YOUR ORIGINAL AND BEST SOURCE FOR JCAHO COMPLIANCE

HPR HOSPITAL PEER REVIEW®

Accreditation • Credentialing • Discharge Planning • Medicare Compliance • Patient Safety • QI/UR • Reimbursement

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

NOVEMBER 2004
VOL. 29, NO. 11 • (pages 149-160)

CMS and JCAHO quality measures now are the same: Will that save you time?

It may reduce redundant data collection, but quality managers have concerns

Are you tired of dealing with multiple data definitions and similar but differing performance measures? You've probably wished many times that the quality measures from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare & Medicaid Services (CMS) were identical.

In an effort to reduce your data collection burdens, the two organizations have agreed to work together to completely align current and future hospital quality measures in their condition-specific performance measure sets, including the Joint Commission's ORYX core measures and CMS 7th Scope of Work Quality of Care Measures on heart attack, heart failure, pneumonia, and surgical infection prevention.

The measure alignment will make it easier and less expensive for hospitals to comply with existing requirements for data collection and reporting, says **Sharon Sprenger**, project director for the group on performance measures in the Joint Commission's division of research. "You don't want it to be so burdensome that people don't have time to use the data to make improvements," she adds.

The decision sends a positive message that JCAHO and CMS are working in a collaborative manner to improve the quality of care for these patient populations, says **Barbara Wilkins**, RN, performance improvement coordinator at Danville (VA) Regional Medical Center.

"This is definitely good news for quality professionals," she says. "I think it's a wonderful thing. Now when we collect data, it meets both agencies' requirements. It reduces duplication of efforts and decreases confusion when we report data to various committees."

Overall, standardizing data definitions will have a positive effect on the care patients receive, predicts **Catherine M. Fay**, RN, director of performance improvement at Paradise Valley Hospital in National City, CA. "It has been a long time in coming and a very positive step," she says. "There has been a sense of serving two masters. The measures are evidence-based, and as such, it has been difficult to clarify to health care staff why the two organizations have selected different measures on which to focus."

Quality professionals responsible for data collection activities would frequently ask JCAHO for identical measures, Sprenger reports.

"At presentations, we would hear from them, 'Why can't you guys get together and have the same specifications?'" she says. "That certainly was an important impetus. We understood that it is difficult to have one set of specifications from CMS and another from JCAHO."

The measures in the four Joint Commission and CMS hospital measure sets currently calculate the same way, but there are differences in the format of the specifications for data elements, types of cases excluded, calculation algorithms, and other measure dimensions, Sprenger explains.

Although the change may seem sudden, JCAHO actually has been working with CMS to align the measures they have in common since May 2001 when JCAHO announced its four initial core measures including acute myocardial infarction, heart failure, and pneumonia, Sprenger notes.

"So when hospitals began collecting data in July 2002, we had worked with CMS on these measures that were common to both organizations. We were close, but we were not exact," she says. For example, one measure included only one data element for JCAHO, but CMS had four data elements for the same measure.

Also, although measures were calculated the same way, the data elements might have differed, or definitions might have been slightly different.

"What we have done now is to completely identify with one another in our measures," she says. "The measures we do have in common have the exact same definition."

Part of the goal was to reduce the data collection burden for quality managers, Sprenger notes. "It will help to decrease some of that duplication of efforts, where previously individuals were looking at different measures and trying to figure out how they were the same. We also have a commitment that we stay aligned moving forward for any future change to these measures or subsequent measures."

"It is reassuring that their joint effort is at the practice level now, where the data collection occurs," says **Janet A. Brown**, RN, BSN, BA, CPHQ, FNAHQ, president of JB Quality Solutions Inc., a Pasadena, CA-based consulting firm. "Any time those with separate and sometimes disparate regulatory control and decision-making authority can come to a consensus, it is a time for rejoicing among quality professionals and all who seek to comply," she explains.

Many quality managers have high hopes for a significant time savings in data collection activities. "Right now, we have two separate processes for data collection for CMS and JCAHO. You have to do it differently for each agency," says **Missi Halvorsen**, RN, BSN, senior consultant for JCAHO/regulatory accreditation at Baptist Health in Jacksonville, FL. "It's always been frustrating, and I think it is a good idea for them to align the measures."

At many organizations, data collection still is a largely manual process, notes Halvorsen. "If you are in a paperless environment and can pull that information electronically, that's one thing. But if you're half and half or all paper, it's still a manual process and very time-consuming," she says.

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Peer Review**®, P.O. Box 740059, Atlanta, GA 30374.

Thomson American Health Consultants is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Homa-Lowry (board member) discloses that she is a consultant with Joint Commission Resources and a Malcolm Baldrige examiner. Spath (board member) discloses that she is a stockholder with Merck & Co. Ball (board member) discloses that she is a consultant and stockholder with the Steris Corp. and is on the speaker's bureau for the Association of periOperative Registered Nurses. Brown, Carter, Higginbotham, Hoil, Mattison, Stephan, and Swain (board members), and Kusterbeck (editor) have no relationships to disclose.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $449. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $75 each. (GST registration number R128870672.)

Editor: **Staci Kusterbeck**, (631) 425-9760.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@thomson.com).
Senior Production Editor: **Ann Duncan**.

THOMSON
AMERICAN HEALTH CONSULTANTS

Editorial Questions

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

Although the organization can access some data electronically through pharmacy billing, other things, such as smoking cessation counseling, still require going through paper charts to see if they were done, she explains.

Despite the initial time savings, Halvorsen is leery of a possible hidden agenda of JCAHO and CMS — that of linking reimbursement with outcomes. "One concern I do have is that this is one step toward basing reimbursement on our outcomes measures, which is currently the case with long-term care facilities such as nursing homes," she says.

Other quality professionals point to the inevitability of additional measures in the near future, which would negate any time savings as a result of the alignment. **Wendy H. Solberg**, CHE, director of quality resources at Gwinnett Hospital System in Lawrenceville, GA, says she doesn't expect any true savings of resources over the long term.

"We have already been collecting all these measures and working through our multidisciplinary team process to improve processes," she explains. "Also, we anticipate another core measure eventually, which will simply add to the data abstraction."

In July 2004, hospitals began collecting additional core measure data on surgical infection prevention. JCAHO is actively developing new measure sets that address the intensive care unit, pain management, and inpatient pediatric asthma.

Although data for all the measures for both CMS and JCAHO already are being collected at Gwinnett, the alignment of the quality measures will simplify data reporting and transmission, says Solberg. "This is a great benefit to us. Having them aligned will streamline our processes and enhance the understanding of what each group is reporting."

Single manual is key

CMS and JCAHO have jointly released and made available on their web sites a common measures specification manual, which includes a data dictionary, measure information forms, algorithms, and other technical support information. **(For more information, see editor's note at the end of this article.)**

The intent is to ensure that measures common to both CMS and JCAHO are completely identical by the time data collection for January patient discharges begins, according to **Andy Kubilius**, project director for database and technical aspects of the ORYX measures.

Having a single specifications manual for both organizations will have a dramatic affect on quality professionals, says Kubilius. "This is key, since prior to this alignment, we had different specifications manuals," he says.

Currently, there is considerable confusion without standardized data definitions and collection specifications, Brown says. For example, one large community hospital struggles to meet the pneumonia core measure related to timely antibiotic initiation because of patients in transitional care, or patients transferred from transitional care to acute. "It is my understanding that currently some hospitals include transitional care patients in reporting pneumonia data, and some do not," she adds.

Having clear standardized specifications, including inclusions and exclusions for common data definitions, will make data collection more reliable over time and, therefore, a fairer playing field for public national comparative reporting and for use in accreditation decisions, Brown says.

The manual includes all measures for both organizations, even those that aren't common. For instance, in the acute myocardial infarction data set, JCAHO has an inpatient mortality measure and CMS doesn't, while CMS has two test measures for lipids that JCAHO is not using. "The pregnancy and related conditions measure set that CMS doesn't have is also in the manual," Sprenger adds. The manuals, which were created jointly by JCAHO and CMS, include specific instruction and guidance for data collection, she explains. "This will hopefully give them more detailed instruction to make their data collection more efficient, or if there is a particular data element they are having some issues with, to give them more guidance."

Something else that will help reduce the data collection burden involves sampling of the patient populations, Kubilius adds. "Both CMS and JCAHO allowed for sampling of the patient population, but again, we had different sampling protocols. CMS was sampling all Medicare patients, and we were sampling all patients."

JCAHO and CMS worked to create the same sampling methodology and worked with the same number of cases for the manual, he explains. "In our case, we decreased the sample size. This will be a big help to larger organizations, although not as big an impact on smaller hospitals, since whenever you are sampling, you want a representative population, and their number may be such that they do

need to take all cases because the number is so small."

A central data dictionary now contains all the different data definitions, Kubilius says.

"Previously, CMS had multiple manuals by topic area, so obviously keeping track of that was a little more complicated. Now anyone wanting to meet the CMS requirements goes to one manual and one data dictionary," he adds.

[For more information, contact:

- ***Janet A. Brown**, RN, BSN, BA, CPHQ, FNAHQ, JB Quality Solutions Inc., 2309 Paloma St., Pasadena, CA 91104-4926. Phone: (626) 797-3074. Fax: (626) 797-3864. E-mail: jbrown@jbqualitysolutions.com.*
- ***Catherine M. Fay**, RN, Director of Performance Improvement, Paradise Valley Hospital, 2400 E. Fourth St., National City, CA 91950. Phone: (619) 470-4263. Fax: (619) 470-4162. E-mail: FayCM@ah.org.*
- ***Missi Halvorsen**, RN, BSN, Senior Consultant, JCAHO/Regulatory Accreditation, Baptist Health, 1325 San Marco Blvd., Suite #601, Jacksonville, FL 32207. Phone: (904) 202-4966. Fax: (904) 334-7628. E-mail: mhalv001@bmcjax.com.*
- ***Wendy H. Solberg**, CHE, Director of Quality Resources, Gwinnett Hospital System, 1000 Medical Center Blvd, Lawrenceville, GA 30045. Phone: (678) 442-3439. Fax: (770) 682-2247. E-mail: wsolberg@ghsnet.org.*
- ***Barbara Wilkins**, RN, Performance Improvement Coordinator, Danville Regional Medical Center, 142 S. Main St., Danville, VA 24541. Phone: (434) 799-2281. E-mail: wilkinsb@drmc.drhsi.org.*

To access the specification manual, go to www.jcaho.org. Under "Joint Commission and CMS Announce Aligned Manual for Hospital Quality Measures," click on "See manual," "Download the Specifications Manual for National Hospital Quality Measures, version 1.0 (effective for 1/1/2005 discharges)."] ■

Try creative strategies for do-not-use abbreviations

Ingrained habits, physician resistance are obstacles

According to recent data from the Joint Commission on Accreditation of Healthcare Organizations, compliance with the National Patient Safety Goals (NPSGs) is more than 94%, with one notable exception: the requirement to standardize abbreviations, which falls to 85% compliance.

"Overall, we have seen great improvements in decreasing the use of unapproved abbreviations," says **Marie Gowdy**, APRN-BC, lead clinical nurse specialist at NorthEast Medical Center in Concord, NC. "But we are nowhere close to meeting the 100% compliance required for Jan. 1, 2005."

The main problem is simply trying to get practitioners, including nurses, respiratory therapists, and physician's assistants (PAs) out of the habit of writing the abbreviations they were taught, says Gowdy. "'QD' continues to be our biggest problem," she adds.

The majority of hospital staff are working very hard on changing behaviors and are doing their best to achieve this NPSG, but there still are problems with compliance, reports **Martha McKee**, RN, MN, OCN, oncology manager at Good Samaritan Hospital in Puyallup, WA. "I think the major obstacle in achieving compliance is the ingrained habits of staff,"she says. "In some cases, nurses and physicians have been using these abbreviations in excess of 30 years."

This particular NPSG misses the "heart of the problem," according to McKee, which she says is legibility of orders and documentation. "If 'QD,' 'QOD,' and 'U' are written legibly in a clearly defined order, there really isn't a problem with the use of abbreviations."

Also, when physicians are writing orders, they concentrate on what their patients need, not on a prohibited list of abbreviations, McKee notes. "Likewise, when the secretaries or nurses are reading the orders written by the physician, they concentrate on carrying out the orders in a timely fashion, not on the prohibited abbreviations."

To improve compliance, use these strategies:

- **Find creative ways to share list of unapproved abbreviations.**

The do-not-use abbreviations are posted throughout the hospital units at Good Samaritan, placed in patient charts, and printed on physician orders and progress notes, to help remind staff that these abbreviations are prohibited, says McKee. "We also have mouse pads with the list of prohibited abbreviations throughout the organization," she adds.

Small pocket cards with the unapproved list are given to practitioners, new clinical employees, residents, and nursing students at NorthEast.

At Saint Joseph's Hospital of Atlanta, the do-not-use list is posted on the computer clinical

system, printed in bright green lettering in front of every physician order section of the patient's chart, listed in the hospital's and physicians' newsletter, and posted in the medical staff lounge and the bathrooms, according to **Kathy Brandeis**, RN, BSN, performance improvement/JCAHO coordinator.

- **Address noncompliant software.**

"The biggest problem we have is with the electronic version, because half of our chart is in the computer," she explains. "When your clinical computer vendor is not compliant with upgrading their software, we don't have control over that."

The problem is that the number of characters for a given field was limited to six, which would not allow for the spelling out of "international units," or "every day" as per the Joint Commission's recommendations, says Brandeis.

"One thing that JCAHO has not made clear is that the list on how to word those abbreviations is a *preferred* list, but is not a *mandated* list," says Brandeis. The Joint Commission clarified this during a telephone conference call after the organization's PPR was completed, she reports.

This meant that "INT UNIT" could be used instead of writing out "international unit," as long as the prohibited abbreviation "IU" was not used, Brandeis explains. Likewise, "QDAY" can be used instead of writing out "every day" as long as "QD" is not used," she says.

- **Check forms and order sets.**

The organization has more than 500 physician order sets, both on paper and in the computer system, since physicians do not use computerized physician order entry yet, says Brandeis. The medical records committee recently audited copies of every form to check for unapproved abbreviations and also to make sure that there is nothing written that says "continue or resume previous medication."

The revised medication management statements require that there be no blanket reinstatement of medications during the patient's entire stay, explains Brandeis. "All medications must be written out, including medication dosage, route, and time," she says.

- **Audit medication orders.**

At Saint Joseph's, the pharmacy director assigned two pharmacy students to audit 700 medication orders for unapproved abbreviations, Brandeis adds.

The three main problems were use of "U" for units, "QD," and no leading zero, she says. This information was presented to managers and directors, the nursing practice council, nursing performance improvement council, and nursing education council, with specific information as to who was compliant and who was not, and which abbreviations were the most problematic. The audits will be done twice a year, Brandeis adds.

If an unapproved abbreviation is used by a physician, nursing or pharmacy will tell him or her to clarify the written order and then rewrite it without the do-not-use abbreviations. The pharmacist will collaborate with the nurses to rewrite that order in its correct form, she says.

"Right now, this is a teaching approach and is not punitive. We try to drill down to find what particular specialty is doing this; then we do specific education for that group," Brandeis explains.

For instance, when it was discovered that an endocrinologist was writing "U" for units, the specific physician group was given feedback and copies of the list, she adds.

Although the organization's audit focused only on medication orders, it's important to remember that the requirement applies to *all* orders, Brandeis notes. "A few people did not realize that and thought it only pertained to medication orders."

- **Educate staff.**

"We have tried to empower staff to call and clarify any unapproved abbreviations, hoping that this will stimulate some change," Gowdy says. Staff have been educated about the importance of clear communication, both written and spoken, she adds. "We have showed them that the No. 1 root cause of most mistakes is related to communication. We give examples, such as actual handwritten orders that are not clear and the potential risks involved," she says.

In 2005, part of the required annual education for clinical staff will include a one-hour session on communication and how it relates to medical mistakes and prevention, Gowdy notes. "In these sessions, we will continue to talk about real and potential mistakes that have actually happened at our hospital and discuss how they might have been prevented. This will include an interactive exercise in verbal and written communication."

- **Take corrective action as needed.**

At NorthEast Medical Center, the medical staff office sends physicians a letter and copy of the hospital policy when a chart reviewer or pharmacist catches an unapproved abbreviation, Gowdy says. Pharmacy also sends orders with unapproved abbreviations to the medical staff office

and to nursing leadership for follow-up and re-education, says Gowdy. "These strategies have been fairly effective, but not 100%," she says. Compliance has gone from 40% based on an open chart audit done in March 2004, to 86% when an open chart audit was done in June 2004.

The audits showed physicians are responsible for 38% of all unapproved abbreviations, followed by nursing (31%), CRNAs (15%), and PAs (3%). "QD, MS04, and no leading zero are the top three culprits," she says.

"At this point, we are kicking around the idea of tying abbreviations compliance to reappointment status," Gowdy says. "However, until JCAHO's Abbreviations Summit occurs, we are holding off on this due to the chance of our unapproved list changing again."

All physician orders are monitored for the use of prohibited abbreviations, says McKee. The secretary circles the unapproved abbreviation and lets the patient's nurse know that the physician must be contacted for a clarification of the order. "We try to cluster these calls to the physician to save time," she says.

For example, if a nurse has to report a patient's temperature, the abbreviation will be clarified at that time, if necessary. "One of the most effective strategies is to try to catch the physician during rounds and get a clarification before he or she leaves the unit," she says.

The backup plan, should the secretary miss circling the unapproved abbreviation, is to have the pharmacist contact the physician for clarification, McKee explains. "This policing has created some angst and strained communication between physicians and nurses at times, but this is the method that was decided upon by the medication safety subcommittee," she says.

There have been a few instances where physicians have refused to clarify an unapproved abbreviation, McKee still. "When a physician is blatantly nonresponsive to a nurse's request to clarify an unapproved abbreviation, the nurse is required to fill out a quality management memo and expeditiously deliver it to the chief nursing officer. Most of the physicians understand that the nurses are simply doing what is required by the hospital and JCAHO."

Weekly chart audits are done by the manager of each unit to search for use of these abbreviations and give feedback to staff having difficulty. "Also, the chief medical officer and the chief of staff take an active role in personally contacting physicians who are having greater difficulty with compliance, and that has helped quite a bit," she adds. "This has only been necessary about half a dozen times. The medical staff are usually very responsive to their superiors."

[For more information, contact:
- ***Kathy Brandeis**, RN, BSN, Performance Improvement/JCAHO Coordinator, Saint Joseph's Hospital of Atlanta, 5665 Peachtree Dunwoody Road N.E., Atlanta, GA 30342-1764. Phone: (404) 851-7506. Fax: (404) 851-5604. E-mail: kbrandeis@sjha.org.*
- ***Marie Gowdy**, APRN-BC, Lead Clinical Nurse Specialist, NorthEast Medical Center, 920 Church St. N., Concord, NC 28025. Phone: (704) 262-4746. E-mail: mgowdy@northeastmedical.org.*
- ***Martha McKee**, RN, MN, OCN, Oncology Manager, Good Samaritan Hospital, 407 14th Ave. S.E., Puyallup, WA 98371-0192. Phone: (253) 848-6661. E-mail: marthamckee@goodsamhealth.org.]* ■

Don't overlook COPs during mock surveys

Patient tracers should include COP requirements

In light of a recent Government Accounting Office report that found that the Joint Commission on Accreditation of Healthcare Organizations failed to detect deficiencies in the Medicare Conditions of Participation (COPs) during surveys, quality managers need to take extra care to ensure their organizations are compliant with, says **Patrice L. Spath**, BA, RHIT, a health care quality specialist with Brown-Spath & Associates in Forest Grove, OR.

"Be aware of the current COPs for hospitals, and make sure you are in compliance," she warns. "The COPs include some regulations that are not fully or specifically addressed by the Joint Commission standards."

For example, the Centers for Medicare & Medicaid Services (CMS)' Patients Rights Regulations require that hospitals provide written information to each patient regarding his or her right to make decisions about medical care, whereas the Joint Commission standard RI.2.20 states that patients must receive information about their rights but does not specify that it must be in writing.

While the Joint Commission standards contain many of the CMS regulations, there also are some new elements or slight differences in interpretation,

says Spath. (Information about the current Medicare COPs can be found on-line at www.cms.hhs.gov/cop.)

If you are doing patient tracers to identify problem areas in your organization, the tracers should include requirements unique to the COPs as well as the JCAHO standards, Spath advises.

The tracer method of identifying system and process faults in the delivery of patient care can be used to assess compliance with any externally or internally defined standards and is not unique to the Joint Commission standards, Spath notes. "If you've got a checklist of things you are looking for during a tracer, you can add anything to that checklist, not just the JCAHO elements of performance."

For example, while tracing the care provided to a patient admitted through the emergency department, you could check to see if the patient received written information about his or her rights, which is a CMS requirement, while also checking for compliance with Joint Commission standards.

The tracer process, if completed on a sufficient sample of patients, also could be used to gather data to measure the effectiveness of improvement actions, Spath says. "There's no limit to what information can be gathered using the tracer methodology." ■

ACCREDITATION
Field Report

Survey finds problems with nonurgent medications

Survey was 'very patient-focused'

A recent four-day Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey at United Regional Health Care System in Wichita Falls, TX, was "very patient-focused, with direct caregivers much more involved," reports **Darlene Adams**, RN, MSN, the organization's patient care safety/quality management officer. "The surveyors had reviewed our prior survey results, priority focus areas, clinical service groups, core measures, and demographics in our application — so they had a lot of information," she says. "They knew where they wanted to go and what they wanted to see from Day One."

For the first time, staff felt they really were a part of the survey process, Adams says. "Surveyors did not want to talk to managers or directors," she says. "I would say if anyone's not doing mock tracers, they need to be doing that. We did a lot of mock tracers, and it really helped the staff a lot."

In retrospect, the mock tracers would have been more effective if a better survey tool had been used, Adams notes.

"We had a tool that wasn't as thorough as the one the surveyors had," she says. "For example, we covered the safety goals but not as extensively as they did. They had a lot of requirements for documentation, and information on the different provisions of care looking specifically for cultural issues and education, which we didn't have."

Here are some of the lessons learned from the survey process:

- **You'll need to demonstrate intervention if legibility is a problem.**

Surveyors specifically pulled a physician's credentialing file because they couldn't read his or her handwriting and wanted to see if the organization had addressed the problem. "It hadn't been identified yet, because we had just only implemented our legibility policy," Adams explains.

The policy states that if three people cannot read an order, it will not be carried out until it's clarified, she says. The physician will be called to clarify this order. During quarterly chart review, if legibility still is identified, the physician is notified by a letter. If the legibility problem continues, another letter is sent with a copy to the chairman, and the next step is a consultation with the chairman, Adams notes.

- **Ensure documentation is adequate.**

"There was less emphasis on paper and more on process, but open charts and documentation was still closely reviewed," she continues.

Surveyors looked for history & physicals, use of do-not-use abbreviations, and documentation of verbal orders and if they were read back. "They would ask the nurse how the verbal orders were handled. They would be looking for 'I wrote it down and read it back,' *not* 'I repeat it back,'" Adams says. "That was not good enough."

- **Make sure your documentation of a timeout is consistent.**

Surveyors wanted to see that any unit, which needed to do a timeout, had a place to document this.

In the operating room and cardiac catheterization lab, the forms had this, but in the emergency department (ED) and critical care units, they did not. "We made that change, and added 'timeout' as a prompt with a place to document this on all forms using the same verbiage," says Adams.

- **Look at the process for checking out-of-date supplies, drugs, test strips, and cleaning solutions.**

In the radiology area, surveyors wanted to see if employees knew the manufacturer's recommendations for all the test solutions used for ultrasound, as to when they need to be tested and replaced, she continues.

- **Testing must be done at required intervals for smoke and fire dampers.**

During a recent construction process, certain areas were slated to be renovated but were put on hold, which meant that the required testing of smoke and fire dampers fell through the cracks. "We didn't have the right documentation to show that they have been tested at specified time frames, and it's going to cost us $100,000 to fix that," says Adams.

- **Nonurgent medications in the ED must be reviewed by a pharmacist.**

According to JCAHO's new medication standards, if a medication is urgent, emergent, or there is a physician in control of the medication, then it doesn't have to be reviewed by a pharmacist. However, even though a dedicated physician always is present in the ED, the surveyors stated that a percentage of ED patients have nonurgent medications, and those nonurgent medications need to be reviewed by pharmacy, and the physician was not "in control" in this case.

"This was a surprise," says Adams. "We did try to discuss that point, but we did get a requirement for improvement. That was a big, big project. Now you are adding time to the process, and ED patients have to wait. Another problem was that we only had one pharmacist at night."

To resolve the problem, at least two more pharmacists will be added, with an additional eight hours of work per day, says Adams. "We also had to change the forms that are scanned from the ED to the pharmacy and have to buy a standalone computer program to help the pharmacists reviewing the medications contraindications," she says.

First, the nonurgent medications were identified, with each having to be reviewed by a pharmacist. Nurses only can override this for three reasons: It would harm the patient by not giving it prior to review; the physician was present and requesting the medication, which would imply he or she is in control; or the medication is part of a protocol, such as aspirin for acute myocardial infarction.

For the nonurgent medications, the patient's chart must be scanned as "stat" to the pharmacist, who has to review it immediately along with the patient's height, weight, allergy and medication list, and reason for being in the ED. "Then, once they approve the medication, they have to notify the nurse that it's in the profile, so this delays the patient's leaving," she says. "Then if the medication is dispensed, they have to label it and send it up by runner or pneumatic tube so that the patient gets the proper instruction."

Currently, a 24-hour retail pharmacy is expected to open across the street from the hospital, so this may alleviate the problem, since not as many nonurgent medications will be dispensed through the hospital pharmacy, says Adams.

With longer length of stay times in the ED, patient satisfaction is likely to decrease, she adds. "If the medication needs to be delivered, we hope we can get it to the ED within 30 minutes, but that may be unrealistic."

[For more information about the organization's JCAHO survey, contact:

- ***Darlene Adams**, RN, MSN, Patient Care Safety/Quality Management Officer, United Regional Health Care System, 1600 10th St., Wichita Falls, TX 76301. Phone: (940) 764-3062. E-mail: dadams@urhcs.org.]* ■

PPR tool soon will be available continuously

It will be available on-line starting in 2005

When the Joint Commission on Accreditation of Healthcare Organizations introduced its periodic performance review (PPR) tool in November 2003, there was a single important criticism from the organizations that completed it: They wanted the tool to be available to them all the time, not just once every three years.

The PPR originally was designed to be available to organizations via a secure web site for the three months prior to the midpoint of their accreditation cycle.

In response to requests from the field, the Joint Commission will make the PPR available to an organization on its "Jayco" extranet on a continuous basis starting Jan. 1, 2005.

Having the PPR continuously available allows the user to apply it year round and share it with others in the organization, says **Michelle Pelling**, MBA, RN, president of the Propell Group, a Newberg, OR-based health care consulting organization specializing in JCAHO compliance and performance measurement.

"The tool will become less daunting and more comfortable to use," says Pelling. "Hopefully, organizations will apply it on an ongoing basis and become more astute as to their level of compliance with the different standards."

"I think that this is great news," says **Susan Mellott**, PhD, RN, CPHQ, FNAHQ, CEO of Houston-based Mellott & Associates. "However, there is a caveat." JCAHO now is going to require organizations to complete or update the PPR on an annual basis, she explains.

"This will make the quality manager or JCAHO coordinator have to shift focus and to begin utilizing this tool as a continuous assessment of the organization's readiness," Mellott says.

After an organization has completed the PPR once, it can then utilize its action plans to assure that the elements of performance (EPs) that were not in compliance are now in compliance, or are working toward compliance, she explains.

The continuous availability allows you to record your progress on an ongoing basis, such as process changes that were made after the 18-month self-assessment, says **Missi Halvorsen**, RN, BSN, senior consultant for JCAHO/regulatory accreditation at Baptist Health in Jacksonville, FL.

"I think it's great to have it available on a continuous basis because it's a great tool," adds Halvorsen. The organization does its own self-assessments through a systemwide accreditation committee, with leadership assigned to certain chapters.

"Since we continually assess, the 18-month requirement was not a real challenge for us because we had already done the assessment," she explains.

A major stumbling block could be the fact that JCAHO already has changed the PPR once, effective July 2004, and now all the coordinators who previously went through their tools will have to go back and see what has been changed, says Mellott.

This could be cumbersome, since JCAHO has not clarified how the scoring of specific elements of performance have changed, she explains.

"Also, whenever new standards come out, these will have to be added to your current PPR to see if action plans will be required to meet those EPs," Mellott adds.

[For more information on the PPR, contact:

- ***Susan Mellott**, PhD, RN, CPHQ, FNAHQ, CEO, Mellott & Associates, 5322 W. Bellfort, Suite 208, Houston, TX 77035. Phone: (713) 726-9919. Fax: (713) 726-9964. E-mail: mellottandassoc@att.net.*
- ***Michelle H. Pelling**, MBA, RN, The ProPell Group, P.O. Box 910, Newberg, OR 97132. Phone: (503) 538-5030. Fax: (503) 538-0115. E-mail: ProPellGr@aol.com.]* ■

THE QUALITY - CO$T CONNECTION

Incident evaluations aid voluntary reporting

Improved reporting first step in reducing injuries

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

A high priority has been placed on improving incident reporting as the first step in reducing unintended patient injuries. The incident reporting system in many health care organizations is evolving into one that focuses on near misses, provides incentives for voluntary reporting, ensures confidentiality (not necessarily anonymity), and emphasizes data collection, analysis, and improvement.

The process of incident monitoring has, in the past, been criticized because of the limited ability it has to identify the systemic problems underlying adverse event occurrence. Some important categories of incidents are unlikely to be identified using this system (e.g., incidents involving errors of omission rather than commission).

If incident monitoring and management is to be effective, it must be facilitated and interdisciplinary. Effective incident monitoring also is dependent on

a commitment to act upon the information that arises from the process for improvements in the systems of care. Such action is the responsibility of the patient safety or quality oversight committee of the facility.

By implementing facilitated incident evaluations to enhance voluntary reporting, a greater range of incidents can be identified. In addition, the interaction between caregivers during the discussion of incidents can lead to a better understanding of the underlying system issues that contribute to incidents. The objective of facilitated incident monitoring is to strengthen the current reporting system, assist in the identification of a greater number of incidents that occur in during the provision of patient care, and provide a forum for acting on the knowledge derived from incident investigations to improve the safety of patient care.

Facilitated incident evaluation is done at the department or unit level. During regularly scheduled staff meetings, time is allocated to a discussion of the incidents occurring in the clinical area in the previous time period, e.g., the past week or past month. Ideally, the quality manager or patient safety officer facilitates these discussions. The participants are provided with a list of incidents that have been voluntary reported using the current reporting process. Next, people are asked to add to the list any other incidents. By asking the group some pointed questions, unreported incidents could be identified. The questions will be slightly different for each department/unit and the incidents being considered. For example, staff members in a surgical nursing unit might be asked the following question: In the past week, have there been any:

- Medication errors?
- Intravenous line infections?
- Unanticipated admissions to ICU?
- Patient falls?
- Wound infections?
- Noncompliance with practice guidelines?
- Inappropriate admissions/treatments?
- Unreported test results?
- Test reports not acted upon in a timely fashion?
- Delayed, premature, or inadequate discharges/transfers?
- Patient or family complaints?
- Any pressure ulcers?
- Any gaps in care?

Staff in other departments would be asked a different set of questions more relevant to their practices and expected incidents.

Pertinent details of the incidents identified through this questioning process are added to the list. If insufficient information is available regarding an incident, a person should be assigned to follow up and re-present the issue at the following meeting. Once the list has been updated, a member of the group or the facilitator leads a discussion about the incidents. Patient and provider information should, when possible, be de-identified. Incident discussion should be robust, but the approach always should be educational rather than faultfinding. The focus should be on identifying the system issues in the care delivered.

To assist the discussions, the following questions can be asked of the group:

CE *questions*

17. Which is accurate regarding the aligned manual for hospital quality measures developed by the JCAHO and CMS?
    A. Only JCAHO measures are included.
    B. Only CMS measures are included.
    C. Only common measures are included.
    D. The manual includes all measures for both organizations.
18. Which is one of the three top unapproved abbreviations used during a chart audit done at NorthEast Medical Center in Concord, NC?
    A. IU
    B. QD
    C. QDAY
    D. INT UNIT
19. Which ED medications did surveyors say required review during a recent survey at United Regional Health Care System in Wichita Falls, TX?
    A. only emergent medications
    B. all medications
    C. all medications whenever a dedicated physician is not present in the ED
    D. all nonurgent medications
20. Which is accurate regarding the availability of the periodic performance review?
    A. The tool will be available continuously as of Jan. 1, 2005.
    B. The tool only is available for three months prior to the midpoint of the organization's accreditation cycle.
    C. The tool has not been changed since it was implemented.
    D. The tool does not allow for the inclusion of new standards.

Answer Key: 17. D; 18. B; 19. D; 20. A.

- What did we do or what did we forget to do that contributed to these incidents? (It should be recognized that errors of omission are far more common than errors of commission.)
- What needs to be done at this level to prevent this incident from occurring again?
- Who is responsible for follow-up action?
- Who else needs to know about this? For example, does it need to be reported to the facility's quality committee — for action or information?

If a deficiency in the system is identified, the group may recommend a new or revised practice, improved lines of communication, or other department or unit-level actions. If there are concerns about an event involving more than one department/unit, then an interdepartmental meeting to discuss the incident in greater details should be arranged. Issues will not be resolved merely by sending finger-pointing memos to other departments. If a broader system/facility issue is identified, it should be reported to the facility's quality or patient safety committee.

Facilitated incident monitoring should be a continuous, ongoing fundamental activity for every clinician and department. The statistical reports of events identified through voluntary incident reporting systems can be very useful; however, facilitated discussions of incidents can yield many additional benefits. Caregivers begin to feel more personal ownership of incident reduction activities and have a firsthand opportunity to experience the nonpunitive value of analyzing incidents.

Another type of facilitated incident evaluation is morbidity and mortality (M&M) review. This meeting, held on a regular basis to review deaths and adverse outcomes in patients of a specified clinical group or specialty, can be a valuable multidisciplinary mechanism for critically analyzing the circumstances that surrounded the outcomes of care. These outcomes should include all deaths, serious morbidity, and clinically difficult cases. M&M review should not be used only to review the exotic cases that may be of interest to a larger group of clinicians. The goal of M&M review is to make recommendations for improving the processes of care, initiate actions on these recommendations, and oversee the progress of these actions.

Ideally, M&M review meetings are multidisciplinary and include all clinicians, technicians, and managers who are involved in the care of that clinical group of patients. Meetings should be held regularly; ideally once a month.

To be effective, the meeting discussions should focus on identifying the issues related to the processes or systems of care that led to the death or incident and not on the individuals who provided the care. To ensure the discussions are used for educative purposes and not for apportioning blame to individuals, a trained facilitator may be needed.

A brief report should be compiled after each M&M meeting that identifies the actions that must be taken as a result of the discussions and review. If there are no recommendations for action, that should be so recorded. If action cannot be taken at the clinical level, a report should be sent to the facility quality council identifying the issues that need to be addressed at that level. All action items should be placed on the agenda for the next meeting.

Poor teamwork and communication contribute to many untoward incidents. Direct interactions between the members of the health care team are beneficial in ensuring that lessons are learned from each near miss and adverse event.

Effectively facilitated multidisciplinary incident evaluations can provide a forum for these interactions. ■

COMING IN FUTURE MONTHS

- ■ How to get the most out of your FMEA
- ■ Effective strategies to reconcile patient medications
- ■ Avoid problems with publicly reported data
- ■ Preventing patients from waking during surgery
- ■ Improve patient safety with learning packets

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.

If you're not an *HPR* CE subscriber and would like to sign up, call customer service at (800) 688-2421. ■

United States Postal Service
Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
Hospital Peer Review	0 1 4 9 - 2 6 3 2	10/1/04
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$449.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305

Contact Person: Robin Salet
Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Russell Underwood, same as above

Managing Editor *(Name and Complete Mailing Address)*
Coles McKagen, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
Thomson American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thomson Healthcare, Inc.	Five Paragon Drive
	Montvale, NJ 07645

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Hospital Peer Review
14. Issue Date for Circulation Data Below: September 2004

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			918	886
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	713	677
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	4	6
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	1	1
	(4)	Other Classes Mailed Through the USPS	21	25
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			739	709
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	8	8
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			25	25
f. Total Free Distribution *(Sum of 15d and 15e)*			33	33
g. Total Distribution *(Sum of 15c and 15f)*			772	742
h. Copies Not Distributed			146	144
i. Total *(Sum of 15g, and h.*			918	886
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			96	96

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2004 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Publisher
Date: 9/27/04

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or if the publication is not published during October, the first issue printed after October.
5. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, September 1999 *(Reverse)*

Hospital Peer Review®

Accreditation
Credentialing
Discharge Planning
Medicare Compliance
Patient Satisfaction
QI/UR/PRO
Reimbursement

Quality role is evolving from number cruncher to leader

Salaries and respect are increasing, but only if you take the right steps

The quality professional's role continues to evolve, with many professionals stepping into leadership and business roles, according to the latest *Hospital Peer Review* salary survey.

"The strategic importance of quality managers in this pay for performance environment is increasing," says **Patrice L. Spath**, BA, RHIT, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates, referring to the linking of core measure outcomes with Medicare reimbursement.

The 2004 *Hospital Peer Review* Salary Survey was mailed to readers in the June 2004 issue.

This year's results show that 44% of quality professionals reported an annual gross income in the $50,000 to $69,000 range, with 9% reporting income more than $100,000.

Slightly more than half of the respondents reported a salary increase of 1% to 3%, 29% reported an increase of 4% to 6%, while 11% received an increase of more than 7%.

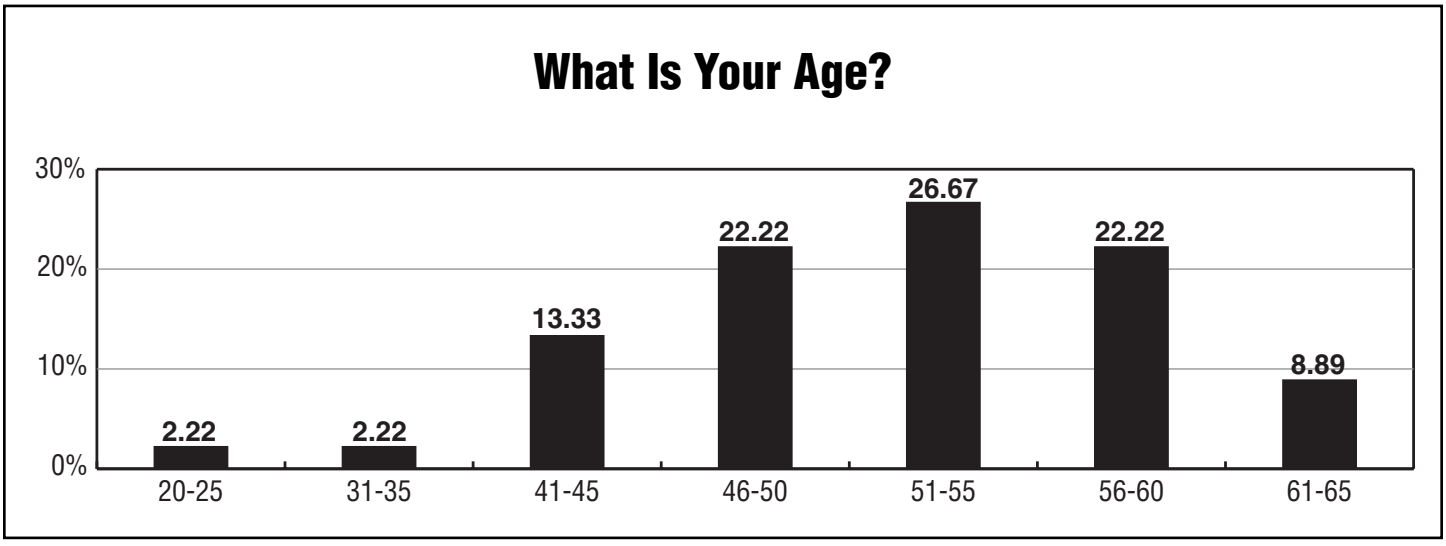
There has never been a time in which the quality of health care services has mattered so much to hospital CEOs, Spath adds.

"But need alone can't guarantee that quality managers will be seen as trusted business advisors. Quality managers must be more than number crunchers," she says.

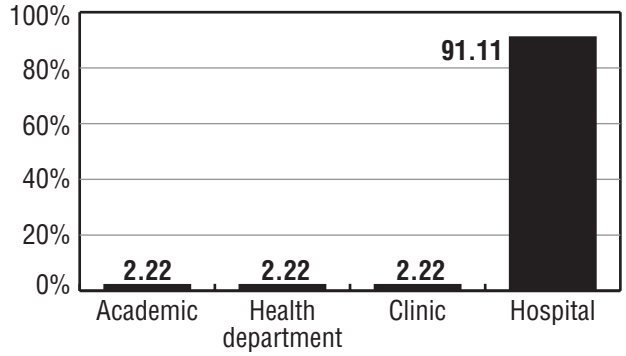
Quality management essentially is a consultative function, Spath explains.

"In many respects, the quality executive is no different from a management consultant. He or she has a great deal of responsibility and very little authority," she points out.

To be heard and be effective in the role, the quality



What is the Work Environment of Your Employer?



manager must gain the respect of senior administrative and medical staff leaders and managers, and establish camaraderie with these individuals, Spath advises.

"Credibility and reliability are only two aspects of the trust relationship that must exist between the quality department and the rest of the organization," she points out.

"Quality professionals often rely solely on these two factors, thus missing many of the other factors that go into creating trusting relationships," Spath continues.

Many times, quality leaders make the mistake of overemphasizing their technical skills and credentials, when people are more interested in results, she explains.

"We need to learn how to measure and articulate the value of quality management activities — talk results, not expertise!" Spath says.

More quality directors are becoming vice presidents than in the past, due to an increased number of individuals getting master's degrees and because of the breadth that quality now has in an organization, says **Janet A. Brown**, RN, BSN, BA, CPHQ, FNAHQ, president of JB Quality Solutions Inc., based in Pasadena, CA.

"There are certainly more salaries over $100,000. I think that's amazing, because there was a time when people thought quality was going by the wayside, particularly in the early 1980s with the implementation of the Medicare Prospective Payment System and the early 1990s with the onset of managed care," she points out.

More organizations are recognizing that quality is a worthwhile investment of money and resources, Brown says.

"I think there is a whole philosophy that quality is valuable now, that it's not just an extra expense," she adds.

Most of the survey respondents appear to be at the middle-management level, Spath notes.

"When quality managers become trusted business advisors, not just technically skilled data analysts, it is quite likely we'll see more of them assuming senior leadership positions in their organization," she predicts.

The role of the quality professional continues to change, Brown says. "Many are becoming patient safety officers, for example. In the past, the safety emphasis was linked to environment of care. The push for patient safety has moved this role more into the quality arena."

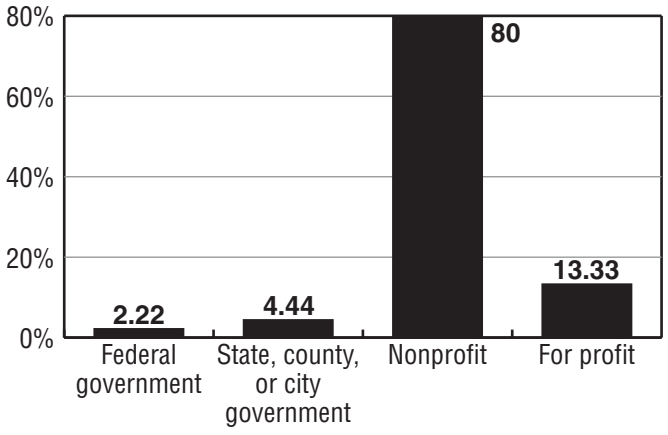
This is largely a result of the Institute of Medicine's 1999 report *To Err Is Human: Building a Safer Health System*, which found that more people die from medical mistakes each year than from highway accidents, breast cancer, or AIDS, and its 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*, Brown adds.

"Since that time, we have seen more of a link between the quality professional and safety," she says.

Patient safety is a role that organizational leaders can grasp easily, Brown stresses. "This is a quality function that administration can get their hands around quickly, because it's a risk management issue and a bottom-line issue as well," she explains.

Still, there is no question that you will need to

Which Best Describes Ownership or Control of Your Employer?



sharpen your skills to advance in today's quality field, Brown notes.

She suggests using the content outline of the Certified Professional in Healthcare Quality (CPHQ) exam as a guideline.

"Those tasks are concrete and are the things quality professionals must be prepared to do," Brown explains. This includes quality management, quality improvement, case/care/disease/utilization management, and risk management activities.

Having an organizationwide role is key, such as being involved in strategic planning, and developing the balanced scorecard for performance measures, she says.

The role of the quality professional should include the processes of organizationwide implementation, measurement, and reporting of performance measures that directly link to strategic goals, Brown adds.

"The skills of the quality professional as leader also include coordination of the quality data organizationwide, not limited just to the medical staff level or departmental level and just collecting data," she says.

"We've got to understand enough about statistics to know which statistical tools and graphs and data displays to use, and what kind of reports are needed at all levels. We've got to know who are the best statisticians and information technology professionals in the organization and how to get to them on a daily basis, if needed," Brown notes.

"However, I can only hope that quality professionals who agree to take on these roles are requesting a commensurate increase in salary. If you have the authority to do the job, you have to have the salary commensurate with that," she says. "I don't know whether that's happening or not."

Above all, quality professionals must be able to work effectively with other leaders in the organization, Brown stresses. "They need to have a comfortable relationship with everyone in leadership and be able to pick up the phone without feeling intimidated," she says. "You need to know your leadership role and use it."

More than half (62%) of quality professionals are working more than 45 hours a week, with 11% reporting spending more than 55 hours a week at work. Just 13% work fewer than 40 hours, and another 24% work between 41 and 45 hours a week.

"The more roles you take on, the longer the hours you are going to be working. There is no way around it," Brown continues. Although long hours go with the territory, you need to master the art of delegation, she says. "You end up knowing every problem in the organization, so people will come to the quality professionals for answers or problem solving. Therefore, you have to be a great delegator."

Whenever you take on a new role, you have to determine what the roll out is going to be, such as identifying the processes that will have to be done and who has the expertise to do them, says Brown.

"If you need more staffing, more time, more computers or other resources, or access to other people like information technology staff or statisticians, that's the leader's responsibility to ascertain and request," she says.

You'll need to determine who in the organization has the skills to meet the new demand and what training may be necessary, Brown explains.

"What can you as a leader train others to do?" she asks.

Communication is the key to thriving in a leadership role, and the leader of any quality team has to meet with them regularly, Brown says. In thinking of the quality umbrella departments, this includes those performing in quality, utilization, risk management, infection control, social services, patient representatives, and data analysts, she says.

Walk around management is easier if you have geography in your favor; but if your team is not

centrally located, you'll need to find a way to communicate, which could mean e-mail, telephones, pagers, and/or meetings, Brown explains.

"You have to have that kind of responsiveness to each other," she says. Brown suggests having purposeful informal meetings to pass on tasks and allow staff to vent their concerns.

"In order to delegate effectively, you need to communicate and assure them that you are equally committed to the task, and be prepared for feedback," she says.

"Ensuring good process flow requires good communication, and the leader has to find ways to make that happen."

The No. 1 goal is to think of yourself as a leader, Brown urges. "You need to see yourself and have others see you as the organizational expert on quality," she says.

"But I think that leader has to design the process model so that all those with skills and desire to perform can flourish. If the leader is too overwhelmed, he or she can't be responsive to other people, or the tasks and objectives are not met," she says. "The organization's performance goals are met when the team works well and feels valued." ■

Work environment may hasten nurse retirement

Work stress and dissatisfaction with the work environment may hasten the retirement of aging nurses, according to a study by the Center for American Nurses, an Austin, TX-based affiliate of the American Nurses Association.

Almost half (47%) of 4,000 nurses surveyed said the relationship with nursing management or administration caused them to think about leaving. Nurses also cited staffing concerns and "the effect of organizational shift from patient to finance or other [issues]" as reasons they might leave.

Yet nurses said they would consider postponing retirement if they could have flexible schedules or a phased retirement with shorter hours or fewer days worked. More than one-third (37%) of the nurses surveyed said they plan to retire between 2015 and 2020.

"Most nurses retire from the bedside at 52 and from the profession at 62," says **Claire Jordan**, RN, MSN, president of the Center for American Nurses, noting that the average age of nurses now is 46.

"We are barely six years away from looking at 50% of the nurse work force leaving the bedside."

To retain nurses, hospitals need to alter the work environment to make it more suitable for older workers, she says.

"Nurses have jokingly said to me, 'I guess we'll keep working if it'll pay for our total hips and our total knees,'" Jordan adds. "The lifting issue is a big issue for nurses."

The need for accommodations came out in focus groups conducted by the Center for American Nurses. But most nurses said administration had not made any changes in scheduling or work environment to take into account the aging work force.

"Twelve-hour shifts in nurses over 52 just becomes almost impossible," Jordan points out.

Meanwhile, hospitals won't be able to fill their nursing needs just with new recruits, she cautions.

"Obviously, one of the best ways to prepare for this shortage is to prolong the working life, to change the plans for retirement. We are trying to work up an agenda for all the acute-care employers [to retain nurses]," Jordan adds.

The aging work force also has a major impact on nursing injuries and workers' compensation. ■