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IN THIS ISSUE

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Controversial report puts JCAHO under scrutiny: Is survey process flawed?

'Surveyors will be more watchful than ever,' expert says

[Editor's note: The following is the first of a two-part series on the Government Accountability Office's (GAO) recent report on the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This month, we cover the report's controversial findings and JCAHO's response. Next month, we'll update you on newly introduced legislation and explain how it could affect JCAHO's hospital accreditation program — and your future surveys.]

A hailstorm of controversy has been generated from a recent GAO report questioning JCAHO's ability to ensure quality care. Based on the report's findings, legislation has been introduced by U.S. Rep. Pete Stark (D-CA) and Sen. Charles Grassley (R-IA), which would give the Centers for Medicare & Medicaid Services (CMS) the same oversight authority over JCAHO that it has for all other organizations with accreditation authority.

That would reverse nearly 40 years of practice, as the original Medicare Act of 1965 granted JCAHO a unique status to deem hospitals as eligible for Medicare payments with limited federal oversight authority.

The GAO report cites alarming statistics from a retrospective survey of 500 hospitals conducted by a team of government inspectors, who found that JCAHO had missed deficiencies in 123 of the hospitals. Those include inadequate infection control, inability to ensure competent performance of physicians and nurses, and failure to adequately protect patients and staff from fire-related disasters.

"Dennis O'Leary and the Joint Commission have been in the hot seat before, and I feel they will weather this storm as well," predicts **Kathleen Catalano**, director of regulatory compliance at PHNS in Addison, TX.

In 1999, an investigation by the Health and Human Services Office of the Inspector General concluded that JCAHO's accreditation surveys were not likely to identify patterns of deficient care.

"In response, JCAHO set to work to really help facilities recognize what they could do to alleviate these patient safety issues, set up standards to help with that process, and implemented the National Patient Safety Goals," Catalano says.

Regardless of whether new legislation puts the program under federal

oversight, it's likely surveyor awareness will be heightened as a result of the report, she warns.

"Thus, those undergoing surveys should be mindful of possible patient safety issues," adds Catalano. "Remember that the surveyors will be more watchful than ever for patient safety problems."

The Joint Commission is pulling no punches, calling the report's findings flawed and misleading. **Margaret VanAmringe**, JCAHO's vice president for public policy and government relations, points out it's largely been overlooked that the report found hospitals to be compliant with the Medicare Conditions of Participation (COP) 98% of the time.

"I think hospital leaders should feel very good about that fact, although it was buried in the report," she says. "Unfortunately, that message was lost."

VanAmringe also points to the thousands of yearly complaint investigations conducted by CMS at accredited hospitals, which find COPs out of compliance less than 2% of the time.

In addition, the number of deficiencies found during the CMS validation surveys isn't necessarily meaningful in itself, she adds. "The name of the game is not to count up the number of deficiencies. It's to look for continuous quality improvement. If they found 10 deficiencies and we found nine, that's not the point. Because we can find nine that may mean more than finding even 25, because they're the right nine."

If the report included data regarding the frequency with which JCAHO and CMS have found similar results in their surveys and compared it to the number of times they found differences, it might be more representative of the actual scope of the problem, says **Patti Muller-Smith**, RN, EdD, CPHQ, a consultant for Shawnee, OK-based Administrative Consulting Services. Muller-Smith works with hospitals on performance improvement and regulatory compliance.

"It might also be of interest to know if JCAHO and CMS are surveying using a similar interpretation of the standards in question," she adds.

While no hospital will give perfect care 100% of the time, the issue is whether problems are identified and fixed when they are found, says Catalano.

"Anyone who has been in any health care facility, or any other industry for that matter, has seen things run extremely well and also fall to pieces. When staff are rushed, have too many patients to care for, or do too many things at one time, incidents occur," she notes. "This is as true in the Top 100 hospitals as it is in the lowest-ranking facility."

All hospitals have deficiencies and should not be punished for their efforts to find and fix them, VanAmringe stresses. "We do not knock down organizations for having deficiencies. We knock them down in terms of their accreditation status for not *fixing* deficiencies," she says.

It's important to note that the federal government is coming from an enforcement perspective, which is different from the JCAHO's continuous quality improvement perspective, VanAmringe explains.

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"When taken together, you have a dynamite combination. But we point to the fact that Congress continues to have problems with nursing home compliance. The reason they do is they are looking at it from the enforcement angle and not from a quality improvement angle and don't infuse that into the process. But the Joint Commission does; that's what we do," she adds.

JCAHO does acknowledge that it needs to improve its assessment of compliance with the Life Safety Code. "We've always admitted this, which is why we took so many actions between 2002 and 2004," VanAmringe says. "That's not to say, however, that we agree that all of the Life Safety Code differences in the GAO report are meritorious in terms of whether they actually put any risk on patients."

To address that, JCAHO will be adding additional engineers during surveys of hospitals that meet criteria putting them at a higher risk for potentially having Life Safety Code problems, such as the size or age of the organization, she says.

According to VanAmringe, only about 30% of the Life Safety Code differences found by the state agencies represented problems that would have been considered moderate to high risk by JCAHO surveyors. "But for the non-Life Safety Code areas, we don't think there is anything different we would do. And for about 70% of the Life Safety Code differences, I'm not sure we would do anything differently there either."

New survey process: Overlooked by GAO?

JCAHO points to its revamped survey process as powerful evidence that the accreditation program is "absolutely moving in the right direction," she says.

VanAmringe notes that hospitals with deficiencies now are required to develop corrective plans of action in a specific time frame, with quality data now publicly reported and surveys to be unannounced as of 2006. "I think hospitals will learn very quickly that if they don't correct things in a specific time frame, they will be in trouble," she says.

However, **Sidney Wolfe**, MD, director of the Health Research Group for Public Citizen, a Washington, DC-based national nonprofit public interest organization, isn't convinced.

"Every time anyone has done a report critical of JCAHO, their response is always the same. They say, 'That was a year ago; we are doing better now.' That is a classic JCAHO response," he says. "But they aren't doing better, and the same critical problems are still there."

A major concern are surveys, which currently still are announced, Wolfe notes. "If you are really doing a policing effort, you would not have 95% of inspections announced so everyone can see good things as opposed to bad things. How many times does somebody have to come up with findings that are very damning for JCAHO before saying, 'We need a real fix,' which is to just get them out of the loop in terms of regulation?"

(All regular JCAHO accreditation surveys will be conducted on an unannounced basis beginning in January 2006.)

In the past, state health agencies often have found serious problems in hospitals accredited by JCAHO, says Wolfe, adding that recent changes are "largely cosmetic.

"Over and over again, hospitals that have disasters occurring to patients often traceable to systemic problems, are the same hospitals that, not long before these disasters, passed JCAHO inspections with flying colors," he notes.

That is not reflective of the current state of JCAHO's survey process and is based on old data from more than a decade ago, VanAmringe counters.

"That is not even worth commenting on. It's irrelevant and meaningless. To put out information about a survey in the 1980s is like driving a car in the 1980s and using that experience to comment on what cars are like in 2004," she says.

According to VanAmringe, hospitals should have a safe harbor enabling them to take steps to fix problem areas without fear of losing accreditation. "In other words, if you identify deficiencies yourself and work with surveyors to correct them, those things are not publicly reported on our web site. It's when you don't fix things on a timely basis or give them the attention they deserve that you are going to be in trouble," she says. "And that's where we ought to be, focusing on the sustainability of quality, and not on 'I gotcha.'"

So what do quality professionals have to say about it? Many say the new survey process is much more effective in zeroing in on problem areas and requires an ongoing process of reporting on designated measures that affect patient outcomes.

"The Joint Commission has just changed its survey methodology in order to look for things of this nature," Catalano says.

"I feel we should give this new process a chance

to show if it's working," she continues.

Surveys no longer are viewed as a crunch time, but rather as an invitation for a trained outside observer to point out things that are not seen by those who work in the environment on a daily basis, Muller-Smith explains.

"The new process requires that the organization develop a quality-driven culture that becomes part of the very fabric of delivering patient care," she adds. "Compliance or noncompliance is less likely to depend on the surveyor than on the actual overall performance of the hospital."

But other quality experts argue that inspections, however they are conducted, are not enough to ensure quality care.

"The GAO report is just another indication that the compliance industry of which JCAHO is a member can never truly generate either quality or safety," says **Martin D. Merry**, MD, adjunct associate clinical professor of health management and policy at the University of New Hampshire in Durham, and a Exeter, NH-based health care quality consultant. All inspections can do is ensure accredited facilities meet minimum standards — a limited but important role, he says.

However, compliance with minimum standards can never result in a high level of safety for patients and serves mainly to induce fear, Merry explains. "Perhaps, fearful people will be more careful in their attempt to avoid lawsuits, loss of license, loss of accreditation or payment, or public embarrassment, all of which might put them out of business," he adds. "But this can never, by its basic nature, inject enthusiasm for excellence."

This has to come from individual leadership in health care organizations, Merry stresses. "This fact is still far too often misunderstood. The inspection and regulation processes, as they are now conducted, continue to drain far too much time and resources in most facilities."

"These resources are extracted from exactly the people who might better use them truly pursuing excellence rather than compliance," he adds.

The problem is that surveyors often are unable to detect truly dangerous practices going on in the institutions they inspect, Merry says. "The inspectees will always be too clever in hiding their deficiencies in order to maintain licensure and accreditation. Therefore, we will continue to see tragic, embarrassing cases emanate from fully accredited institutions."

Thousands of patients are harmed every year due to medical errors despite caregivers' and JCAHO's best efforts to prevent these injuries, he says, adding that JCAHO surveyors lack a high-powered lens to detect the multitude of ways in which patients potentially can be harmed.

"However, I'm convinced that their leadership fully understands this and is moving as fast as they can to improve their inspection process. I hope that the inspectors and regulators continue to move away from often meaningless ritual to genuinely effective inspection and regulation," Merry adds.

The GAO report's verdict is it's too early to tell whether the new survey methodology will actually improve detection of deficiencies, as the process was just implemented in 2004**.**

In addition, the report claims JCAHO failed to do adequate pilot testing. VanAmringe counters that, in fact, extensive pilot testing was conducted, and the GAO was provided with compelling data that the new process improved significantly.

The use of tracer methodology during surveys is an important and hopeful sign, Merry adds, as it shows JCAHO is focused on the patient's perspective. "This is an important departure from talking to caregivers and administrators and reading documentation about what *they* think patients are experiencing," he adds.

Merry also acknowledges that unannounced surveys could, in fact, be a powerful tool to improve detection of problems. "This allows inspectors to learn what really is happening in hospitals vs. what appears to be happening during a largely staged event that the facility has had months to prepare for, perhaps with high-priced coaching from consultants," he says.

The bottom line is that increased oversight and transparency is a reality for all health care providers today — and JCAHO is not immune to being put under the microscope, says **Patrice L. Spath**, BA, RHIT, a health care quality specialist with Brown-Spath & Associates in Forest Grove, OR.

"It is hoped that open and candid discussions of the best way to ensure quality and cost-efficient health care for the American public will have positive results," she says.

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- *The GAO report,* Medicare: CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals, *can be downloaded free from Rep. Pete Stark's web site: www.house.gov/stark. Click on "News," "7/20/04 — Press Release — Hospital Accreditation," "GAO-04-850."]* ■

Handling data: Concurrent vs. retrospective approach

Concurrent data collection has some advantages

Are you collecting data elements concurrently, while patients still are receiving care, or retrospectively after discharge? Each approach has distinct advantages and disadvantages, and which is best depends on the individual situation, says **Patrice L. Spath**, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates.

"The biggest mistake that people make is to view data collection as an all or nothing activity, by gathering all data either concurrently or retrospectively," Spath explains.

At Freeport, IL-based FHN, quality managers do both concurrent and retrospective data collection, depending on the scenario, says **Glenda Koeller**, assistant vice president of performance excellence.

Concurrent data collection is used to determine appropriateness of utilization, while retrospective data collection is used for clinical indicators for clinical pathways and guidelines and data collection for the Joint Commission on Accreditation of Healthcare Organizations, the Centers for Medicare & Medicaid Services, VHA, and the FHN's own internal balanced scorecard.

The cost of quality falls into three broad categories: prevention, appraisal, and failure; and data collection is an appraisal cost, Spath notes.

As a quality manager, you must find creative approaches to data collection so appraisal costs don't outweigh the benefits, she explains. "Well thought-out investments in cost-efficient appraisal mechanisms can be repaid many times over by significant decreases in the costs of failure."

Here are advantages and disadvantages for each approach:

- **There is lack of data quality control with concurrent data collection.**

If several different people will be gathering data, make sure your data collection form is easy to use, Spath advises. "This means that data entry maps in sequence with how things occur, it is placed as close as possible to the point of action, and it doesn't require so much entry time that the data collectors throw their hands up in frustration. The more disruption, the lower the accuracy."

She recommends meeting with data collectors often during the first few days of data collection. The goal is to be sure they understand what data they are to collect, how important they are, and to gain their feedback as to what may need changing to make it easier or more meaningful. Then review data at the end of day one to validate they are accurate and complete, and follow up with individuals who are not following instructions, Spath adds.

- **Concurrent data collection may require additional retrospective review to correct errors or gather missing data.**

When doing concurrent data collection, some cases may be missed and require retrospective data collection. For example, data collectors have to go back to determine if any patients with a short length of stay slipped through the cracks, Koeller explains.

In addition, retrospective data collection gives you the benefit of having all the necessary data elements, including criteria and justification for patient care interventions that were not done, she says.

For instance, if you are doing concurrent data collection for a pneumonia patient, there may be a justification for why the antibiotic wasn't given in a four-hour time frame that isn't apparent until after the patient is discharged, Koeller notes. "It isn't always there until we pull it all together with the discharge summary, so you can see the whole picture."

- **With retrospective data collection, medical record documentation may be inadequate.**

The patient record can be incomplete at any point in time, but once the patient is discharged,

it is difficult to get the doctor to add additional information in the progress notes, Spath says.

To address that issue, consider implementing a concurrent documentation improvement program, with a nurse or health information management professional reviewing patient records concurrently and working with physicians and other caregivers to ensure documentation in the record accurately reflects what actually is happening with the patient, she suggests.

She gives an example of a quality measure for patients admitted for treatment of an acute myocardial infarction (AMI): Percent of patients without beta-blocker contraindications who received a beta-blocker within 24 hours after hospital admission.

If a patient does not receive a beta-blocker, the documentation improvement specialist would check to be sure the record includes information about *why* the patient did not receive this medication, and if documentation is lacking, the physician is asked to record why a beta-blocker was not prescribed, Spath says.

- **Concurrent data collection allows for real-time improvements.**

"Concurrent data collection gives us the opportunity to do proactive improvements, so we can actually improve on the spot," Koeller adds. For example, physicians can correct incomplete documentation in real time, she says.

Patient care can be impacted, such as administering aspirin to an AMI patient if it was not given prior to arrival; or if the patient should have received a beta-blocker, the physician can be reminded to order the medication, Spath adds. "If data collection is more than merely gathering data elements — if it is interventional — potential quality of care problems can be addressed immediately."

If you are including intervention to resolve potential quality problems, then data elements should be gathered concurrently, she advises. "But if people are merely placing a check in a box indicating that a beta-blocker was not given so that aggregate results can be compiled later on, then it may be more efficient to collect the data retrospectively," Spath says.

As organizations switch to paperless medical records, concurrent data collection should increase because all the information will be readily accessible, Koeller predicts.

"We have a partial electronic medical record but not total. Right now, it's still pretty much a paper system," she says. "We are going in that direction, but we aren't there yet."

Retrospective data collection can be incorporated into routine post-discharge record review activities, and all data elements can be collected at one time, Spath notes.

At first glance, this method is less expensive, since the patient record only is reviewed once to gather all data elements at one time, she adds. "However, retrospective data collection can be more expensive if you are missing opportunities to improve quality at the point of care."

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Are you complying with medical staff standards?

Some suggestions for complying with key changes

There are several key changes for the Joint Commission on Accreditation of Healthcare Organizations' revised medical staff standards, which became effective as of January 2004. "I see these as nothing less than revolutionary," says **Martin D. Merry**, MD, adjunct associate clinical professor of health management and policy at the University of New Hampshire in Durham.

The previous detailed, prescriptive standards have been scaled back to a much more simplified medical staff chapter, he notes. "I interpret this as JCAHO saying, 'Medical staffs, here's the simple, basic structure. We don't know how you can generate quality and safety beyond this, so be creative and show us how to create more effective hospital medical staffs.' There is much more to happen here, and stay tuned!"

Here are key changes in the medical staff standards, with suggestions for how to comply with each:

- **The physician health standard (MS.4.80) has been expanded to include all licensed independent practitioners**.

"The survey process will include peer review of not just physicians but of residents and fellows as well," says **Joan M. Hoil**, RN, associate administrator for quality management at State University

(Continued on page 127)

PATIENT SATISFACTION PLANNER™

Evidence-based design could help quality of care

Literature review shows impact on outcomes

You may not be an architect, but it might be time for you to start paying a little more attention to the way your hospital is designed — especially if you're about to have a new facility built or you're embarking on a substantial renovation.

That's the message coming from the Concord, CA-based Center for Health Design (www.healthdesign.org), which recently commissioned an analysis of more than 600 research studies. The analysis shows a direct link between patient health and quality of care and the way a hospital is designed.

The review, conducted by **Craig Zimring**, PhD, professor of architecture and an environmental psychologist at the Georgia Institute of Technology in Atlanta, and **Roger Ulrich**, PhD, director of the Center for Health System and Design at Texas A&M University in College Station, outlines the benefits of an evidence-based approach to hospital design.

"Just as evidence-based medicine is revolutionizing health care treatment, evidence-based design is transforming the health care environment," says Zimring. "We now have at our disposal proven architectural methods for improving patient outcomes, safety, and satisfaction, as well as staff retention and service efficiency."

According to his report, evidence-based design can:

- enhance patient safety by reducing infection, risk, injuries from falls, and medical errors;
- eliminate environmental stressors, such as noise, that negatively affect outcomes and staff performance;
- reduce stress and promote healing by making hospitals more pleasant, comfortable, and supportive for patients and staff alike.

It's important to note that evidence-based design can reduce stress, not only for patients and families, but for staff as well, Zimring explains.

"I think hospitals are very risky and stressful places for the people who work in them, but also for patients and families. We know that according to the Institute of Medicine (IOM), between 44,000 and 88,000 people die each year due to preventable errors, which is more than the number of people who die of breast cancer, automobile accidents, or AIDS. Likewise, an estimated 88,000 die due to nosocomial infections," he continues. "We also know that the IOM and the IHI [the Boston-based Institute for Healthcare Improvement] argue that one of strongest measures we can take to boost safety is to hire more nurses."

At the same time, Zimring points out, the United States is starting one of the largest hospital building booms in history. "It's a perfect storm — aging baby boomers, people moving to the Sunbelt, and replacing all the hospitals built in the '60s and '70s. The prediction is that in this year there will be between $16 billion and $27 billion worth of hospitals built," he adds.

The good news, Zimring says, is that "there is a body of scientifically defensible evidence that says the physical environment can affect patient safety, stress, the ability of staff to do a good job, staff stress, and nursing turnover."

For example, the national average for nursing turnover is 20% a year, he explains. "But some facilities, like the Mayo Clinic, have 3% to 4% a year. "What's clear is that the environment impacts outcomes — it reduces medical errors, nosocomial infection, and makes it a better place to work," Zimring observes.

The findings hold a big lesson for quality managers, he says. "The physical environment matters for quality outcomes, and the quality manager will either be working with or against that physical environment. Many hospitals, even new ones, are simply places that breed errors and infection."

On the other side of the coin, however, facilities that have invested in evidence-based design have reaped real benefits. Bronson Methodist Hospital, for example, used such an approach in the $181 million redevelopment of its hospital campus in downtown Kalamazoo, MI.

The redesign included private rooms with rooming-in accommodations for all patients; creative use of artwork, music, light, and nature to create a more pleasant and less stressful environment; shorter walking distances for patients and families with seating along the way; and touch-screen

An evidence-based design reaps benefits for users

Here are a few examples of benefits derived by hospitals that pursued an evidence-based approach to design, according to a report from the Concord, CA-based Center for Health Design (www.healthdesign.org):

1. Patient falls declined by 75% in the cardiac critical care unit at Methodist Hospital in Indianapolis, which made better use of nursing staff by spreading out their stations and placing them near patients' rooms.
2. Nurse turnover rates dropped from 5.9% to 0.6% in six months, compared to 20% nationally, at a new family birth center that Memorial Hermann Healthcare System built at The Woodlands (TX) Hospital. Bed units were designed as pods with six private rooms for patients, a control station, physician's dictation room, and a workroom for nursing staff.
3. Medical errors fell 30% on two new inpatient units at the Barbara Ann Karmanos Cancer Institute in Detroit that allocated more space for their medication rooms, reorganized medical supplies, and installed acoustical panels to decrease noise levels. ■

information kiosks at every main entrance.

Among the results cited in the report:

- 11% reduction in nosocomial infections;
- nursing turnover rates of 6.5%;
- 95.7% overall patient satisfaction;
- improved staff satisfaction;
- 6% increase in market share.

Texas A&M research indicated that such changes increase overall costs by about 5%, "but if you look at it very conservatively, you'd get it back in one year," Zimring adds. **(For other examples, see box, above.)**

He concedes that none of those improvements occur in a vacuum. "You need quality improvement initiatives as well, but do you want to work *against* the building or use it as a tool to make these things easier and more permanent?"

Remember, that what is built today will be in place for decades. "If we do it wrong now, it will haunt us for the rest of our careers or it will help us for the rest of our careers," Zimring notes. That is precisely why the quality manager should be heavily involved in the design process, he says. "Common sense and research suggest that where you get the biggest bang for your quality buck is if the system and the process design are in concert."

Zimring and Ulrich offer the following recommendations for designing your facility in a way that will support your QI efforts:

- Get rid of double-occupancy rooms and provide patients with single rooms that can be adjusted to meet their medical needs as they change during their stays.
- Improve indoor air quality with well-designed ventilation systems and air filters to prevent nosocomial infection.
- Use sound-absorbing ceiling tiles and carpeting to reduce noise, which will lower stress for patients and staff alike.
- Provide better lighting and access to natural light to reduce stress and improve patient safety.
- Create pleasant, comfortable, and informative environments to relieve stress and promote satisfaction among patients, their families, and staff.
- Make hospitals easier and less stressful for patients and their families to navigate.
- Design hospitals that help staff do their jobs.

"We now have 600-plus studies that show the physical environment can be a tool in improving quality, so QI managers should be brought in very early in the design process and throughout the process," Zimring says.

"Quality managers need to know the potential of the physical environment and what the key decisions are," he adds.

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How to boost satisfaction rates: A tale of two EDs

To please patients, timing is everything

In 1997, the emergency department (ED) at Parkview Hospital in Fort Wayne, IN, was in the 45th percentile in South Bend, IN-based Press Ganey Associates satisfaction rankings. That same year, Southern Ohio Medical Center in Portsmouth, languished in the ninth percentile.

Since 1998, however, Parkview has consistently been between the 90th and 99th percentiles almost every quarter, and Southern Ohio also has gotten its Press Ganey numbers into the 90s.

What were the keys to Southern Ohio's dramatic

turnaround? "Our hospital made the decision in 1997 that we wanted to become known for service," says **Mary Kate Dilts-Skaggs**, RN, MSN, CAN, director of nursing for emergency and outpatient services at Southern Ohio.

"We had to use what the public was saying about us to really improve processes." And what did the customer surveys say? "The No. 1 complaint was time," she explains.

Parkview saw the same overriding issue. "The No. 1 goal we always have is to get the patient to the doctor [quickly]," adds **Deb Richey**, MPA, director of emergency services.

"They come to the ED to see the physicians, so any opportunity you have to streamline processes will benefit satisfaction," she notes.

Richey says it's important to take a broad-brush approach. "Obstacles can be in the parking lot, in triage, in registration. There is a variety of things that can impede access."

One step at a time

With such a long way to go, Dilts-Skaggs says that success did not happen overnight. "It took slow but sure increments of improvement."

One of the keys at the starting point was an interdisciplinary team. "If you want to make changes, you need all the stakeholders at the table," she explains. Have all the departments interface with the ED so they know what the goals are. "For example, it's hard for the laboratory to understand that all work in the ED is STAT unless they are at the table and hear it, because the [intensive care unit] and everyone else all want their attention," Dilts-Skaggs says.

The team, which included physicians, nursing, unit clerks, patient representatives, ED technicians, registration, medical imaging, the laboratory, and human resources began meeting monthly. Here are some of the key changes they implemented that have reduced process times:

- **STAT lab.** Some testing is performed in the ED, which has decreased the time it takes to get results to the physicians. "We do general screenings and a fair amount of testing," says Dilts-Skaggs.
- **Rapid-cycle change.** This tool, which enables staff to turn change on and off rapidly, was learned though work on a Veterans Health Administration initiative to decrease door-to-doctor times. Southern Ohio has cut their time from 90-100 minutes to 37.
- **Bedside registration.** There are dedicated registrars in the ED who use bedside computers on wheels.
- **Computerized medical imaging.** The doctors have reviews stations in the ED so they can look at X-rays and computed axial tomography (CAT) reference scans.

In addition, several initiatives were adopted that directly addressed patients and their families:

- A new ED was built with all private rooms.
- If patients have to stay all night in the ED because a bed is unavailable, the hospital sends them a small flower or plant to acknowledge their inconvenience.
- Beverage cart service is provided twice a day, and patient representatives regularly check on patients and families to see if they need anything.

Outside consultants were brought to Parkview to train staff in customer service to get patient satisfaction efforts started, Richey recalls. The combination of lectures and role-playing helped increase awareness of the need to serve customers. Then, several timesaving measures were instituted:

- **The registration process was streamlined, and bedside registration was instituted.**

This produced immediate positive feedback from patients and reduced turnaround time by 40 minutes.

- **Nurses were trained in a faster triage process.**

"If there is a bed available and you can look at a patient and see what kind of bed [he or she] needs, it's not critical to do vitals or a huge history in the triage area," Richey explains.

- **TVs were put in most exam rooms.**

"This creates white noise and helps pass the time," Richey notes.

Interestingly, both Parkview and Southern Ohio adopted the "FISH philosophy of customer service." The approach draws its name from a series of books based on the successful customer service approach in Seattle's Pike Place Fish Market. "They include a number of simple principles that help make your team passionate about customer service," Dilts-Skaggs says. "It makes it fun."

Richey adds, "We've really gotten a lot of mileage out of it. We've repeated the program each year and presented new customer service goals for each year."

Drawing on the FISH philosophy, Dilts-Skaggs says she celebrates the successes of staff.

"For example, the first time monthly bedside registration hit 800, we had ribs and chicken," she relates. "Happy employees make happy customers. It all plays into patient satisfaction."

[For more information, contact:

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Team nursing improves staff morale, patient care

Teamwork improves employee retention

Do you want to increase satisfaction scores, improve patient care, and boost staff retention all in one shot? Consider switching to a team model of nursing.

"There is a growing trend toward team or zone nursing," reports **Lisa DiMarco**, RN, BSN, MBA, CEN, administrative director for emergency services at Edward Hospital in Naperville, IL.

Morale of nursing staff has improved dramatically since the team model went into effect in August 2000, she reports.

If you are planning to switch to team nursing, consider these significant benefits:

- **Nurses help one another more readily.**

Previously, attitudes such as "it's not my patient" were all too common, says DiMarco.

With the team model, if a nurse is caring for a trauma patient while assigned to two other patients, another nurse automatically steps in to cover these rooms.

Nurses are more eager to assist their peers without being asked, says **Randy Schmidt**, RN, charge nurse for the ED. "Often, you will hear a nurse say 'I'll take that patient,' only to hear another nurse say, 'No, I can take them, you already have three,'" he says.

Now, every nurse knows at least something about all the patients, says Schmidt. "This makes it easier to assist a patient or answer questions when you might not be their primary nurse," he adds. "Assistance is generally acknowledged with a sincere thank you, which is in itself a great morale booster."

- **Employee satisfaction scores increase.**

Staff satisfaction is measured by South Bend, IN-based Press Ganey Associates every other year, and an internal survey tool is used during the off years, says DiMarco. "After we get the results, we sit down and have sessions with staff to talk about problems," she says.

Employee satisfaction ratings for the 2002-2003 year scored in the 58th percentile, a significant increase from two years earlier when it was in the 22nd percentile, reports DiMarco, who attributes this to the team nursing model being implemented.

However, about 10% of nurses still are resistant to the team model, DiMarco acknowledges. "You will always have a handful that never will buy into this, and they do create a lot of stress for the group," she says.

To combat this, insist that resistant nurses be included in any decision-making process, advises DiMarco.

"They are not allowed to just complain. If they are going to complain, they have to give a suggestion to fix it," she says.

For instance, several nurses complained about doing the lion's share of the workload and were told to share their concerns directly with their colleagues. "Their tendency is to avoid confrontation and just complain to the management. But we just keep sending them back to the team," DiMarco explains.

- **The system provides additional mentoring opportunities.**

The team concept pairs expert nurses with novice nurses. "The thing we were most surprised about was that retention is so much better," she says. "I believe that speaks to the mentoring atmosphere of the team model." Previously, if a novice nurse needed help but didn't go out of her way to ask, experienced nurses weren't necessarily going to jump in and offer assistance, DiMarco explains.

Now it is much easier for new nurses, interns, and transitional nurses to approach more experienced nurses, she adds. "The preceptors are typically assigned to a new hire and follow that person's schedule." Having the correct skill mix on each team is key to success.

"The nurse manager does the scheduling and considers individual unit clerks, technicians, nurses, and doctors to make sure there is the right combination of skill mix on the team," DiMarco points out.

Many of the less experienced nurses have gained significantly in self-confidence, patient care skills, and efficiency, Schmidt notes.

"They have been less hesitant to ask questions, and the more experienced nurses have been less reluctant to offer assistance," he says. ■

(Continued from page 122)

of New York (SUNY) Downstate Medical Center, University Hospital of Brooklyn. "And the data sources aren't quite so firm, and people will have to do a lot of reaching."

Hospital information systems are a good source of data about physicians who admit or do procedures and consultations, but there is limited information about house staff, she explains.

"Computerized order-entry systems are one source. Another may be the data collected within the Graduate Medical Education program and the performance appraisals done by the supervising physicians," Hoil notes.

When cases are peer reviewed, particular attention should be paid to the resident's decision making and communication skills, she advises. "Supervising physicians may be reluctant to participate because residents are, in fact, students."

Previously, the standard required hospitals to have a physician health policy, with a process for dealing with health issues separately from disciplinary action. "The difference is that now it must apply to all licensed independent practitioners. Our policy was revised accordingly. Basically, we just substituted the words 'licensed independent practitioner (LIP)' for 'physician,'" says **Kathy Downs**, CPMSM, CPCS, CPHQ, director of medical staff services at Paradise Valley Hospital in National City, CA.

At Paradise Valley, this now includes dentists, podiatrists, psychologists, certified registered nurse anesthetists, certified nurse midwives, and certain other allied health professionals, she says.

- **There is a new process for credentialing.**

One of the key changes that affects the medical staff is in the leadership standard LD.3.70, Downs explains. In the past, physician assistants and advanced practice registered nurses who were employed by the hospital usually were processed by human resources, and those who were not employed by the hospital were credentialed through the medical staff process, she adds.

"Rather than bringing employees into the credentialing process, our board of directors has determined that human resources has an equivalent process that contains all of the elements required by the Joint Commission," Downs says.

However, one difference in human resources' previous process is there will be communication with the interdisciplinary practice committee and the medical executive committee prior to appointment and reappointment, she notes.

- **Standard 4.30 addresses the expedited credentialing and privileging process.**

The standard says an organized medical staff may use an expedited process for appointing individuals to the medical staff and for granting privileges, when criteria for that process are met. "We already had a similar process in place," Downs says. "The elements of performance then address what that criteria should be."

This is the exact wording from the organization's medical staff bylaws:

"Following a positive recommendation from the medical executive committee and in order to expedite appointment, reappointment, or renewal or modification of clinical privileges, the governing board may delegate the authority to render those decisions to a committee consisting of at least two governing board members. The board of directors may authorize a delegation of the governing board consisting of two members."

An applicant usually is ineligible for the expedited process if at the time of appointment, or if since the time of reappointment, any of the following has occurred: incomplete application submitted; medical executive committee adverse recommendation or with limitation, current challenge, or a previously successful challenge to licensure or registration; has previously received an involuntary termination of medical staff membership at another organization; or has received involuntary, limitation, reduction, denial, or loss of clinical privileges, or adverse final judgment in a professional liability action.

- **Standard 5.1.1 says the governing body may elect to delegate the authority to render initial appointment, reappointment, and renewal/modification of clinical privileges decisions to a committee of the governing body.**

"What changed is that certain criteria must be met, whereas before, there were no specific criteria as to what recommendations could go to a committee of the governing body," Downs adds.

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Are you doing enough to prevent infant deaths?

Recommendations made in Sentinel Event Alert

It's without question one of the most tragic things that can occur at any hospital: An infant's death during delivery.

According to a recent *Sentinel Event Alert*, nearly 75% of hospitals in the Joint Commission on Accreditation of Healthcare Organizations' health care errors database cited communication breakdowns as a major reason for these devastating events. According to the alert, the hospitals identified problems including lack of teamwork and an atmosphere that discourages team members from speaking up to ask for clarification.

Staff competency and training, inadequate fetal monitoring, and unavailability of monitoring equipment and/or drugs also are listed as root causes. The *Sentinel Event Alert* recommends the following:

- conducting formal team training sessions for the obstetrical/perinatal team;
- using care guidelines established by the American Academy of Pediatrics, the American College of Obstetricians, and Gynecologists, and the Association of Women's Health, Obstetric, and Neonatal Nurses;
- developing clear procedures for fetal monitoring of potential high-risk patients;
- taking steps to ensure key personnel are available for emergency interventions;
- making certain that neonatal resuscitation areas are fully equipped and functioning.

"As with all *Sentinel Event Alerts*, there is good evidence-based information," says **Angie King**, BSN, CPHQ, quality management director at Tift Regional Medical Center in Tifton, GA. "My concern is that during this time of medical malpractice crisis, plaintiff's attorneys will use this as a hammer."

Infant death and injury during delivery does not automatically constitute fault on the caregivers' part, yet these occurrences are very difficult to defend in a malpractice lawsuit because a jury is predisposed to feel sympathy when it comes to infants, King notes.

"I have seen plaintiff's attorneys use the Joint Commission's *Sentinel Event Alerts* to set a standard," she says. "They will use the recommendations not as a point of causation, but as a symbol of hospitals not following the standard of care."

King points to the alert's recommendation for conducting team training to improve communication. "If that is not documented, it could be used as a cause of poor communication. The onus is on the hospitals to closely review the entire alert, implement as much as possible, and document the implementation," she adds.

After King received the alert, she immediately developed an action plan by working directly with the organization's chief of obstetrics and nursing leadership. A task force was formed comprised of obstetrics nurses and managers, education personnel, and obstetricians who will review both the recommendations and the organization's risk reduction strategies.

"Action plans and timelines are assigned with our task force," King notes. "Special team training will be held for the current staff and then added to unit-specific orientation."

The biggest take-home message from the alert is the urgent need for better communication among caregivers, urges **Fay A. Rozovsky**, JD, MPH, assistant vice president and manager of the risk management health care group at Chubb Specialty Insurance in Simsbury, CT.

"You can have the best systems in place, but if people don't communicate effectively, accurately, and in a timely manner, then it is all for naught," she says.

She gives the example of a nurse who says that the reading on a fetal monitoring strip "looks OK."

"To me, that might mean we should be watching and checking back in a couple minutes; and to someone else, it may mean that everything is fine and I can move on to the next patient," adds Rozovsky.

All team members must have the same understanding as to the meaning of the terminology used, or dangerous misunderstandings may occur, she says, noting that this is difficult when working with residents or agency personnel.

Rozovsky suggests using consistent terminology and avoiding use of terms that can be interpreted a variety of ways. Another solution is to encourage staff to repeat back what they are hearing, which is done routinely in the food, law enforcement, and aviation industries.

"If they can do that, why can't we?" she asks. "It's not enough to say, 'I understand,' — the caregiver should repeat back what they've heard."

Rozovsky also recommends encouraging staff to speak clearly, using a consistent chain of command

system with a quick response time when communication problems arise, and using checklists for communicating with patients.

"As a risk management professional, it's astonishing to see how communications play such a major role in loss prevention and yet persists as a major issue," Rozovsky says.

"This is not something that requires a capital expenditure, but it goes right to the core of patient safety. If people would learn how and when to communicate with one another, a lot of the problems that we see might not make it to the light of day," she adds.

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THE QUALITY - CO$T CONNECTION

Worst practices used in conducting FMEA projects

Part 2 of a two-part series

By **Patrice Spath**, RHIT
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As often occurs when new Joint Commission on Accreditation of Healthcare Organizations standards are introduced, hospitals are rushing to complete failure mode and effect analysis (FMEA) projects to comply with patient safety requirements.

Organizations caught up in the whirlwind of standards compliance are tempted to execute the FMEA project work without proper training. It's important to note that there are many different FMEA models, and no one particular technique is most suitable. However, some FMEA difficulties are common to all organizations.

This is the second of a two-part series on how FMEA projects can prove more valuable to the facility when "worst practices" are avoided. Worst practices numbers 1-8 were described in last month's *Quality-Co$t Connection* column.

This month, the remaining four worst practices are covered, along with suggestions on how to avoid these practices.

✔ **Worst Practice #9**: *Fail to critique the effectiveness of proposed actions.*

To make a health care process safer, actions should result in a reduction of the criticality score for each high-priority failure mode. Lowering the probability of occurrence, decreasing the severity of the effect, and/or improving the detectability score will reduce the criticality score. If an action plan is not expected to reduce the criticality score of the failure mode, then another action should be developed.

For instance, to reduce the possibility that a physician would order an inappropriate medication or dosage, one FMEA project team recommended there be a consistent spot on all nursing units for medication reference materials for physicians. That was the only recommendation for reducing the likelihood of this failure mode. What are the chances that this action will reduce the probability, severity, or detectability of an inappropriate medication order?

FMEA project teams should subjectively analyze the predicted effect of proposed actions before implementing the changes. This involves recalculating the failure mode criticality scores based on what the team imagines will occur after the proposed action is implemented.

For example, the team is asked, "After creating a consistent spot for medication reference materials, what is the probability that a physician will order the wrong medication dosage?"

If the action is expected to make a difference, then the probability of the failure should go down. This recalculation exercise should be done for each of the high-priority failures for which actions have been proposed.

During pilot testing of actions, data about the occurrence and detection of failures can be gathered. After a period of time, the data are used to objectively recalculate the failure mode criticality scores. As part of the evaluation of the effectiveness of actions, the team's predicted post-action

failure mode criticality scores can be compared to what actually happened.

✔ **Worst Practice #10**: *Don't adopt a systems view.*

For the most part, the actions taken to reduce the likelihood of failures are directed at changing people or processes. New double-checks are added, record forms are revised, individuals are retrained, procedures revised, etc. Unfortunately, during the action planning step of the FMEA, the latent system failures that set up people to make mistakes often are ignored.

If the organization's underlying system for managing processes is not addressed, the future safety of patients remains in jeopardy. For example, hospitals have implemented surgery-site marking and pre-incision site and patient verifications to reduce wrong-site surgery. However, if the system of care in the operating room expects the surgical nurses to regularly function with heavy mental workloads, this latent failure can contribute to a future accident. Numerous organizational factors directly affect the safety of patient care, as well as the work conditions and actions of individuals at all levels.

Those latent failures generally revolve around issues related to resource management, organizational climate, and the characteristics or conditions of work that have been established by management. Those factors must be carefully considered during the development of actions intended to reduce the likelihood of failures.

✔ **Worst Practice #11**: *Overlook human factors.*

Preventing failures in the delivery of health care services requires changes in the macro and micro aspects of the systems in which people work. Changes in procedures, rules, workflow, automation, the introduction of new technology and equipment, and other system changes help make people effective. However, the needs of the people working in the system also must be considered when developing action plans. In this regard, FMEA projects often fail by:

- creating additional work for fewer people;
- removing people from roles in which they were comfortable;
- placing people in unfamiliar new roles as if they were interchangeable parts;
- not involving or consulting with the people affected by decisions. Instead, assumptions about what is good for them are made.

When introducing workflow changes, automation, new roles, and other interventions designed to make a process safer, the FMEA team members should always ask, "What needs of the people involved are affected, how will their energy and interests in the job change, and what skills will the proposed changes affect *positively and negatively*?" Interventions to reduce failures and improve patient safety work best when they address both the needs of the system *and* the individuals who inhabit them.

Optimal solutions occur when system- and individual-level needs are addressed. The question to answer is: What is in the best interest of the system, the people who work in it, and the individuals we serve? That question involves three groups of players. It would be a mistake to implement risk reduction strategies that leave one of the stakeholders out.

✔ **Worst Practice #12**: *Don't broadly apply lessons learned.*

The risk-reduction strategies implemented during an FMEA project often have application beyond the scope of the FMEA investigation. Yet the lessons learned in one project seldom are applied to other, similar processes.

For example, to reduce the risk of wrong-site surgeries, the surgery department in one hospital created a rejection process to be used when physicians fax orders for patients who will be coming in for surgery. If the orders are incomplete or unclear, the orders are faxed back to the physician with a rejection form indicating the deficiencies that need to be corrected before the patient's arrival. If this action works well for the surgery department, why not use the same process in patient registration for all pre-admitted patients?

To ensure everyone learns about the good ideas that come out of FMEA projects, the lessons learned need to be shared throughout the organization. Lessons learned are the knowledge or understanding gained by the improvement experience. The experience may be positive, such as reduced errors, or negative, such as solutions that didn't work as intended.

Many hospitals use staff meetings, newsletters, training conferences, or program reviews to communicate lessons.

Listed below are some other examples of what could be done to improve knowledge sharing.

- Designate an individual to serve as the "lessons learned" coordinator to lead and manage efforts to share lessons learned in all improvement projects, including FMEA projects.
- Develop ways to broaden and implement mentoring and storytelling as additional mechanisms for lesson sharing.

- Identify incentives to encourage more collection and sharing of lessons among employees and improvement project teams, such as links to performance evaluations and awards.
- Solicit user input on the value of the organization's current lesson-sharing efforts to determine how knowledge can be better disseminated.
- Initiate information technology pilot projects to evaluate the usefulness of electronic information sharing.
- Track and report on the effectiveness of the lessons-learning efforts using objective performance measures.

A common barrier to sharing lessons learned from any process improvement project is the perception that people will be punished if a recommended action does not achieve its intended goal. Overcoming this barrier requires strong support from the organization's leaders. Perceived intolerance of mistakes by management will cripple any knowledge-sharing efforts.

FMEA is a new tool in a health care organization's process improvement toolkit. If used sensibly, this tool can effectively reduce the risk of unintended patient harm. By converting worst practices into best practices, the value of individual FMEA projects will be greatly enhanced. ■

NEWS BRIEF

2005 National Patient Safety Goals are final

The Joint Commission on Accreditation of Healthcare Organizations' 2005 National Patient Safety Goals that will apply specifically to hospitals have been finalized — but many eager quality managers didn't wait for this news to take action.

CE *questions*

9. Which is a key recommendation of a recent Government Accountability Office report on the Joint Commission?
   A. Give CMS greater power to monitor the hospital accreditation program.
   B. Postpone unannounced surveys.
   C. Have state health agencies review all JCAHO survey results.
   D. Lessen requirements for compliance with the Medicare Conditions of Participation.

10. Which is an advantage of retrospective data collection?
   A. Inadequate physician documentation can be corrected.
   B. Patient care can be impacted in real time.
   C. All necessary data elements are present.
   D. Potential quality problems can be resolved before the patient is discharged.

11. Which problem was identified by almost 75% of hospitals as a major contributing factor to infant deaths during delivery?
   A. insufficient staff levels
   B. inadequate infection control
   C. communication problems between caregivers
   D. lack of appropriate training

12. Which is a requirement of Joint Commission's revised medical staff standards?
   A. The survey process includes peer review of physicians only, not other allied health professionals.
   B. The physician health standards apply only to members of the medical staff.
   C. There is no circumstance in which an expedited process may be used for granting privileges or appointing to the medical staff.
   D. An expedited process for appointing to the medical staff and for granting privileges may be used when criteria for that process are met.

Answer Key: 9. A; 10. C; 11. C; 12. D

COMING IN FUTURE MONTHS

- How to ensure compliance with Medicare COPs
- New ways to utilize patient tracers during mock surveys
- Compliance strategies for 2005 National Patient Safety Goals
- Avoid common mistakes with measures of success
- Update on new legislation that will affect JCAHO

"When the draft 2005 goals were published, our hospital began to work on many of them," says **Jann Robinson**, RN, MA, CPHQ, patient safety officer at Good Samaritan Hospital in Puyallup, WA.

"Because of our work on the draft goals, we are a step ahead for the final goals. We felt a sense of urgency and that we needed all the time we could get to comply on Jan. 1, 2005," she notes.

Robinson says the organization viewed the draft 2005 goals as best practice and doesn't consider its efforts wasted, even in light of changes in the finalized goals.

"We still continue to encourage nurses to take a second nurse to the IV pump even though it was dropped off the list," she says.

Two new goals focus on reconciling medications across the continuum of care and reducing the risk of patient falls.

Here are things that Good Samaritan is doing to comply with the 2005 goals:

- The patient safety committee started a performance improvement project on falls reduction. "We are beginning by identifying all barriers to falls reduction in our facility and exploring multidisciplinary and creative interventions to prevent falls and injuries from falls," Robinson says.
- The medication subcommittee began working on look-alike/sound-alike and high-risk medications; and revised policies and staff education are under way. This committee also is preparing a performance improvement project on reconciliation of patients' medications across the care continuum.

"We continue to disseminate information on all the National Patient Safety Goals through hanging posters that ask questions about the goals with the answers on the back, our *Patient Safety Tips* publication, and incorporating them into our mock tracer surveys," Robinson adds.

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

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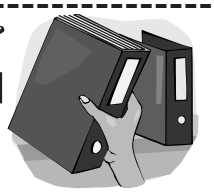

CE objectives

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

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

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