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Avoid pitfalls with corrective action plans: Quality experts share strategies

You won't receive accreditation until 100% compliance is demonstrated

Imagine the moment when surveyors leave after your next Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey — or when you just have submitted your organization's periodic performance review (PPR). You may be tempted to breathe a sigh of relief — but if noncompliant areas are identified, your work has just begun.

You will have problems with JCAHO if corrective action plans are not successful in bringing the organization into compliance in required time frames, warns **Catherine M. Fay**, RN, director of performance improvement at Paradise Valley Hospital in National City, CA. "When you receive your official report, you will have 90 days to become compliant with the standards. You have to be 100% compliant when you submit your Evidence of Standards Compliance (ESC) at the 90-day submission date."

Requirements for Improvement (RFIs) are received at the time of your survey, just as Type I Recommendations were previously, Fay says. Through June 2005, organizations will have 90 days to submit an ESC, because they will not have the benefit of completing a PPR and identifying standards that are not compliant prior to the on-site survey.

After June 2005, organizations will have 45 days to submit an ESC to the Joint Commission because the PPR will be available to them. If your hospital doesn't receive any RFIs after your survey, you will receive your accredited status right away, but otherwise, this is not determined by the JCAHO until your organization submits the ESC, she explains. "At the end of the survey, you know what requirements for improvement to expect, which enables you to start working on compliance before you receive the official results."

The most difficult part of the new process was to develop and implement the action plans to be 100% compliant within 90 days of receiving the hospital's official accreditation report, Fay says.

As in the past, you'll need to develop and implement an action plan, but the new survey process requires demonstration of compliance within 90 days and identification of how ongoing compliance will be measured over the next four months, Fay explains. "There is no longer a six-month progress report," she says. "Action plans have to be implemented so to be 100% compliant."

Here are key points to address in your organization's ESC, Fay explains:

- State what actions actually have been taken, as opposed to planned actions, to become 100% compliant.
- Use short, concise sentences.
- Address each specific element of performance (EP) noted in the RFI.

For example, IM.6.20 lists information that should be found in the medical record, but one or more of the EPs could be identified in your RFI.

- Identify how compliance will be measured for each standard.

For example, "The health information management staff will collect and maintain data on the completeness of the history and physical."

- Include the sample size, to show that you are reviewing an appropriate sample to determine the measure of success (MOS).

Recommended sample sizes can be found on the JCAHO web site (www.jcaho.org). Click on "Accredited Organizations," "Hospitals," "Survey Process," "Guidelines for Submission of Evidence of Standards Compliance."

- Identify an MOS.

When you submit your ESC, you have to be 100% compliant, but when you report your MOS, the lowest acceptable score is 90%, Fay notes. "When you submit your ESC, you include what your measure of success goal will be for the four months of monitoring," she explains. "Less than 90% does not demonstrate compliance with the standard."

Submit the ESC before the deadline, so if all of the required information isn't included, you have the time and opportunity to make corrections, Fay advises.

The hospital will not receive accreditation unless the ESC is accepted by JCAHO. "If the ESC does not meet the requirements for compliance, you automatically receive provisional accreditation," she adds. "This reinforces the need to submit earlier than your deadline date."

You are notified by e-mail when your ESC is accepted, and your MOS for each standard is placed on the Internet with a space to enter results and the date you are required to report your actual MOS, if needed. "While all RFIs require an ESC, not all require measures of success," Fay explains. "This can be found in the *JCAHO Comprehensive Accreditation Manual for Hospitals*."

Monitoring of the ESC is required for four months, and the MOS that is reported for each standard is the average of the four months of monitoring results, she says.

The responsibility for developing and implementing actions to demonstrate compliance has to fall to those with the greatest responsibility for the standards addressed in the RFI, Fay adds. "You have to keep on top of the actions you have implemented to maintain compliance. We used newsletters, bulletin boards, and reminders at meetings to keep focus on our need to be compliant."

After a recent JCAHO survey at United Regional Health Care System in Wichita Falls, TX, the organization received several RFIs, and a corrective action plan was submitted for each, says **Darlene Adams**, RN, MSN, the organization's patient care

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safety/quality management officer.

"Right after the surveyors left, we set up teams to address each issue," she says. Multidisciplinary teams should include administration, management, direct care staff, and quality managers — both those involved with the process changes and those whom the change affects, including physicians, she recommends. "I spoke with my liaison and several other support staff persons from JCAHO to get instructions for these action plans," Adams points out. "I had also attended a workshop on the new survey process that had a section on the corrective action plans."

The JCAHO liaison gave helpful tips and direction to ensure the action plan was complete, she adds. "There was much emphasis on concise information and no extra submission of policies, procedures, data, or other papers."

The liaison instructed Adams to outline the process of correction, implementation, education (including who attended and gave inservices), and how compliance would be demonstrated. "We had to show how our assessment forms were changed, the planning and input from staff for this change, the education of staff on this change, when it was implemented, and what data are being collected to show sustained compliance for the next four months," says Adams.

In addition, you need to show leadership support and physician involvement if indicated, and she suggests writing action plans in a report format. "When we changed our forms to reflect the time-out requirement, we did not send in the actual forms. The JCAHO does not want policies, forms, or papers. They want everything input into the on-line secured access 'JAYCO' extranet site."

To sustain corrective actions, quarterly monitoring will be done until 95% compliance is achieved for two quarters, and then spot checks will be done biannually, Adams explains.

Sample ESCs submitted to JCAHO

One of the organization's RFIs involved the initial assessment, pain assessment, and reassessment, which was being completed inconsistently, she says. Here are the steps that were taken, which were submitted to JCAHO:

- The safety opportunity session, a subcommittee of the quality council, developed a proposal for the RFI pending the final JCAHO report. The quality council approved specific plans and made assignments to address each RFI.
- The medical/surgical nursing director led a team to improve initial assessment documentation. The group developed a plan to help staff improve. Each week, a specific section of the patient assessment was presented to staff on each unit. A "Topic of the Week" inservice reviewed all major areas of the assessment record, including pain, Braden Scale/skin assessment, medication/allergies, functional screening, and referrals. At the end of the five-week cycle, an inservice to review all five areas was held on both shifts, and staff were given an opportunity to ask questions and resolve any misunderstandings. A synopsis of the topics was published in the hospital newsletter.
- The ambulatory nursing director led a team to develop a plan for improving pain assessment and reassessment. This inservice was presented at the clinical manager's meeting, and the topic was revisited with a poster presentation at the units.
- A videotape — *Documentation: Sharpening Your Skills* (Nashville, TN-based Envision Inc.) — was purchased and incorporated into skills fairs, including a post-test, and now is part of the nursing orientation process. Directors for the medical/surgical, ambulatory, emergency department, critical care, pharmacy, and respiratory divisions presented this information at unit meetings. Clinical managers presented a review of initial assessment requirements during staff meetings.
- The initial assessment tool was revised to emphasize specific areas related to skin assessment, pain assessment, and fall risk.
- Staff from nursing, respiratory, and radiology were educated with formal training sessions on improving documentation of the initial assessment, including initial assessment and reassessment for pain. These training sessions have occurred in skills fairs, inservices, and unit poster presentations.
- A section on documentation was added to employee performance evaluation tools. Orientation was revised to include more emphasis on documentation of initial assessment, pain assessment, and reassessment.
- Managers reviewed open medical records for compliance to the standard from September 2004 to January 2005. The audit tool has been edited to include the items related to assessment standards. Fifty reviews will be completed each month and submitted to quality management, which will tally results and report compliance to the quality council. Each staff nurse also has

several reviews by peers to determine compliance to these standards, and this information is used in the evaluation process to further reenforce continuous compliance.
- Directors are conducting tracer activities monthly to assess compliance and validate employee understanding and knowledge. Compliance will be at 90% for the next four months.

To address another RFI involving the requirement for intravenous (IV) admixtures to be made only in pharmacy unless urgent/emergent or a stability concern, the following was submitted to JCAHO:

- The RFI was presented at medical staff department meetings by the vice president of clinical services and the director of quality to facilitate the change in ordering practice related to medications being added to the present hanging IV.
- The quality council approved recommendations to address this RFI, and the medication management committee, a multidisciplinary clinical group, recommended a special team to develop a new policy with restrictions for IV admixtures. This special team included representation from nursing, parental nutrition, oncology nursing, pharmacy, critical care, cardiac catheterization lab, quality management, patient safety, and administration.
- The new policy was brought by the director of pharmacy for review and approval by the pharmacy and therapeutics committee, and the team met again to finalize the implementation. Here is a summary of the new policy:
  1. Pharmacy will provide commercially available sterile IV admixtures or sterile IV systems when available. IV admixtures that are not commercially available will be mixed by the pharmacy in an appropriate laminar flow hood. Exceptions to the policy are nonstable medications and urgent and emergent medication such as Pitocin, Levophed, epinephrine, and Neo-Synephrine.
  2. IV flow sheets and documentation tools have had prompts added to remind staff not to add any medications to hanging IVs.
  3. Staff in nursing and pharmacy were educated about this new policy by their managers.
  4. Pharmacy has purged the automated drug-dispensing machines of nonurgent medications used as admixtures. Automated drug-dispensing machine reports will be monitored by the pharmacy for compliance to this process.

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Is your falls prevention program getting results?

JCAHO will look for evidence of reduced risks

To comply with the Joint Commission on Accreditation of Healthcare Organizations' new National Patient Safety Goal to reduce the risk of patient harm resulting from falls, you must assess and periodically reassess each patient's risk of falling — including the potential risk associated with the patient's medication regimen — and take action to address any identified risks.

However, even if your organization has a falls prevention program in place, it doesn't mean you're getting significant results. At St. Marys Hospital Medical Center in Madison, WI, a program had been in place for years to prevent falls, but the organization wasn't seeing a reduction in the fall rate.

"Our population was getting older, sicker, and more acute," says **Christine Baker**, RN, PhD, APRN, BC, CEN, clinical nurse specialist and director of clinical outcomes management and decision support. "So it was difficult to know if we were actually making gains, when our population was more prone to falls."

The organization's nursing research council began by researching existing fall prevention programs and grading scales. "We decided to borrow from the best of them and then incorporate our own twist," she explains.

All of the existing grading scales ask questions such as whether patients are on a certain medication or if they have fallen in the past year, Baker notes.

"That really takes away that aspect of nursing judgment. You could have healthy people on Lasix who aren't at increased risk of falling; or a

patient may have fallen twice on the ice, but that doesn't mean that they are at risk for falling in the hospital," she says.

An algorithm was developed that identified all patients as being at universal risk of falling because of factors such as being sick, sleep-deprived, and in an unfamiliar environment.

"We borrowed that element from universal precautions — something that exists for all patients just because they are in the hospital," Baker says.

A second category of patient is put at higher risk for falls because of specific risk factors such as disorientation. "The last question on the algorithm asks the nurse to put all of that together and make a nursing assessment, as to whether this patient is at high risk for falls," Baker says.

Even after the algorithm was implemented, the fall rate didn't drop significantly, so the organization trialed two interventions. The first was a protocol that reduced the use of sleeping pills, particularly those that had long half-lives and would make patients drowsy the following day. Instead, patients were offered comfort measures such as a backrub, warm milk, or herbal teas.

"Although physicians did adopt the protocols and use of sleeping pills dropped markedly, we still didn't see significant reductions," Baker says. "Where we saw our payoff was in our 'Safe Room' setup — we cut our fall rate by half."

This intervention involved making the patient's room safer, by placing intravenous poles on the same side where the patient would exit the bed and removing physical barriers so patients were less likely to trip on the way to the bathroom.

As a result, the number of patient injuries related to falls fell sharply. "By having the beds in a low position, the patient didn't have far to fall," she says. "We'd like to prevent the fall, but if it happens, to have no injury result is the best outcome."

Posters placed in every room reminded family and visitors to call a staff member to assist the patient with getting to the bathroom, as opposed to trying to help the patient themselves. "So we involved another pair of hands and eyes in watching the patients," Baker explains. "We also teach patients who are cognitively intact about how to prevent falls, such as using their call light, and not trying to exit when there's a side rail up."

As a result, the severity of injuries has dropped significantly, she says. "It's been a long time since we had more than a minor bump or bruise from a fall," reports Baker. "The nurses are pleased as well. It was frustrating to put a patient on fall precautions when they knew the patient wasn't really at risk. Also, this gives them license to use the protocol when the nurse has a gut feeling that a patient is at risk, even if they don't screen in."

The organization uses comparative data from the Maryland Hospital Association database and the National Database of Nursing Quality Indicators to set fall rate goals for the year, which are incorporated into the annual nursing QI plan. "Each unit reports fall rates at a monthly QI council. If they exceed the fall rate goals, the unit has to have a plan in place to bring the fall rates down," says Baker.

The organization's fall prevention program recently was revised by its falls workgroup to reflect the most current research. "What we needed to do was clarify things that should trigger a reassessment, such as the patient coming back from surgery and a new medication added," Baker says. "Typically, patients are reassessed after a shift, but something could happen mid-shift to increase a patient's risk of falling. Every time you have patient contact, the caregiver should be thinking: Has anything been done to put this patient at risk for falling?"

Major fall injuries are nonexistent

At the VA Medical Center in Lexington, KY, patient falls have been incorporated in the incident reporting system for many years, says **Linda Cranfill**, quality manager. "But with the evolution in patient safety approaches in recent years, we have taken fall analysis, assessment, and prevention to new levels," she says.

One effective strategy involved the use of hip protectors, which provide padding so fractures can be prevented if a fall does occur, Cranfill says. The implementation of hip protectors resulted in a projected cost savings of $16,065 to $44,415.

Another major change was the implementation of a falls collaborative group. "Nationally, the VA requires its facilities to do aggregate root-cause analyses on patient falls," Cranfill notes. "Our falls collaborative group does those, and much more, here. They are the core group for aggregating and analyzing data as well as for developing and implementing improvement strategies."

A combination of facilitywide and patient-specific interventions has resulted in dramatic improvement in both fall and major injury rates, says **Mary Ann Ford**, RN, MSN, CRRN-A, the VA's director of utilization management. "The acute medical-surgical units have had a 20% reduction in the fall rate and no major injuries for 2½ years," she reports.

Some of the interventions include:

- education of interdisciplinary staff on fall risk assessment and fall prevention interventions;
- integration of the fall risk assessment into the electronic initial nursing assessment and reassessment;
- implementation of tools for more in-depth patient assessment to identify factors that could be modified to decrease fall risk, such as gait and balance assessment in nursing home care units, revised drug regimen review, delirium management guidelines, and orthostatic blood pressure guidelines;
- use of hip protectors, low beds, signs posted in patient rooms as reminders to call for assistance, bed alarms, exercise programs, and toileting programs;
- initiation of the use of flip charts or fall communication boards on the units to improve communication among staff;
- ongoing feedback to staff about results of their efforts.

"We measure the success of our fall prevention program with the outcome measures of fall rate and major injury rate, using national and internal benchmarks," says Ford. "A rate is used in order to take into consideration fluctuation in patient census."

The fall rate is the number of falls per 1,000 days of care, and the major injury rate is the number of major injuries per 100 falls. Additionally, to aid the review team and target interventions, fall data aggregation also includes tracking circumstances surrounding the falls, such as history of falls, where and what time falls occurred, and patient cognitive and functional abilities, Ford says.

Data are collected via incident reporting and analyzed quarterly by an interdisciplinary team that includes the patient safety officer. Analysis of fall and major injury rates is done through the use of run charts, noting when interventions were implemented, and circumstances of falls are analyzed with bar graphs and run charts.

Staff education efforts have focused on assessment of patients for risk of falls, and identification and implementation of strategies to reduce risk of falling, or risk of serious injury should a fall occur, Ford says. "The education focuses on basic fall prevention interventions and individualized patient care," she says. "I recommend that a valid, reliable tool be used to provide a basic assessment and periodic reassessment of risk of falling, to guide staff toward taking actions to reduce the risk of falling."

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Are you ready for JCAHO's medication standards?

Proposed changes call for revamped policies

If you're expecting that the Joint Commission on Accreditation of Healthcare Organizations' proposed revisions to medication management standards will add to your workload, you're probably right.

"As with everything else, a few new things will be added to the data collection to-do list of the quality manager," says **Kathleen Catalano**, director of regulatory compliance services at PHNS Inc. in Addison, TX. PHNS provides information technology, health information management, coding, transcription, and receivables management services to approximately 160 hospitals.

The proposed revisions would increase safe practices related to the selection and procurement of medications and address safe medication management practices for medications brought into an organization by a licensed independent practitioner. In addition, the revised standards would address risks associated with medications that are used as part of a procedure, regardless of whether there is a specific order for the medication.

It is unclear how greatly the new medication management standards will affect quality managers because the category of the elements of performance is not known at this time, says **Sherryl Ray**, RN, CPHQ, director of quality improvement at Arkansas Children's Hospital in Little Rock. "Regardless, services and departments across an

organization will be affected by the changes if approved," she says.

The most challenging aspect will be the measurement component, says Ray. "I am not sure what we would be required to measure; it all depends on whether there is an associated measure of success," she says. If there is, organizations would need to collect data to assess compliance, and if a standard is noncompliant, measurement is required for the Evidence of Standards Compliance, she explains.

Key focus for 2005

Regardless, medication management will be a key focus during surveys in 2005, predicts Ray. "Medication management is such an integral aspect of overall patient safety," she says. "We saw patient safety become a real focus for surveys in 2004, and there is no reason to think that it will be any less so in 2005."

In many cases, organizations will bring the new requirements to the pharmacy and therapeutics committee for decisions on how best to implement them, Catalano says. "A group may be selected to act as an ad hoc committee and assigned the task of determining what will be in the best interest of the organization and also allow compliance with the standards," she says.

To develop a policy, organizations may rely on LD.4.20, the standard that discusses the design of new or modified services or processes, Catalano adds.

"A literature search may be helpful, or even site visits to see how other organizations are implementing these standards," she says. "There will also be a need for in-depth education and training regarding any changes made."

Data collection and documentation of quality control procedures most likely will be performed by pharmacy personnel and then reported through pharmacy and therapeutics to the quality committee, depending on the committee structure of the organization, Catalano notes.

The deadline for feedback on the proposed revisions was Jan. 10, 2005. "JCAHO can move very quickly when they choose, but I don't expect these revisions to be implemented until June or July of 2005," she says. "But they may do this sooner — it's hard to tell."

Since medication management was a system tracer for 2004, it may well be a system tracer in 2005, Catalano adds. "Perhaps some of the findings regarding the medication management systems in 2004 led JCAHO to write these revisions."

Organizations probably will implement some of the changes faster than others, she says. "I believe many organizations already are in compliance with the proposed revision for MM.2.20, regarding how medications are to be properly and safely stored throughout the organization."

As for standard MM.4.10, which would require that all prescriptions or medication orders be reviewed for appropriateness, the Elements of Performance (EPs) 8, 9, and 10 will need some planning, Catalano adds. These EPs require evaluation of the risk of medications used as part of a procedure, when there is no specific order for the medications or the medication is not directly provided by the pharmacy. Strategies to address these risks must be based on literature review, best practices, and internal data, and developed in conjunction with the medical staff and pharmacy.

"Medications typically used for different types of procedures will be reviewed and decisions made accordingly," she explains.

Standard MM.4.20 would require a policy addressing safety and the use of medications acquired by a practitioner from sources other than the organization, specifying when these medications may be used and the process to evaluate them. "This type of policy may already be in place in many facilities," Catalano adds.

According to proposed standard MM.4.50, medications that are obtained after hours by nonpharmacist health care professionals now must be maintained outside the pharmacy and must be locked.

"How will the organization decide which medications they will place in this area? What type of training will be required for those who are allowed to access these medications?" she asks. "I believe the quality control, requiring an independent second check by another person or secondary verification system such as bar coding, may be more difficult to accomplish — but it is doable."

The EP requiring a pharmacist to be on call or available at another location may present a dilemma for some organizations, Catalano notes. "This is doable in most organizations, but it may be problematic in the rural areas," she says.

One surprise was EP 16 for MM.2.20, which requires the organization to define in policy how practitioners "carry and maintain" medications. "This is the only EP that may be outside the current policy of organizations — I'm not sure all policies address this," Catalano explains.

The requirement may be related to clinicians

carrying medications in "fanny packs," which typically is done by respiratory therapists for inhalation treatments, suggests Ray. "There has been some literature recently related to this practice and how body temperature affects medication stability," she says. "It seems that the USP storage requirements should be the universal standard."

MM.8.10 requires the organization to evaluate its medication management system, including risk points and areas in which safety can be improved, routine evaluation of literature for new technologies or successful practices that have improved safety in other organizations, and a review of internally generated reports for trends and issues in the organization's medication system.

"It is my opinion that this is already done by the majority of pharmacies today. This is simply good practice," Catalano notes. "Of course, the organization is to take action to implement improvements, by using information from data analysis to identify subsequent changes to improve its medication management system."

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JCAHO alert gives new recommendations for PCA

Patients must be screened and educated

Serious adverse events can result when unauthorized family members, caregivers, or clinicians administer patient-controlled analgesia (PCA) for the patient "by proxy," warns a *Sentinel Event Alert* issued by the JCAHO.

Although the JCAHO's Sentinel Event database contains only one medication error related to PCA by proxy, 6,069 reports of PCA errors have been submitted to U.S. Pharmacopeia in Rockville, MD. Of this number, 460 resulted in some level of harm to the patient, with five fatalities.

"The alert has given us some good suggestions about making our PCA process safer," explains **Suzanne Compau**, BSN, MHSA, director of patient safety at Gwinnett Hospital System in Lawrenceville, GA.

Here are key recommendations from the alert:

- **Develop criteria for selecting appropriate patients to receive PCA and nurse-controlled analgesia.**

Some patients may not be appropriate candidates to receive PCA because of their age, mental state, level of consciousness, psychological stability, or intellectual capacity, according to the alert.

"We have appointed the director of pharmacy and a nursing ad hoc committee to work with the chief of anesthesia on developing a checklist of criteria to determine appropriate candidates for PCA," says **Angie King**, BSN, CPHQ, quality management director at Tift Regional Medical Center in Tifton, GA. "It's still too new to determine effectiveness, but we will be measuring outcomes and patient satisfaction."

The criteria still are a work in progress, says King. "We know that mental state prior to initiating treatment will be a factor, as well as assessment of patient comprehension," she says.

Appropriate screening of patients is an important safety mechanism, says **Cindie Lou Roger**, MSN, RN,BC, ANP,BC, AOCN, oncology/pain management clinical nurse specialist at Gwinnett, and co-chair of the organization's pain committee.

"A well-meaning daughter might recognize that her elderly mother is in pain faster than a nurse, but if that patient is not competent, then they shouldn't have a PCA." Instead, family members should alert nurses that the patient needs pain relief so that a proper assessment can be done and the right dosage given, she adds.

- **Carefully monitor patients**.

Even at therapeutic doses, opiates can suppress respiration, heart rate, and blood pressure, so the need for monitoring and observation is critical, according to the alert.

- **Teach patients and family members about the proper use of PCA.**

The alert recommends giving written instructions to family members about the dangers of others pressing the button for the patient, and alerting staff to the dangers of administering a dose for the patient outside of a nurse-controlled analgesia protocol.

At Tift Regional, a question will be added to the

organization's patient satisfaction surveys asking patients, "Did you have a PCA pump, and did you feel it was adequately explained?"

PCA by proxy currently is not permitted at Gwinnett, Compau reports.

"Patients and families are educated at the time PCA is started and are warned against anyone but the patient activating the PCA button," she says. "Although discussion has arisen from time to time about allowing nurses to perform PCA by proxy for certain situations, we have not implemented such a protocol because of the very safety concerns outlined in the alert."

Roger plans to investigate current research on whether PCA by proxy can be done safely. "But for the time being, it's a no-go here until we know more about it," she says.

Currently, IV pain medications only are given in these ways: PCA by self-administration, nurse-administered PRN bolus injections, or continuous infusions for end-of-life patients as per physician orders, Roger explains.

Patient education materials will be revised to specifically state that no one but the patient should push the button, she continues. "Previously, it's just been verbal instructions; but considering the alert, we need to have a more formal process in place."

In addition, the organization's policy will be revised to specifically state that PCA by proxy is not permitted, and this policy will be added to the mandatory annual competencies of nursing staff.

- **Consider placing warning tags on all PCA delivery pendants or warning signs in areas where PCA therapy is used.**

At Gwinnett, signs will be placed on PCA pumps stating, "Only patients should press this button."

"When educating the patient right after surgery, they may not hear everything that you are saying," Roger adds. "Just a simple label being placed on the pump would further instruct them."

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THE QUALITY - CO$T CONNECTION

Taking measure with focus groups

Feedback technique can foster frank discussion

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Health care organizations everywhere are using focus groups of consumers to critique services, rate educational materials, offer feedback on patient safety, or register kudos and gripes about the quality of patient care.

The major appeal of the focus group process is its versatility. Focus groups can provide a convenient forum for frank discussion and stakeholder feedback on different aspects of health care services at various stages, from new ideas to long-standing programs. The ideas and options of focus group participants can be valuable to leaders conducting formative evaluations to improve services as they are implemented or to make existing services even better. Another appeal of the focus group technique is that customers enjoy being asked to share their opinions in a short meeting with other people who have similar interests, passions, or experiences.

Yet despite the buzz about focus groups, the information gained is not always worth the effort. Without adequate pre-planning and precise execution, gathering data from stakeholders through focus groups can be a waste of time. There are several essential ingredients in the focus group process that affect whether the activity yields solid qualitative data:

- **A topic that matters**

The discussion topic for the focus group should have immediacy and be of interest to every member. The topic of the focus group session should be

stated clearly in the invitation to participants. Indicate the group's purpose, what your organization hopes to learn, and what you aren't able to do in the session. For example, if you need to hear what caregivers can do to help patients feel safe during their health care experience, make those parameters clear at the beginning. Participants' job in a focus group is not to solve problems or to create a new system or plan. Their job is to focus on the topic, give their unedited ideas, respond to others' points, explain their preferences, and share their experiences.

- **The right people**

Selecting the right participants for a focus group can be tricky. Random sampling is unnecessary and probably won't produce the right mix of people. Purposeful sampling usually works well. First, develop a pool of potential participants. Include people who have something to say. Group those with a common connection to the topic. You might want to hear several different perspectives, but you need different focus groups for that result. Individuals' connection to the topic is the common bond that helps create a comfort level that propels the conversation.

A focus group on patient safety could include former patients or their family members, as well as potential future customers. You may wish to host one patient safety focus group for patients with chronic conditions at higher risk of hospitalization and another group for patients who only interact with the hospital episodically (e.g., for maternity care, short-stay elective surgeries, etc.). Sometimes the common bond is something all focus group participants have NOT done, i.e., none of them have been hospitalized in the past year, but they have an opinion on the safety of hospital services.

Six to 10 people is about the right size for a focus group, which means you'll need to invite 12 to 14 people. Most likely, some people won't participate or will have a last-minute conflict. Fewer than six participants will not produce enough discussion. Too many people can result in side conversations that distract from the discussions. Ideally, the focus group participants do not know each other well or at all.

- **A trusting atmosphere**

A trusting atmosphere is critical to capturing good focus group data. Provide a comfortable setting in a convenient location. It may be less threatening to hold focus groups at community centers or churches, rather than within the hospital building. Create a welcoming atmosphere with easy-to-read signs directing participants to the location and a registration table. A staff member or volunteer should greet each person. Provide nametags or table tents to encourage participants to address each other during the discussion.

Refreshments are not essential but help break the ice and make people comfortable. Make them available 30 minutes before the session. Depending

CE *questions*

5. If an organization receives RFIs after a JCAHO survey, which is required?
   A. The organization must prove steps have been taken toward compliance.
   B. Paper copies of revised policies and forms must be submitted.
   C. The organization must submit Evidence of Standards Compliance.
   D. The organization must submit documentation of actions planned to achieve compliance.
6. Which of the following dramatically reduced patient falls at St. Marys Hospital Medical Center in Madison, WI?
   A. making patients' rooms safer by removing physical barriers
   B. using standardized grading scales to assess fall risk
   C. reassessing patients only if specific medications are administered
   D. increasing use of sleeping pills
7. Which is required by the proposed medication management standards?
   A. Only intravenous medication orders must be reviewed for appropriateness.
   B. Medications obtained by nonpharmacists must be maintained outside the pharmacy and locked.
   C. Organizations must address how practitioners carry and maintain medications only if problems have been identified.
   D. If used as part of a procedure, the risk of medications does not need to be evaluated.
8. Which is recommended by a S*entinel Event Alert* issued by JCAHO?
   A. Family members should be encouraged to administer patient-controlled analgesia (PCA).
   B. All patients should be offered PCA.
   C. Staff should administer PCA for patients upon request.
   D. Family members should be instructed not to administer PCA doses.

Answer Key: 5. C; 6. A; 7. B; 8. D

on the topic, some participants may bring their children. Anticipate this potential and have supervised child care available. This can be a separate play area or a children's movie offered in an adjoining room.

- **A skilled facilitator**

Facilitating a focus group requires skill and an appreciation for the process. The facilitator should not be closely involved with the issue being discussed. For example, if the group's discussion will focus on patient safety, use a facilitator who will be viewed as being neutral (for instance, someone from a nonclinical department or a member of the clergy).

The success of group discussions is strongly linked to the facilitator's skill in asking questions, tracking the flow of conversation, and soliciting feedback from everyone. The facilitator must be able to model good listening skills and make it possible for participants to respond to one another, not just answer direct questions. Different points of view must be encouraged. Don't use untrained facilitators who lack the skills to probe for clarification, get examples from participants and encourage participants to respond to each other. If most interactions are between the facilitator and one participant, the value of group dialogue is lost.

- **Some good questions**

Different kinds of pre-planned questions should be used during the focus group discussions. Open the session with questions intended to get everyone to speak without discussing the topic in any depth. Then move on to key questions about one-third of the way through the meeting. Questions that might be asked during a focus group on patient safety include:

1. Did your nurse spend a sufficient amount of time explaining tests or procedures?
2. Did you feel appropriately involved in your care?
3. Were you encouraged to ask questions?
4. Were there any unplanned events in your care? If so, were you kept informed in a timely and satisfactory manner?

Responses to each key question should take 15 to 20 minutes, depending on how people answer. A well-trained facilitator will clarify responses when necessary, encourage feedback and new ideas, and know when to move on. At times it may be appropriate for participants to write their answers, rather than respond verbally. For example, participants might rank how safe they felt during their last hospitalization from 1 to 10 on an index card.

Closing the discussion session involves more than thanking everyone and bidding him or her farewell. The facilitator should offer some "final thoughts" comments that synthesize the discussion. During closure, the facilitator can ask questions such as, "If we were to change the patient care process to help you feel safer during your next hospital stay, what is the one change that you consider most crucial?"

- **A system for recording discussions**

There are many ways of recording focus group discussions: note taking or audio or video recording. Interpretation of the results relies on the quality of the record of the session. So it is important

COMING IN FUTURE MONTHS

- Achieve core measure results you can brag about
- Update on new medication management standards
- Reduce mortality rates of hip fracture patients
- Foolproof ways to prepare staff for unannounced surveys
- Data collection requirements for new staffing effectiveness standards

to make adequate provisions for recording the discussions.

To obtain a complete and accurate record of discussions, plan to audio- or videotape the session. These recordings provide a record of the whole session for anyone who was not present but would like a detailed knowledge of the results of the focus group. Recording also can be helpful for note-taking observers to clarify issues that may be unclear after the fact. Always ask permission of the participants to record the session.

Some organizations rely solely on note taking to record the focus group discussions; however this does have some limitations. Don't expect the facilitator to keep notes. Another individual should be designated as the observer and be responsible for recording the discussions. Often, it is nearly impossible to fully document each participant's response verbatim. Pen-and-paper note taking usually can capture only summaries of each response. However, the observer should try to record direct quotes when interesting or informative statements are made.

If the session also is being recorded electronically and will be transcribed later, note taking can be limited to jotting down a few words that are used later to remind people of what was said and when. If the electronic recording is merely a record that will be used only if necessary, then written notes should be as complete as possible. After the session, it may be helpful for the observer and facilitator to add remarks about any nonverbal messages that were exhibited during the discussions.

- **A plan for data analysis**

Analyzing the results of focus group discussions involves examining the data from various perspectives to determine the major and minor themes and subpatterns. If your organization has sponsored more than one focus group on the same topic, the evaluation process also should include a cross-group analysis.

The people who analyze the data should have observed the discussions, either by being physically present with the group or by reviewing an electronic recording. Often, nonverbal messages cannot be expressed adequately in a written transcript.

Focus group sessions are an excellent way for health care organizations to discover the attitudes of external and internal customers relative to a wide variety of different topics. The interaction between organizational representatives and customers is one of the most important parts of the process. With careful planning and precise execu-

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- 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. ■

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■