lau reminds, is a process, not a program.

"Ideally, you want to have all the aspects related to performance communicating very well," she explains.

"For example, information services [IS] always has a ton of data, but I can tell you that I've gone into hospitals where you'd be amazed how few people know that data exist, and how much reinventing of the wheel gets done. IS decision support, benchmarking, risk management, your national effort — all have to be a part of the process," Lau says.

Should all this responsibility come under one report? "I don't know," she continues. "But there are so much data, so many requirements to prove you are keeping track of things — that data intensity that has probably brought this to a head.

"You have to know where the data are and work on it together. Also, you have to make sure everyone is educated in how to do quality the right way at the right time," Lau adds. ■

Program enables 50 new initiatives in four months

'Transforming Care at the Bedside' program

Seton Northwest Hospital in Austin, TX, launched nearly 50 new quality initiatives in a single four-month period after deciding to participate in the "Transforming Care at the Bedside" (TCAB) program, which was launched by the Robert Wood Johnson Foundation in Princeton, NJ, and the Boston-based Institute for Healthcare Improvement.

The program, which targets bedside care on a standard hospital medical or surgical unit, aims to enhance the quality of patient care and service, create more effective care teams, improve patient and staff satisfaction, and improve staff retention.

Key Points

- Program targets bedside care on a standard hospital medical or surgical unit.
- Each staff nurse took on several projects, and all progressed simultaneously.
- Post-op order sets were adopted by nearly 100% of OB/GYN and orthopedic surgeons.

Seton Northwest joined the program in November 2003, recalls **Mary Viney**, MSN, RN, director of patient care services. "The process we used is what allowed us to complete nearly 50 initiatives in about four months," she says.

And just what did that process involve? First, she notes, having a large number of staff nurses on the core team was critical. Other members included pharmacists, two clinical managers, Viney, and a physician consultant.

"Each one of the staff nurses took on two or three projects and led the changes, so we were able to work on several of them at one time," Viney explains.

Significant improvements made

It might seem that four months is not a lot of time to make significant changes, but Viney says several of the projects were quite successful.

Perhaps the most impressive project involved standardization of the post-op order sets. "Our gynecological surgeons took what they thought were our highest volume of cases and looked at their order sets as they came up to the med-surg floor," Viney notes.

"Each of the 13 surgeons had their own handwritten post-op order sets," she adds.

One of the nurses then took this on as a project, gathering all the different order sets, noting the

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common elements and the most frequently used best practices.

Once that was done, it was time to sell the new form to the staff. "We went to one of the physician champions," Viney recalls. "We told him it was more difficult for the pharmacy and nurses [to use the different hand-written forms] and noted the safety issue of legibility. He agreed to pilot the new form on one of his post-op patients."

All of this happened within two weeks, she adds. "The physician was quite open and used the form. Then we asked him to use it again the following day with two more patients," Viney shares. "He said he had absolutely no concerns, that there were no changes needed on the new order set."

The team then asked the physician to go to the group in which he practiced and asked them to try the form. "They did so, and then he went to the whole OB/GYN section meeting and led a discussion about the need for change," she explains. "Within a month, we got 12 of the 13 docs to do it."

Numerous benefits reaped

The new forms are now available in the recovery room, "all pre-printed, so they are legible and all consistent," Viney notes. This, in turn, allowed the pharmacy to create a standard record that could be entered into their computer. "And the nurses did not have to spend as much time transcribing," she says.

Viney notes that the new form has saved nurses between 18 and 20 minutes per patient — and has saved the pharmacy close to seven or eight minutes per patient.

"It was safer, took variation out of the practice, and we were able to get more than 90% of the docs to use it in one month," she says.

Subsequently, the same process was tried with total knee and total hip replacement surgeries. "We had two large surgical groups; we went to one surgeon, he tested the form, and it began to spread," Viney reports. In this case, 100% physician participation was achieved, as were similar time savings.

What was the key to success in this initiative? "We laid the issue out, gave examples of how the new forms looked and how similar they were to the old forms," she says.

"We had to go through the process, but they saw that we only changed maybe two or three things on the form, so they all agreed to it. Plus, this was a real predictable population, and they understood that. And in terms of staff, it's been a huge satisfier all around," Viney says.

In addition, she says she was not required to wait for 100% buy-in before proceeding with the new process.

"Before, we had to. Now, we can progress by little steps — that's part of TCAB." ■

Research to practice is a hard journey, experts say

Meeting stresses need of research-to-practice process

"Evidence-based medicine"; the term just *sounds* right — doesn't it? Yet, while it flows easily off the tongues of quality professionals these days, that ease belies the true challenge of "TRIP," Translating Research into Practice, which served as the focal point of a conference held in Washington, DC, July 12-14.

The TRIP 2004 conference, Translating Research Into Practice: Advancing Excellence from Discovery to Delivery, featured sessions on the most current information technology for translating research into clinical practice, top strategies for leveraging research findings to improve care for patients with low health literacy, and key lessons learned in developing programs such as reducing health disparities.

Key Points

- Conference brings together researchers and users to address greatest challenges.
- Presenting information at several different levels increases chances of practice improvement.
- Networks of delivery systems jointly pursue studies, and shared research results.

The conference was sponsored by the Agency for Healthcare Research and Quality (AHRQ), the National Cancer Institute, and the Department of Veterans Affairs, with support from the Substance Abuse and Mental Health Services Administration, the National Institute of Mental Health, and the National Institute on Drug Abuse.

Asked if there was an overriding theme that emerged from the conference, **Jean Slutsky**, PA, MSPH, acting director of AHRQ's centers for outcomes and evidence, whose staff played a key role in putting the conference together, replies, "Probably the biggest take-home message is that it's really hard to do this."

Which makes forums like this all the more important, she points out. "Putting together researchers and users at conferences like this is incredibly fruitful. There were people there like your readers, who use the information, and then there were researchers, who produce it. It's a unique opportunity for that interaction to take place," Slutsky observes.

Progress being made

Slutsky notes that there are already examples developing where research can be translated into practice.

"For example, there are certain uses of IT [information technology] that actually deliver this information to the bedside or the nurse's station where it is needed, such as CPOE [computerized physician order entry], and PDA [personal digital assistant] downloads. The web sites can come up on your screen. Also, some electronic medical records can access evidence-based information," she says.

The advantage of systems like these, Slutsky explains, is that all the required information is delivered in a packaged form; the health care professional does not have to conduct his or her own haphazard search.

Being able to deliver the information at different levels of sophistication is equally important, she adds.

"One of the issues for patients is that there is very sophisticated work being done on the web. It may even be directed at the health professional," Slutsky adds. "There are some patients, however, who either speak a foreign language or are not well-educated or facile, which puts them at a disadvantage."

Thus, presentation should be adjusted so as not to shut these patients out, she says.

"We must target health information to a literacy level appropriate for different groups and perhaps translated into different languages," Slutsky suggests.

Networks showing promise

One approach showing particular promise is networks of health care organizations that share information and suggest needed areas of research, says **Cynthia S. Palmer**, MS, a research scientist at AHRQ who runs the Integrated Delivery Systems Research Network (IDSRN), which consists of nine partners and about 40 collaborating organizations.

"It's a network of health plans, hospital systems, community health centers, safety nets, ambulatory care centers, and so on," she explains.

"What it does is act as a test bed to try to implement evidence-based practices. We have a very practical, applied approach, and highly demand-driven research. We try to look at issues that are important to people out in the field and try to help them resolve solutions to some of the key issues they are dealing with," Palmer adds.

At the TRIP conference, during a session moderated by Palmer, three examples were shared by Research Triangle Institute, which had its own small consortium. "One of the delivery systems is Providence Health Care in Oregon," she relates.

"They had some money for patient safety improvement, and they were looking to reduce medical errors for discharged patients. They developed a model that showed they might be able reduce them by up to 50% if they used an electronic medication list to accurately identify all meds the patient was on when they entered the hospital, and then tracked the meds throughout their stay," Palmer says.

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The researchers discovered it would be too burdensome for one of their own pharmacists to take on this responsibility, but they were so optimistic this improvement could be achieved that they hired a transition pharmacist, she explains.

"We're now doing a study about how this can reduce errors and improve care," Palmer reports.

Already, she adds, the researchers "learned they needed a team approach, a champion, a tool, and technical assistance, which is the transition pharmacist. That's what they found they needed to effect any change."

When study results are received, the findings are presented to the operational leadership of the delivery systems involved, and the research is written up and published. "If it works, we try to disseminate the tool and approach to the rest of the network," Palmer says.

What can quality professionals be doing in general if they're not already? "Very simply things: subscribe to AHRQ's electronic newsletter; visit our web site very often, and review the several collateral tools the agency maintains on the web they can sign up for," Slutsky notes.

The tools include the National Guidelines Clearinghouse, the National Quality Measures Clearing House, and the Quality Tools Clearing House. "People can sign up and get an e-mail update every week," she adds.

(See these links for the tools mentioned in this article:
- *www.guideline.gov/whatsnew/subscription.aspx;*
- *www.qualitymeasures.ahrq.gov/whatsnew/subscription.aspx;*
- *www.qualitytools.ahrq.gov/whatsnew/subscription.aspx.)* ■

JCAHO resource compares more than 16,000 facilities

Consumer-friendly language aids comparisons

As previously reported by *Healthcare Benchmarks and Quality Improvement,* hospital executives are paying more attention every day to report cards and other comparative data that provide information about hospital quality. **(See *HBQI,* August 2004, cover story.)**

With the launch of a new tool called Quality Check, from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), it has become even more apparent they are wise to do so.

Key Points

- Proponents seek to take the guesswork out of choosing a hospital for consumers.
- Facilities' care compared in heart attack, heart failure, pneumonia, and pregnancy-related conditions.
- National quality goals, and patient safety goals are incorporated into evaluation process.

Using a database that compares more than 16,000 local hospitals, home care agencies, nursing homes, laboratories, and ambulatory care organizations, Quality Check offers consumers the ability to compare health care information about the quality and safety of care provided in an accredited health care organization with others on state and national bases.

"We hope this will take the guesswork [out of choosing a hospital]," said **Dennis S. O'Leary**, MD, president of JCAHO, during a recent news conference announcing the launch of Quality Check. "It includes new information about thousands of health care facilities and how their individual performance compares nationally and statewide."

For example, he noted, if patients want to know about heart failure treatment, "They can compare different facilities in doing things experts agree improve outcomes."

Or in terms of safety, they can see if the facility complies with hand hygiene guidelines, O'Leary added. "You can see if they take a time-out before surgery to ensure they are doing the right procedure on the right body part on the right patient," he observed.

At present, Quality Check compares facilities in four major conditions: heart attack, heart failure, pneumonia, and pregnancy-related conditions. Individuals also will be able to determine how health care organizations compare with others in meeting national requirements that help them prevent medical accidents.

The requirements specifically seek to avoid misidentification of patients, surgery on the wrong body part, miscommunication among caregivers, unsafe use of infusion pumps, medication mix-ups, problems with equipment alarm systems, and infections acquired in the health care setting.

These incorporate JCAHO's National Quality

Improvement Goals, as well as National Patient Safety Goals. Other information available to the consumer includes:

- the organization's accreditation decision and effective date;
- health care services provided by the organization that are accredited by JCAHO;
- special quality awards and other distinctions;
- commentary about the Quality Check report (if the organization chooses to submit one for inclusion;
- requirements for improvement (if applicable).

How it works

When an individual goes to the Quality Check site, he or she can select the search function either for consumers or for health care professionals.

"We try providing layers of information, from the high level down to as much information as you want," explained **Evelyn Lockett Woods**, executive vice president for support operations and chief information officer for JCAHO, while demonstrating the use of the site during the conference.

"On the professional side, we provide things such as benchmarks. On the consumer side, we use language for the lay public," she says.

"I applaud JCAHO's effort to make more information available, easy to use and to understand," noted **Kenneth W. Kizer**, MD, MPH, president and chief executive officer of the National Quality Forum (NQF).

Kizer said he was pleased the commission was using NQF's endorsed measures where they could be used, and that it had "publicly committed to continue to expand and use them as they become available.

"I'm hopeful the AHA [American Hospital Association] and others in the voluntary hospital reporting initiative will make a similar commitment as well," Kizer pointedly added.

Consumers can obtain a wealth of information about a selected hospital. On the first page, they can select "type of provider" and narrow their search by state, county, and zip code. Having picked a facility, they can request a quality report, which includes an index of all the information they can find.

In comparisons against national averages in all the aforementioned categories, consumers will see either a plus ("this organization performs significantly better than other organizations"), a minus ("this organization performs significantly lower than other organizations"), or a check (the hospital is "within the pack").

Hospitals also can be compared, for example, to the top 10% or top 50% in a given category.

"You can drill down farther," Lockett Woods explained. "Say you are looking at pneumonia: You can double-click to specific measures that led to [the plus, minus, or check] — like adult smoking cessation programs."

It also will show the number patients treated and the percentage who received such education. Similarly, it can show how often a best practice procedure is followed. A star indicates the best possible result.

Consumer friendliness praised

Several conference participants praised the commission for making Quality Check user-friendly.

"When people are making these choices, they want to feel safe and confident," noted **Judith Hibbard**, DrPH, a professor in the department of planning, public policy, and management at the University of Oregon.

"Often, such things are not written in a way a nonmedical person can understand. This, however, is understandable and easy to use. It helps consumers learn what they should be looking for when they choose a hospital," she said.

"We view this as an important step toward engaging employers and consumers in health care quality, added **Suzanne F. Delbanco**, PhD, chief executive officer of The Leapfrog Group.

Noting that "very few consumers know how to spend their health care dollars wisely," **Debra L. Ness**, president of the National Partnership for Women & Families, called Quality Check "a good start," but added that more is needed.

"We still need data from a broader range of conditions, about more outcomes of care, and better ways of discerning among providers, and how to assess the cost-effectiveness of treatment," she asserted.

Hibbard predicted still another benefit from

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- **Joint Commission on Accreditation of Healthcare Organizations**, Oakbrook Terrace, IL. Web site: www.jcaho.org. Quality Check web site: www.qualitycheck.org.

the launch. "Our research shows making performance public increases QI efforts and performance improvement," she observed. "This can also be an important motivator for hospitals to improve quality of care." ■

Study shows 12-hour shifts increase errors

Research on impact of long hours on nurses

A study published on-line by the journal *Health Affairs*[1] indicates that hospital nurses working shifts of 12.5 hours or more are three times more likely to make an error than nurses working shorter shifts.

The study is based on data from 393 members of the American Nurses Association who kept a log of their hours worked, overtime, days off, and sleeping patterns for 28 days.

The researchers found that in 39% of the 5,317 total shifts worked, the nurses worked at least 12.5 consecutive hours, but only 7% involved mandatory overtime. And 14% of the respondents reported working 16 or more consecutive hours at least once during the four-week period.

On average, participants worked 55 minutes longer per day than scheduled and 40.2 hours per week.

They reported making a total of 199 errors and 213 near errors during the period. About half the errors involved medication administration, while others involved procedural, charting, and transcription errors.

"Our analysis showed that work duration, overtime, and number of hours worked per week had significant effects on errors,"[1] the authors wrote. In fact, they noted, the likelihood of making an error increased with longer work hours and was three times higher when nurses worked shifts lasting 12.5 hours or more.

Key Points

- Anonymity was key in ensuring candid reporting of errors and near-errors.
- The likelihood of making an error increases as the total number of hours worked increases.
- The data are to be used for pilot study to test a fatigue countermeasures program.

One of the reasons for the study, the lead authors noted, is that there was not a great deal in the literature about the prevalence of extended work hours for nurses or the effects on patient safety.

"There really is nothing, though there are lots of studies on physicians — even though nurses are the largest group of health care providers," observes **Ann E. Rogers**, PhD, RN, FAAN, an associate professor at the University of Pennsylvania School of Nursing in Philadelphia, and the study's lead author.

Combating fatigue

The original impetus for the study, Rogers notes, was her desire to do a pilot study to test a fatigue countermeasures program for nurses.

"It has been used in transportation, in the nuclear power industry, and should be applicable for any group doing 24-hour-a-day type work," she asserts. "I found out that we didn't know enough [about nurses' working conditions], so we had to go out and get the data."

Now that Rogers has scientific data that demonstrate the long hours nurses work, they will inform different recommended interventions.

"For example, one of the things to look at is the timing of ingestion of caffeine; I would suggest it at different times during 12- and eight-hour shifts. This turned out to be very important information," she explains.

It didn't surprise Rogers that there was a greater risk of making an error after 12 hours.

"In studies of truck drivers or factory workers, we start to see accidents become more prevalent after nine hours or so," Rogers points out. "When people who work in nuclear plants, for example, work extensive overtime, they misread dials and things like that, so it would seem that nurses really aren't different than other human beings."

It was critical, she adds, that the diaries the participants kept were totally anonymous.

"I absolutely did not know anybody's name or address," Rogers asserts. "If these were not anonymous, it would have affected the sharing of errors and near errors."

The questions were modeled based on the researchers' experience with sleep research, as well as with adult patients and nurses.

"For example, my background in sleep research tells me that e*veryone* has trouble staying alert between 4 a.m. and 6 a.m.," she adds.

"Even if they are motivated and rested, they

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still have trouble. So we wanted to know, for instance, if the nurses were having trouble being alert."

As for the most significant finding of the study, Roger says, "Basically, it is hazardous for patients when nurses work 12 or more consecutive hours. It is hazardous for patients when nurses work overtime — and they do that almost every day they work. So we need to pay closer attention to the hours they work and try to reduce overtime and long shifts."

As for her pilot study to test the fatigue countermeasures program for nurses, Rogers says, "It will take a good year or so" before she will be able to begin the program.

Reference

1. Rogers AE, Hwang W-T, Scott LD, et al. The working hours of hospital staff nurses and patient safety. *Health Affairs* July/August 2004. DOI: 10.1377/ hlthaff.23.4.202. ■

JCAHO unveils National Patient Safety Goals

The Joint Commission on Accreditation of Healthcare Organizations (JACHO) has released its 2005 National Patient Safety Goals that will apply specifically to hospitals.

The goals and associated requirements, which were approved by JCAHO's board of commissioners at its July meeting, include five of the 2004 goals and add two new expectations. The latter focus on reconciling medications across the continuum of care and reducing the risk of patient falls.

The National Patient Safety Goals set forth evidence-based requirements that address critical aspects of care known to involve significant risk to patients.

The goals are reviewed and revised annually by the sentinel event advisory group. This panel consists of physicians, nurses, pharmacists, and patient safety experts who work closely with JCAHO staff members on a continuing basis to determine priorities for, and develop, goals and associated requirements.

The goals are largely, but not exclusively, based on information from the JCAHO sentinel event database. As part of the development process, candidate goals and requirements are sent to the field for review and comment before they are finalized.

The 2005 Hospital National Patient Safety Goals are as follows:

- **Goal: Improve the accuracy of patient identification.**

Use at least two patient identifiers (neither to be the patient's physical location) when administering medications or blood products; taking blood samples and other specimens for clinical testing; or providing any other treatments or procedures.

- **Goal: Improve the effectiveness of communication among caregivers.**

For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result read back the complete order or test result.

Standardize a list of abbreviations, acronyms, and symbols that are not to be used throughout the organization.

Measure, assess, and, if appropriate, take action to improve the timeliness of reporting and the timeliness of receipt by the responsible licensed caregiver of critical test results and values.

- **Goal: Improve the safety of using medications.**

Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride > 0.9%) from patient care areas.

Standardize and limit the number of medication concentrations available in the organization.

Identify and, at a minimum, annually review a list of look-alike/sound-alike medications used in the organization and take action to prevent errors involving the interchange of these medications.

- **Goal: Improve the safety of using infusion pumps.**

Ensure free-flow protection on all general-use and patient-controlled analgesia IV infusion pumps used in the organization.

- **Goal: Reduce the risk of health care-associated infections.**

Comply with current Centers for Disease Control and Prevention hand hygiene guidelines.

Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with health care-associated infection.

- **Goal: Accurately and completely reconcile medications across the continuum of care.**

During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient's current medications on the patient's entry to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

A complete list of the patient's medications is communicated to the next provider of service when the patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization.

- **Goal: Reduce the risk of patient harm resulting from falls.**

Assess and periodically reassess each resident's risk for falling, including the potential risk associated with the resident's medication regimen, and take action to address any identified risks. ■

Need More Information?

For more information, contact:

- **Joint Commission on Accreditation of Healthcare Organizations**, Oakbrook Terrace, IL. Web site: www.jcaho.org.

NEWS BRIEFS

Leapfrog offers web-based compendium of incentives

The Leapfrog Group, based in Washington, DC, has developed the first public web-based compendium of incentive and reward programs aimed at improving health care in both inpatient and outpatient settings. The compendium is available free of charge at www.leapfroggroup.org/ircompendium.htm.

The compendium documents and categorizes both financial programs, such as those that reward providers with quality bonuses, and nonfinancial programs, such as those that reward providers with public recognition.

Currently, the Leapfrog compendium details 77 programs from around the country, including 17 that incorporate the group's performance measures. Users are able to sort by location and program target and search the programs using a built-in keyword search function. For example, a search might focus on HEDIS measures of Leapfrog's four quality and safety practices.

Intended users are purchasers, health plans, and providers. ▼

CDC reports four deaths related to transplants

The Centers for Disease Control and Prevention (CDC) has reported four organ transplant recipients died of rabies after receiving organs from the donor, an Arkansas man who died in May of what was then diagnosed as a brain hemorrhage.

The fourth case was reported later than the initial three reported on July 1, noting the deaths that had occurred from June 8-21.

Officials plan to screen employees who may have come in contact with the fourth patient and said employees found to have "significant exposure" to the donor or three earlier patients were being treated.

Officials said any remaining blood vessels or tissue procured from the infected donor have been destroyed. The cases mark the first reports of rabies transmission through solid organ transplants, though the virus has been transmitted through cornea transplants.

The CDC says it is working with health officials in Arkansas, Texas, Oklahoma, and Alabama — states where the transplants took place, or where the donor and recipients resided — to identify health care workers and family members who might have come into contact with the infected patients and determine whether treatment is needed.

The agency also says it is working with federal agencies to evaluate potential future steps to reduce the risk of rabies transmission through organ transplants, but emphasized that human rabies is exceedingly rare in the United States with only one to three cases reported each year.

There have been no cases of transmission of the virus from an infected person to family members or health care workers in the United States. ▼

FCC: TRS use does not violate HIPAA privacy rule

The Federal Communications Commission has published a notice clarifying that telecommunications relay services (TRS) can be used to facilitate telephone calls between health care professionals and patients without violating the Health Insurance Portability and Accountability Act's privacy rule, and without requiring the TRS facility or its communication assistants to sign a disclosure agreement.

The notice can be found under "Federal Communications Commission" at www.access.gpo.gov/su_docs/fedreg/a040708c.html. ▼

Software helps hospitals prepare for flu pandemic

The Centers for Disease Control and Prevention has developed a software program to help hospitals and public health officials prepare for the next flu pandemic.

The spreadsheet-based software, FluSurge 1.0, estimates the potential surge in demand for hospital beds, intensive care unit beds, and mechanical ventilators for each week during a pandemic and compares it with actual capacity. It's a companion to the previously released FluAid 2.0, which estimates the total deaths, hospitalizations, and outpatient visits that might occur during an influenza pandemic.

Both software programs and accompanying manuals are available free at www.dhhs.gov/nvpo/pandemics/. ■