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

MARCH 2005
VOL. 30, NO. 3 • (pages 29-44)

Will staffing effectiveness standard make data collection more fruitful?

JCAHO hopes to convey that staffing is 'more than just numbers'

During a mock survey at NorthEast Medical Center in Concord, NC, a nurse was asked how she determined whether her unit had effective staffing, and replied, "When I get to go to lunch."

"In the real world of professional nursing, she was right," says **Karen Holtz**, MS, CPHQ, the facility's education and accreditation specialist. "But I want the nursing staff to understand that the Joint Commission [on Accreditation of Healthcare Organizations'] new staffing effectiveness standard is one way in which we're targeting specific areas for improvement to achieve and maintain effective staffing," she explains.

The new staffing effectiveness standard is effective as of July 2005. The Joint Commission found that organizations didn't understand the intent of the original standard, which has been in place since July 2002, according to **Carol J. Gilhooley**, director of survey methods, development, and testing in the Joint Commission's division of standards and survey methods.

For example, the use of the word "correlation" caused a lot of confusion. "We didn't mean that in the statistical sense — we meant it in the process improvement sense," she says. "But this really caused a lot of confusion for organizations, who were looking at this from a statistical correlation perspective."

The Joint Commission expects you to collect data on key indicators, track that over time, and if there is variation from what you are expecting, to drill down and find out if the root cause of this variation is staffing-related, Gilhooley explains. "We added a rather lengthy rationale so that organizations would understand the performance improvement [PI] approach and the need to incorporate this into their daily activity."

Here are key changes in the standard:

- **Data collection efforts will be focused on a minimum of two units or divisions.**

Instead of asking for data to be collected on units organizationwide, the new standard asks you to focus your efforts on at least two units. "Those two units should be based on some information that identifies those areas as being particularly vulnerable," Gilhooley notes. These factors may include patient population, sentinel event data, incident reports, PI reports,

or previously identified staffing issues likely to affect patient safety.

The approach is similar to the targeted surveillance concept that JCAHO uses for infection control, she adds.

NorthEast's nursing and PI departments will identify units with the lowest compliance for human resources (HR) indicators and the highest fall rates. "From there, we'll select at least two units to write 'Plan, Do, Study, Act' reports. These same units will bubble to the top on both the HR reports and falls reports," says Holtz. "This allows us, as an organization, to focus on unit-specific improvements and really make a difference."

Since data collection efforts are targeted toward specific units, the burden of analysis and report writing will be reduced, although the organization still plans to continue to collect and disseminate data for other unit PI projects, notes Holtz.

"All units report a PI indicator to the PI committee, and some report their fall-rate data," she explains. "Therefore, we will still collect and disseminate the fall rate data by unit and for the organization. However, staffing effectiveness data reporting will be more focused."

- **The list of approved screening indicators will include the National Quality Forum (NQF) nursing-sensitive patient care measures.**

"This will streamline data collection efforts that we already have in place," says **Missi Halvorsen,** RN, BSN, senior consultant for JCAHO/regulatory accreditation at Baptist Health in Jacksonville, FL. Since data already are collected for NQF, additional sets of indicators will not be required, she explains.

This change will make the quality manager's job "much easier," Halvorsen predicts.

"However, we are still challenged by submission requirements, as each agency and accrediting body has a different format for data submission," she says.

The Joint Commission has received grant support from the Robert Wood Johnson Foundation to create a technical implementation guide for the NQF national voluntary consensus standards for nursing sensitive care, reports **Sharon L. Sprenger**, project director for the group on performance measures in the JCAHO's division of research.

The standardized guide is expected to be available in November 2005 and will include a specification manual with an individual measure information form with measure name, rationale, numerator, denominator, and population inclusions/exclusions, a data dictionary with data elements, definitions and allowable values, measure calculation algorithms, and any applicable tables such as medication lists.

"We are hearing from a lot of quality managers who ask if JCAHO can give more information about exactly what data should be collected and how terms should be defined," Gilhooley says. "Soon, we will have clearly defined specifications for those indicators."

This will allow organizations to benchmark their performance against other organizations, she notes.

"If everybody is speaking the same language, you will be able to use that data not only for your

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 nursing education 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.

Ball (board member) discloses she is a consultant and stockholder with the Steris Corp. and is on the speaker's bureau for the Association of periOperative Registered Nurses. Homa-Lowry (board member) discloses she is a consultant with Joint Commission Resources and a Malcolm Baldrige examiner. Merry (board member) discloses he is on the speaker's bureau of the American Governance & Leadership Group. Spath (board member) discloses she is a stockholder with Merck & Co. Brown, Hoil, 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: ahc.customerservice@thomson.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.

own PI throughout the organization, but you will also be able to look across organizations — which is the ultimate goal," Gilhooley adds.

The new standard gives you more specific guidance and direction for data collection and reporting, says **Patti Muller-Smith**, RN, EdD, CPHQ, a consultant for Shawnee, OK-based Administrative Consulting Services. Muller-Smith works with hospitals on performance improvement and regulatory compliance.

"Although this may not lessen the complexity of your job, it should answer questions regarding what data to collect and report," she says. "Many of the revised performance measures are already in place and will support and validate the work that is done by quality managers."

- **Input from clinical staff for the selection of indicators to be measured now is required**.

"We really want this to be part of the organization's day-to-day activities, and we want the people involved in patient care to be involved in this," Gilhooley adds. "They are the ones who know where there could be risks."

Staff also can give valuable insights as to which indicators are not worth looking at, she notes. "It wouldn't make sense to collect indicators for patient falls if you are a nursery — and we've actually had people do that. We don't want you collecting information for the JCAHO that is useless. We want the data to be of value to the organization in improving safety and quality care."

The Joint Commission found that many organizations were collecting the same indicators throughout the whole organization. "This may not be appropriate, if the indicators are not relevant organizationwide. We want organizations to choose indicators that have a connection to the quality of care, in specific settings," Gilhooley explains. "The JCAHO doesn't want people to be doing busy work."

At Baptist Health, input is solicited from staff through clinical practice committees based on service line, which include nurses and physicians. "Using the criteria of problem prone, high-volume, and high-risk, the committees make recommendations for indicator selection," Halvorsen notes. "We have had a lot of success obtaining input from our clinical staff."

Ultimately, the decision for indicator selection remains with senior leadership staff, who are very involved in indicator approval and in prioritization of performance improvement activities, she adds.

"Most likely, our indicators will change," says Halvorsen. "We will probably drop some of our previous indicators that have been stable over time, to study some of the new indicators that are in line with other national indicator projects."

At NorthEast, nurses are asked for feedback on indicators during staff meetings. "Staffing effectiveness graphs and data are posted on unit bulletin boards and in staff break rooms," says Holtz. "We also ask about staffing effectiveness in mock surveys."

Use comparison data gathered on various performance measures to provide a picture for clinical staff, so they can compare the quality of the care they provide to patients with other similar units or departments, Muller-Smith suggests.

"Most clinical staff are curious about how they measure up and are motivated to provide patients with the best care possible," she says.

Routinely report data during staff meetings, or post it in an area where staff can see the results of their efforts, Muller-Smith advises. "Looking at patient outcomes using comparison data can help the patient receive better care, without having to do investigation that has already been done."

- **All nursing staff must be included in the HR indicators for all identified units.**

The previous standard had asked organizations to include both direct and indirect caregivers, but it became clear that nursing was the area where staffing problems were identified most often, Gilhooley says. "When other disciplines were short, nursing seemed to pick up the slack in many instances," she adds. "So we have changed the standards to focus on nursing, but we are leaving the option for the organization to add other caregivers as they wish. We would certainly encourage that, of course."

More meaningful data

The new standard will make it easier to obtain meaningful analysis from the data collected, so appropriate change can be implemented, explains Halvorsen. "Hopefully, narrowing the focus of performance measurement will help organizations get to the heart of staffing effectiveness issues," she says.

The new standard will help target specific nursing units that need to improve their HR or clinical indicators, Holtz explains.

She adds that the organization's nursing units already are aware of the NQF indicators and already collecting and reporting these to the PI committee on a quarterly basis. "This does make my job a little easier, but more meaningful work

is the biggest benefit," she says.

The key is to determine whether the nursing units identified as having the lowest compliance with the chosen indicators have shown improvements after six months. "If so, we can then select another unit. If not, then we will continue to collect and measure data," she says.

Instead of focusing on the collection of data, surveyors want to see that you actually are making use of it to improve safety, Gilhooley emphasizes.

"We want to move the PI directors toward the analysis of the data, turning it into information that will improve the safety and quality of care," she says.

For instance, if you have two or three staffing-related indicators that vary at the same time, that should be a warning signal to drill down and determine the cause, says Gilhooley.

She points to an organization which saw an increase in patient falls during pilot testing of the new standard, but quality managers were perplexed as to the cause, since data showed that staffing numbers were not a problem.

"So we encouraged them to drill down further, and they found out that they had a high use of agency staff who had not been oriented properly to the falls risk assessment," she says. "To address this, they implemented a performance improvement process for orientation of their agency staff."

To address identified staffing issues, the Joint Commission suggests looking at whether staff have appropriate training for the patient population, service curtailment, increased technology support, adjustment of skill mix, additional ancillary or support staff, and reorganization of work flow.

"We want to make people understand that staffing is more than just numbers," Gilhooley says.

Staffing effectiveness is not just a numerical or competency exercise — it is effectively matching resources to patient needs, Muller-Smith underscores. "The challenge for organizations is to efficiently use available resources to provide quality care in a safe environment," she says.

Health care workers will continue to be in short supply, so other alternatives must be explored, Muller-Smith adds.

"The task for both clinical staff and quality managers is to work together to do things differently, use measures that will demonstrate the effectiveness of the changes they have made, and be able to compare themselves with other providers," she says.

[For more information on the JCAHO's staffing effectiveness standards, contact:

- ***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) 202-4920. E-mail: Mary.Halvorsen@bmcjax.com.*
- ***Karen Holtz**, MS, CPHQ, Education and Accreditation Department, NorthEast Medical Center, 920 Church St., Concord, NC 28025. Phone: (704) 783-1631. Fax: (704) 783-2080. E-mail: kholtz@northeastmedical.org.*
- ***Patti Muller-Smith**, RN, EdD, CPHQ, Consultant, Administrative Consulting Services, P.O. Box 3368, Shawnee, OK 74802. Phone: (405) 878-0118. E-mail: mullsmi@aol.com.]* ■

Use these strategies with new medication goal

Patient safety calls for going 'beyond the walls'

If your hospital had a completely paperless system, and all institutions in your community could communicate with one another electronically, then compliance with the Joint Commission on Accreditation of Healthcare Organizations' medication goal would be a breeze.

Unfortunately, this is a pipe dream for most organizations.

"Without a single electronic medical record that is accessible for all health care providers, how do you communicate from one institution or level of care to another?" asks **Kim Shields**, RN, clinical systems safety specialist at Abington (PA) Memorial Hospital. "It is going to be quite some time before everybody is operating at that level of technical sophistication. So the challenge is, what do we do in the meantime? We are struggling with this, as I'm sure are other institutions."

Of all the Joint Commission National Patient Safety Goals, quality professionals agree that the requirement to reconcile a patient's medications across the continuum of care is their biggest challenge.

"By far, this is the toughest goal," Shields points out. "For many goals, it's just a matter of committing to doing them. But this is not something we have full control over, because it involves providing and receiving accurate medication information beyond the walls of

our institution. That's what makes it so difficult."

Still, Shields says the goal is moving in the right direction, to get health care providers "thinking outside their silos" and focusing on patient safety across the continuum of care.

The complexity of the health care system adds to the difficulty of compliance, says **Marie Mercier**, APRN-BC, CNS, lead clinical nurse specialist at NorthEast Medical Center in Concord, NC.

"The success of this goal will take a lot of communication and collaboration across all health care settings," she says. "This is definitely the most challenging goal for our organization."

Tackling standardization of the medication reconciliation process requires a performance improvement approach — "plan, do, check, act," says **Patrice L. Spath**, BA, RHIT, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates.

The quality department staff may be involved in measuring compliance with the hospital's procedures and evaluating measurement results to identify improvement opportunities, she says. "Quality managers should be involved in facilitating improvement teams and measuring the effectiveness of pilot projects."

The first hurdle to overcome is helping people understand that this is not a new requirement — the Joint Commission is just asking that the reconciliation process be performed consistently, notes Spath.

"While medication reconciliation may seem like something new, caregivers have been doing it for years — we just haven't called it by that name," she says.

Identifying the owner of the process is a challenge because so many different caregivers are involved in medication reconciliation.

"The process owners in the emergency department may be different than in the intensive care unit," Spath explains.

Establish accountability

Organizations must determine who ultimately is responsible for reconciling a patient's medications in each different care setting. "Establishing accountability for the process is especially important for enforcing and measuring compliance," she says.

To comply with the goal's requirements, consider the following:

1. **Start small**.

NorthEast's strategy is to begin with a single inpatient adult medical unit and expand the process throughout the organization, Mercier says.

This is based on the work of the South Carolina Hospital Association and the Massachusetts Coalition for Patient Safety, which use one patient, one nurse, one physician, and one unit as a pilot for process changes, she adds.

"The patients on this floor are seen by hospitalists and discharged back to their primary care provider," Mercier notes. "This seems to be the best population to start with, since most patients are chronically ill and take multiple medications. Therefore, communicating information is even more critical and challenging."

2. **Improve communication within your organization.**

You must create a user-friendly process that does not require significant staff time or add unrealistic documentation burdens, Spath says. Here is what is required:

- At the time of admission to the hospital, someone must find out what prescribed medications the patient has been taking at home. The name of each medication, dosage, frequency, and route must be documented.

"This can be particularly challenging if the patient is unable to assist in creating this list, either because of their illness or language barriers," notes Spath.

- The home medications must be compared to what the physician has ordered for the patient.
- When patients are transferred among units in the hospitals, a similar reconciliation must occur — with medications the patient was taking while in the previous unit compared to the medications ordered for the current unit.
- At discharge, someone needs to compare all medications that the patient has taken in the hospital with what the physician orders for the patient at discharge.

Consider creating a medication form that includes space to document the reconciliation process at each phase in the patient's hospitalization, Spath advises.

Since patients enter the hospital through various entry points, staff at each point must be trained in how to use this form, she adds.

"This can be an enormous undertaking, and that's why many hospitals should start small. It is best to do pilot projects in just one or two units and refine the process with feedback from physicians and staff," Spath points out.

Don't roll out process changes throughout the organization until those involved in the pilot are

satisfied with both the forms and the procedure, she advises.

At Abington Memorial, a new computer system (Sunrise Clinical Manager 3.5 XA, manufactured by Boca Raton, FL-based Eclypsis) recently was implemented, allowing for immediate access to the patient's hospital electronic medical record, which facilitates timely review and medication reconciliation.

Patients' medication information moves with patients as they transfer within the institution, allowing physicians and nurses to add information along the way. "We aspire to use one communication tool throughout the hospital — it's key for everybody to be working off the same documentation," says Shields.

The discharge instruction sheet is faxed to the patients' primary care physician and involved specialists as a way of passing the baton with accurate patient information to the next health care provider. For patients transferring to an extended-care facility, a computerized printout is sent, which legibly lists patients' discharge medications, says Shields.

3. Measure your compliance.

You need to determine whether the required documentation is present in the patient's record, Spath says. "The form developed by the hospital for medication reconciliation should be present in patient records and should be used by caregivers as defined by hospital procedures," she says.

You also need to determine the percentage of medications that are actually reconciled, which can be calculated by dividing the total number of medications on the list by the number for which there is evidence of reconciliation, such as a check mark or other notation, Spath explains.

At a minimum, measurements should be taken on admission and on discharge, and if patients are transferred within the facility, measurement also should occur at that time, Spath advises. "Evaluating every patient record would be an enormous data collection task, so most hospitals only review a sample of charts from each unit," she says.

This review can be done on closed records or concurrently by quality department staff, case managers, or nursing supervisors, Spath says.

At NorthEast, open chart review is done to capture compliance on admission, and closed chart review measures compliance at time of discharge, to see if the patient's medication list was sent to the next level of care.

"Initially, data will be collected concurrently by the patient safety committee members working on this project," Mercier notes. "After the process is up and going, I suspect retrospective review will be done."

4. Make patients more accountable.

Although organizations must do everything they can to ensure seamless communication about patient medications between health care facilities, part of the onus must fall on the patients themselves or a designee to provide correct medication information, Shields adds.

"The new JCAHO goal has challenged us to assure our patients understand the importance of being the historian of the medication they take, particularly since many patients have multiple health care providers prescribing medication," she says.

The organization currently is developing a system to reconcile medications for patients who arrive at the institution, Shields notes. "Part of our plan includes patient accountability. Including the patient as a member of the health care team is critical for achieving compliance with this goal."

The following are being implemented:

- A Partnering for Patient Safety program will be offered to the community. It will stress the importance of patients and their advocates knowing the medication and doses they take.
- At discharge, patients are given medication cards and advised to keep the card current and with them at all times.
- A one-page Partnering for Patient Safety education sheet was developed, outlining what patients can do to help ensure a safe experience during their hospital stay.
- Patients are encouraged to register with the Turlock, CA-based nonprofit organization MedicAlert, so that medical information, allergies, and DNR status could be accessed in a worldwide database. "We need to provide patients with tools to help them keep track of what medication they take," Shields explains.

It's important to collaborate with health care providers outside your organization, she adds. "We are working toward the important goal of providing safe patient care across the health care continuum," says Shields.

NorthEast Medical Center plans to work with the North Carolina Hospital Association to endorse a statewide form for patients to keep up with their medication list, since compliance with the goal depends on patients and families to provide a correct and current list.

(Continued on page 39)

PATIENT SATISFACTION PLANNER™

Service excellence begins with behavioral change

Initiative works because everyone owns it

"This is a journey; we'll know we've arrived when they don't need us anymore," says **Sandy Gregg**, RN, MN, MHA, director of service excellence for Providence Health System in Portland, OR. "My goal is to work myself out of a job."

Although Gregg's is a full-time position, the team that is responsible for implementing the message throughout the system's Oregon hospitals is not comprised of full-time service excellence employees, she adds. "That's purposeful, because service excellence is not a role; it's the organization's work. So everyone owns it."

To further explain the concept, she first makes note of the strategic planning that takes place to determine the health system's visions and then the steps by which it will turn those visions into reality.

The service excellence initiative, Gregg says, "is about *how* we do that work. It's not a goal in itself, but the culture in which we do our work." Service excellence, she continues, addresses not only the employees' technical skills but their behaviors.

"It's not just being technically competent, but being value-based and respectful." The service excellence team is responsible for setting what the expectations are for those standards and holding people accountable for them," Gregg explains.

"We are committed to being the best place to work, the best place to be a patient, and the best place to practice medicine," she says. In the Oregon region, of which the Portland service area is the largest component, that effort starts with chief executive Russ Danielson.

Providence has had strong quality programs in place since the 1980s, Gregg says, so the focus on process improvement is not new.

However, in the past three or four years — with a formalizing of roles in September 2004 — the commitment has become, "We'll measure, communicate this, and build an infrastructure," she adds.

There is the understanding, Gregg explains, that for all Providence customers to have an excellent experience, "it takes every person in the room. It's about helping all of the staff to understand how they impact that experience, whatever their role is."

The service excellence initiative follows a model created by Quint Studer, founder of the Studer Group (www.studergroup.com) and author of the book *Hardwiring Excellence,* she notes.

In examining the goal of wanting all customers to have an excellent experience, Gregg notes, it's important to recognize that "some of our patients, as a group, are always more satisfied. When we look at the reason for that, we find out that it's not just technical. We find out that it's something about the staff on those floors."

Taking it a step further, she says, the question becomes, "Why are some groups of nurses so much more satisfied with their jobs?" The answer, she adds, "is almost always that they have a very good manager."

Every hospital needs to have "great medical care, good nurses, OK food, but meeting all those needs just gets you to a certain level of satisfaction," Gregg explains. "We're trying to find out how to get [patients on] every [nursing] floor [to the level of the most satisfied and] to get the management skills that build a high performance level."

Over the last half of 2004, she says, Providence began obtaining monthly feedback on patient satisfaction, with plans for moving to weekly surveys in 2005. To get even more immediate feedback, the system is introducing discharge phone calls, Gregg adds.

Every patient who leaves the hospital — unless it is not appropriate for some reason — will be called within 48 hours in an effort to understand what his or her experience was, she says. "If they tell us [the stay] was wonderful, we can thank them, and if the experience was not good, we can hear about it in a timely way and do whatever service is necessary," Gregg notes.

One way the health system is improving the

quality of inpatient stays, she adds, is by placing in every person's room a white board on which pertinent treatment information is written.

Listed there, for example, are the nurse's name, if and at what time blood will be drawn, and when the physician will be in, Gregg says.

"If someone comes in to draw blood and that's not on the board, that's a quality check for us."

Providence also has a "5-10 rule," she says, meaning that employees must look at people who pass within 10 feet, and greet those who pass within 5 feet. "The idea is that no one is invisible. You don't break up a conversation, but you let people know that it matters that they're there."

Apart from being a courtesy, Gregg points out, the practice is "an amazing way of finding out who has walked into our facility. If you greet people, often they will ask you a question. It's a simple way to reach out to people who are really vulnerable."

Creating service excellence is about "key words at key times," she adds, and about every person who leaves an interaction asking, "What else can I do for you?" and meaning it.

"Regardless of your ZIP code, when you walk into Providence, we want your experience to be that people take the time to hear you," Gregg says. "It's the customer experience that's important to us." ■

Learning collaboratives help improve primary care

Patient-friendly environment needed

A Commonwealth Fund study reports that while community health centers deliver primary health care to much of New York City's low-income population, the design and delivery of health care services at the centers can be made more patient-friendly. There often are delays in access to care, according to researchers **Pamela Gordon** and **Matthew Chin**, making it difficult to get an appointment. Inefficiencies in patient flow also are common, they wrote, resulting in office visits that are needlessly long.

To help the community health centers improve, the nonprofit Primary Care Development Corp. (PCDC) implemented a learning collaborative model at four New York City community health centers.

"Using PCDC's methods, each center made dramatic improvements in key operations: getting patients in and out of the center quickly; offering appointments with the patient's primary care provider on demand; enhancing revenue collections; and attracting and retaining patients," the researchers wrote.

The researchers said a successful implementation model is based on clear, simple, and effective principles, with five strategic principles applying to all collaboratives:

1. Build a high-functioning team.
2. Cultivate leadership support and involvement.
3. Track data and map the process from the patient's perspective.
4. Open lines of communication.
5. Use the expertise of PCDC coaches and program leaders.

The four models stress providers to:

- **Redesign the patient visit program.**

The redesign reduced the cycle time 40% from 68 minutes to 41 minutes, with a 58% increase in productivity from 2.85 patients per hour to 4.5 patients per hour. The researchers said the Jerome Belson Health Center serves a developmentally disabled population, which made the task of reducing patient cycle times even more challenging than usual. "Even so," they said, "the principles of redesign successfully transformed an overcrowded waiting room that was far from user-friendly into an environment where the patient comes first, and providers and staff are highly productive."

Redesign principles include: Don't move the patient; eliminate needless work; increase clinician support; communicate directly; exploit technology; monitor capacity in real time; get all the tools and supplies you need; create broad work roles; organize patient care teams; start all visits on time; prepare for the expected; and do today's work today.

- **Redesign the patient visit process.**

At Union Health Center, PCDC said the key to reducing backlog and meeting demand was to measure the third next-available appointment time. Union patients commonly had to wait as long as 15 days before they could schedule an appointment.

After the seven-month redesign, patients received appointments in one day or less, a 93% decrease in appointment scheduling time. And the patient no-show rate dropped as staff and patient satisfaction levels increased. Redesign principles include: Do today's work today; work down the backlog; reduce appointment types and times; develop contingency plans; reduce demand

for visits; and balance supply (provider time) and demand (patient visits) daily.

- **Improve efficient revenue collection.**

The Brownsville Multi-Service Family Health Center undertook an effort to collect revenues efficiently through the entire collection process. The center serves a low-income community living predominantly in public housing. Its challenge was how to sustain revenue while meeting its clients' overwhelming needs. As a result of changes made through the learning collaborative process, average weekly cash receipts increased by 46%. Reimbursement per visit rose 55%, from $78 to $121. The researchers reported that the case study also documents how the work of the learning collaborative improved employee morale and encouraged high performance throughout the organization.

Another significant result of the effort was the adult medical care unit increased patient visit volume by 5% after several years of decline. Ten revenue-maximization principles identified in the redesign are: Do it right the first time; collect money due at the point of service; eliminate lag times between service and billing; manage claim rejections; redesign bad processes; encourage teamwork; leverage technology; share data; establish good internal control systems; and maintain appropriate staffing.

- **Improve marketing and customer service.**

This case study provided insight into how the South Bronx United Health Plan (UHP) health center adapted highly targeted marketing practices and increased and sustained patient volume in a very competitive environment. UHP had conducted an extensive media campaign for a new facility, which had generated much interest. But it realized it needed help in understanding the process of marketing without relying on expensive consultants. UHP enrolled in PCDC's Marketing and Customer Service Learning Collaborative.

PCDC helped UHP understand the importance of a two-pronged approach to community outreach — creating an in-house marketing division able to customize outreach efforts to narrowly defined populations, and creating and maintaining employee and customer satisfaction.

Marketing principles applied included situational analysis, marketing objectives, marketing strategies, marketing tactics, and evaluation. Eight customer service principles are leadership commitments, service defined from a patient perspective, service standards, continuous improvement, internal communication, ongoing communication, reward and recognition, and patient satisfaction measures.

Re-engineering patient throughput, provider paneling, and patient scheduling is at the heart of the PCDC collaborative approach, according to the researchers. "Overhauling these processes is the key to enhanced health care success, provider and customer satisfaction, and operating efficiency," they said.

"The end result is the delivery of patient-centered care. Patients are very satisfied with these changes. They are able to access their primary care provider on the same day instead of next week or next month and are able to complete the visit in less than one hour instead of the typical two to four. For staff, the days run more smoothly. Employees are able to work at their highest level. People are able to go to lunch and the clinic closes on time. Ultimately, clinicians have better support for their work and can focus on building relationships with patients," the researchers explained.

All PCDC collaborative participants use the same collaborative model, which has three different stages. At each stage, elements of the collaborative are introduced and implemented.

PCDC cautioned, however, that the path through the stages is not linear but rather is more like a spiral, with each collaborative stage overlapping the stage that comes before it and also the one to follow. The work of one stage spills into and informs the work of the other stages.

"Rather than following directions that take them from Point A to Point Z," the researchers said, "participants also move forward in an elliptical path that is marked by their growing awareness of what works and what does not what at their particular health center. With this awareness comes an ability to use tools to make and sustain permanent changes in productivity, efficiency, and attitude."

3 learning sessions for teams

The first step of the pre-work stage is to form a team from multiple disciplines within the center and start to gather the baseline patient tracking data that will be the basis upon which all improvements are measured. Teams participate in three learning sessions facilitated by PCDC staff and nationally recognized leaders in the collaborative field being worked on.

Two action periods take place between the

three learning sessions. During the action periods, teams run through rapid tests of change in highly controlled situations.

These sessions use the "plan, do, study, act" cycle method that leads to a final redesign model that is completed over a period of three full days. Once the process is finalized, the methods are passed on to nonteam personnel.

Transform how people work

According to the evaluation, collaboratives do more than simply fix particular operations problems. They transform the way people work, expand the boundaries of responsibility, and instill a sense of accountability to patients.

PCDC contended it is very important to engage health center leadership in the process. Organizational leaders are inspired when they experience the change process through the perspective of their newly motivated staff, officials said. Senior leadership must be involved if the collaborative team is to be successful over the long run.

Teams with weak organizational leadership frequently reach their goals. But without consistent, engaged leadership, few teams can sustain success.

PCDC said it is difficult to tell if gains delivered by learning collaboratives can be maintained. Data collection often stops shortly after a collaborative ends, and there is no strong evidence that supports sustainability of the gains long term.

"PCDC has often observed that when a collaborative ends, there is little focus on sustaining the initiative," the report said. "Inevitably, the improvements do not last. Teams are consistently able to make breakthrough changes and completely overhaul existing processes, but if they do not build in accountability for ongoing measurements, the improvements are lost. . . . Health center leaders must recognize that they should take steps to preserve these gains, even after the collaborative concludes."

Gordon and Chin said a model familiar to many people that is able to extend involvement without creating dependency is Weight Watchers. The program is based on three simple principles — eat less, move more, and drink eight glasses of water every day. The principles are easy to understand, but often quite difficult to follow.

Likewise, principles for redesigning the patient visit and advanced access are simple and easy to understand, but hard to follow. For redesigning patients' visits, the principles are: Don't move the patient; eliminate needless work; increase clinician support; communicate directly; exploit technology; monitor capacity in real time; get all the tools and supplies you need; create broad work roles; organize patient care teams; start all visits on time; prepare for the unexpected; and do today's work today.

For advanced access, the principles are: Do today's work today; work down the backlog; reduce appointment types and times; develop contingency plans; reduce demand for visits; and balance supply (provider time) and demand (patient visits) daily.

The researchers suggested that those who participate in a learning collaborative need ongoing support after the process every bit as much as Weight Watchers participants do. "Perhaps, the problem lies in the way a collaborative is described as a framework for learning a new method," they wrote.

"Instead, it should be recast as a process used by a community of participants to make lifelong behavioral changes. Transforming the dismal patient experience into one that is satisfying for both patients and health care workers takes effort. Health centers must permanently change their individual and collective work behaviors: the way they treat patients, the engineering of work processes, the ability to work together in teams, and the use of technology.

"Problems arise because an organization's leadership often views the collaborative journey as a consulting engagement. Leaders demand solutions that require little effort or time on the part of management. Despite their health center's participation in the collaborative, many leaders never learn how to initiate and sustain change," the researchers said.

PCDC said it understands that gains achieved through the collaborative process are fragile and are almost certain to unravel if left unattended because the organization's transformation is incomplete.

The solution, it noted, is to make a health center's leadership responsible for anchoring the new culture in the organization.

First, management should communicate to employees frequently and clearly that the new methods and new ways of measuring results are not part of the organization's culture. And second, management should implement clear, consistent systems for defining, measuring, and sharing key results. "These two actions by management form the foundation of a strong organizational culture," the report said. ■

(Continued from page 34)

"Communication and collaboration is something we in health care need to improve on," Mercier adds.

[For more information on reconciling a patient's medications, contact:

- ***Marie Mercier**, APRN-BC, CNS, NorthEast Medical Center, 920 Church St., North Concord, NC 28025. Phone: (704) 262-4746. E-mail: mgowdy@northeastmedical.org.*
- ***Kim Shields**, RN, Clinical Systems Safety Officer, Abington Memorial Hospital, 1200 Old York Road, Abington, PA 19001-3788. Phone: (215) 481-4378. Fax: (215) 572-9087. E-mail: KShields@amh.org.*
- ***Patrice L. Spath**, BA, RHIT, Health Care Quality Specialist, Brown-Spath & Associates, P.O. Box 721, Forest Grove, OR 97116. Phone: (503) 357-9185. E-mail: patrice@brownspath.com. Web: www.brownspath.com.]* ■

JCAHO announces its proposed NPSGs for 2006

Assess your compliance for new requirements

If you've taken a look at the Joint Commission on Accreditation of Healthcare Organization's proposed 2006 National Patient Safety Goals (NPSGs) for hospitals, the long list may seem overwhelming at first glance.

"I was amazed when I saw how many proposed patient safety goals there are," notes **Kathleen Catalano**, director of regulatory compliance services at Addison, TX-based PHNS Inc. PHNS provides information technology, health information management, coding, transcription, and receivables management services to approximately 160 hospitals. "I doubt they will all be adopted — and the good thing is that JCAHO has asked for comments from the field," she adds.

The newly proposed goals address providing an organizationwide culture of safety; encouraging patient involvement; preventing patient harm associated with health care worker fatigue; preventing health care-associated decubitus ulcers; eliminating patient harm from the use of anticoagulants, insulin, and narcotic analgesics; and reducing risk of harm from emotional and behavioral crises.

"Quality managers will have more to worry about — but when you review the majority of these patient safety goals, many of these have already been adopted by some organizations," Catalano says.

The biggest challenge for quality managers will be to develop a methodology to effectively monitor the 2006 goals, determine compliance, and implement further education and any other changes necessary for the organization, says **Frederick P. Meyerhoefer**, MD, principal of the Canton, OH-based Meyerhoefer Organization, a consulting firm that specializes in compliance with Joint Commission standards.

"Many of the requirements for these goals will be hard to assess in order to determine the effectiveness of the organization's compliance, since measurable objective criteria for some of the new NPSGs to readily or easily perform this assessment will be difficult to come up with," he adds.

"Tied to these processes will be the added hours to do those and the associated staff needs," Meyerhoefer explains.

The Joint Commission's proposal also includes additional requirements for existing goals, such as implementing a process to address handoff communications, such as interdisciplinary face-to-face debriefings for changes of shift.

"This is going to require a change in the way change-of-shift reports are typically done," says Catalano.

Your organization will need to determine what handoff communications will be necessary and how much information is to be provided, she explains. "The problem here may be learning what is or is not important. Organizations will need to define this very well."

Another proposal requires eliminating the use of multiple-dose medication vials when possible.

"This is an excellent consideration," Catalano says.

She points out that multiple-dose medication vials are not used as much with unit-dose medications, and mainly are used in the emergency department, operating rooms, and clinics.

When multiple-dose vials are used, JCAHO is calling for steps to be taken to reduce risk of transmission of infection between patients.

"Infection control will need to set some firm rules regarding use of multidose vials, and then someone will need to monitor their use," says Catalano.

"If there are not many of these vials in use, all the better for the facility," she adds.

[For more information, contact:

- ***Kathleen Catalano**, Director, Regulatory Compliance Services, PHNS Inc., One Lincoln Centre, 5400 LBJ Freeway, Suite 200, Dallas, TX 75240. Phone: (972) 701-8042, ext. 216. Fax: (972) 385-2445. E-mail: Kathleen.Catalano@phns.com.*
- ***Frederick P. Meyerhoefer**, MD, 1261 White Stone Circle N.E., Canton, OH 44721. Phone: (330) 966-6717. E-mail: meyerorgconsult@aol.com.]* ■

ACCREDITATION
Field Report

Surveyors impressed with best practice strategies

Exchanging ideas with surveyed hospitals pays off

Sharing best practices with other organizations was a key factor that enabled Winthrop-University Hospital in Mineola, NY, to excel in its recent Joint Commission on Accreditation of Healthcare Organizations survey.

"I don't think there were any surprises during the survey — and we attribute that in large part to having very strong communication with other hospitals that were recently surveyed," notes **Barbara Kohart Kleine,** vice president of administration and Winthrop's JCAHO coordinator.

Quality professionals at Winthrop collaborated with their peers through the Rensselaer, NY-based Healthcare Association of New York State, the New York City-based Greater New York Hospital Association, and their colleagues in the New York Presbyterian Healthcare System.

"We were bombarded with so much information about other hospitals' processes and survey experiences, and we borrowed from their best practices," says Kohart Kleine.

Surveyors took a collaborative approach when talking to staff, says Kohart Kleine. "No one was fearful of giving a wrong answer, and they really enjoyed themselves," she adds. "It was a conversation and a dialogue."

The management team members acted mainly as observers, in a marked departure from previous surveys, says **Eileen Magri**, the hospital's director of nursing for maternal and child health.

"When the surveyors came onto a unit, they would say to a staff member, 'Tell me about your patient,'" she says. "That was the perfect opportunity for staff to talk about patient care with a clinical focus — the questions didn't need to be pulled out of them."

Surveyors focused on the care the patient was receiving, Magri says. "As a result, it really was a much more collaborative discussion that the staff had with the surveyors."

There was less "JCAHO-speak" and more of an interest in whether staff really understood the principles behind the National Patient Safety Goals, says Kohart Kleine. "They were very accommodating in that regard," she says. "If you didn't use the exact terminology, that didn't matter to them. They were interested in whether patients were being given safe care."

Here are key survey practices that impressed surveyors:

- **Poster boards were created that listed every inpatient and outpatient area with the clinical service represented.**

These boards were located in the conference room where the surveyors met each morning and afternoon and ate lunch, and provided easy access to this information.

"The surveyors were able to see at a glance what our patient population was — they knew by looking at these grids what to expect on each patient care unit," Kohart Kleine continues. "They were prepared for the types of patients and didn't have any surprises when they arrived on the units. It took stress off them and consequently took the stress off the staff as well."

Surveyors met with Kohart Kleine twice a day. "We would sit down and look at this giant grid with big boxes for them to check off, and we were able to coordinate services and product lines that flowed together," she says. "It was a very collaborative process."

The poster board idea was shared by colleagues at Nyack (NY) Hospital and showed the surveyors that the organization really knew its priority focus areas, says **Susan Robertson**, assistant vice president for quality improvement.

"We found it to be a brilliant strategy," she says. "It really shows the surveyors that you have put some forethought into their visit and are trying to make it as easy as possible for them to do their work. The more you can take that planning out of their day, the more autonomy the hospital has with the survey process."

- **Invite surveyors to a medical staff luncheon**.

Kohart Kleine asked the physician surveyor if he would like to attend a medical staff leadership luncheon and got an enthusiastic response.

"He came in and did a PowerPoint presentation for 80% of the executive committee of the medical staff, the chairman of board, and the president of the hospital, which reinforced leadership communication," she says. "I would recommend that any hospital take the time and do this, because it shows that your medical staff really takes an interest in their consultations."

Ensuring that key members of the medical staff are present during the survey is a challenge, since visits to patient care areas no longer are scheduled in advance. To address this, Kohart Kleine put departments on "red alert" on the first day of the survey, updating them continually during the next five days as to when they should expect a visit.

"The chairpersons and chiefs would tell me which were particularly good or bad times," she says. "So I was able to say to the surveyor, 'I know you really want to go to OB or pediatrics, and our chairman would really like to participate.' Our medical staff never felt like they were being pulled at the last minute, and they and the surveyors made accommodations."

The organization took advantage of its three scheduled systems tracers for data, medication management, and infection control as an opportunity to get several physicians to be present and speak to surveyors directly. "For example, I was able to get our chief of cardiology to present our core measure results during the data tracer," says Robertson. "Our physicians greatly enjoyed having that forum as well."

• **Give physicians a tool to improve legibility**.

The organization's medical staff executive committee has taken a very aggressive stance on the issue of legibility and recently amended its rules and regulations to reflect the requirement for legible medical record entries, reports Kohart Kleine. As part of this campaign, any member of the medical staff who attended a patient safety update conference was given a special self-inking pen that stamps his or her name, credential, and phone number. "This makes it easier for staff to follow up with them if they have questions about a progress note or order," says Kohart Kleine.

Surveyors were impressed when reading through the medical staff executive committee minutes and learning they had taken a leadership role to address legibility, she says.

"No doubt about it, there were some illegible entries up on the units. But when they asked nursing staff what they do about it, they consistently said that if an order can't be read, nothing is done until it's clarified," Kohart Kline notes.

In addition, nurses told surveyors that they could call the order's author because he or she was identified with the pen's stamp, she adds. "The surveyors really felt that was a very positive approach to ensure legibility."

[For more information, contact:

- ***Barbara Kohart Kleine**, Vice President, Administration, Winthrop-University Hospital, 286 Old Country Road, 2nd Floor, Mineola, NY 11501. Phone: (516) 663-2204. E-mail: Bkohart-kleine@winthrop.org.*
- ***Eileen Magri**, Director, Nursing, Maternal and Child Health, Winthrop-University Hospital, 286 Old Country Road, 2nd Floor, Mineola, NY 11501. E-mail: emagri@winthrop.org.*
- ***Susan Robertson**, Assistant Vice President, Quality Improvement, Winthrop-University Hospital, 286 Old Country Road, 2nd Floor, Mineola, NY 11501. E-mail: srobertson@winthrop.org.]* ■

THE QUALITY - CO$T CONNECTION

Reporting performance results to the board

Use narrative and statistical summaries

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

Your organization's governing board has ultimate responsibility and accountability to the community for ensuring the quality of patient care and services and, therefore, must be kept well informed on all issues related to quality.

Boards need to know what activities are being done to monitor and evaluate medical care and services, they need to know what is being done to improve and/or correct problems and deficiencies, and they need to be assured that those to whom they have delegated the day-to-day responsibilities of performance management are

performing their duties. These needs influence the format and content of the board's performance report.

Periodic reports

The information included in the periodic reports to the governing board should help them answer questions such as:

- Is every department and medical staff service adequately monitoring its performance?
- Are the professional staff competent? Are their licenses current?
- Are we measuring what's important to our patients?
- Is this organization constantly improving performance, or are departments measuring the same thing each month without any documented improvements?
- How does our performance compare to similar organizations?
- Are both clinical and business processes being improved? Are patient and staff recommendations considered when making improvements?

Selecting the right information to pass along to the board starts with an orientation meeting in which the board is acquainted with the many different performance measurement and improvement going on throughout the facility.

Board members must be educated about the medical staff and facility performance measurement endeavors as well as the improvement mechanisms. The orientation also is a good time to discuss the facility's involvement in comparative measurement projects such as the Joint Commission on Accreditation of Healthcare Organizations' core measures.

The quality director can take this opportunity to explain thresholds and benchmarks and how these are used in the performance assessment and improvement process.

In addition, board members should be introduced to the performance measurement priorities of local health plans and/or business coalitions, peer review organizations, state regulators, and other external groups.

Following the briefing, board members will be better prepared to select the information they want to receive on a regular basis and what should be given to them only periodically.

In some instances, facility policies may influence how often performance reports go to the board. For instance, the leaders are expected to ensure the competence of all staff members.

If the hospital's human resource policy states that staff competencies are assessed at least annually, then the board should receive a summary report of findings at least annually. The findings from other activities, such as medical staff peer-review activities, may be summarized and reported quarterly or as often as determined by the board.

To minimize the amount of paperwork received by the board, use a combination of narrative and statistical summaries.

Reporting performance results

Performance results that are reported regularly to the board should be displayed graphically or in a matrix **such as the one illustrated in the chart on p. 43.**

In this report, the results of all performance measures used by the medical staff and departments are categorized into patient-focused and organization functions (as defined by Joint Commission standards).

Measures relevant to the Joint Commission's National Patient Safety Goals are grouped together in the last category.

Detailed results only are reported for those measures that failed to meet pre-established goals. In addition, actions taken in response to failed expectations are detailed.

At least annually, each department can prepare for the board a one-page abstract of performance improvement activities.

This report, a combination of narrative and measurement data, should include information such as:

COMING IN FUTURE MONTHS

- Update on JCAHO's performance measures for stroke
- Data collection requirements for 2006 NPSGs
- Novel strategies to ensure staffing effectiveness
- Impress administrators with financial quality data
- Quality managers share their tips for continuous preparedness

- The important patient care and/or organizational functions that were evaluated.
- How performance was measured for those functions.
- The results of measurement activities.
- Significant improvements that were made.
- Improvement priorities for the upcoming year.

The flexible Joint Commission standards give organizations considerable latitude in selecting measures and improvement projects.

This flexibility extends to the reporting process. The higher up the organizational ladder, the

Executive Summary Of Measurement Results (Excerpt)

Time Period: 4th Quarter 2004

	This Quarter		Year to Date
Function	**# of Measures of this Function**	**% Meeting Goal**	**% Meeting Goal**
Ethics, Rights, and Responsibilities	9	100%	95%
Provision of Care, Treatment, and Services	31	80%	75%
Medication Management	25	82%	95%
Surveillance, Prevention, & Control of Infection	9	100%	98%
Leadership	3	100%	100%
Management of the Environment of Care	28	91%	95%
Management of Human Resources	12	100%	100%
Management of Information	15	90%	95%
Compliance with National Patient Safety Goals	18	72%	65%

Measures not meeting expectations	Goal	Actual Results	Action Taken
% of restrained patients assessed by MD within 1 hour of restraint order.	100%	70%	Professional Practices Committee continues to discuss ways of ensuring compliance with this standard.
% of nursing care plans completed according to department standard.	95%	92%	No action taken. Expect improvement next quarter after inservice of new employees
% of dietary consultations completed within 24 hours of request.	100%	85%	Holiday schedule caused delays in consultations. No action taken as problem is expected to be resolved next quarter.
% of treatment plan goals for home health patients that are met within 30 days of start of services.	80%	65%	Home health team reviewed cases in which goals were not met and determined that initial goals were unrealistic. Staff involved received inservice on goal setting.
% of patients requesting chaplain visit who are seen by chaplain within 12 hours.	100%	75%	Community relations office working with local churches to increase chaplain coverage.
% of physician orders for medications that are incomplete and require clarification before Pharmacy can fill order.	0%	22%	Pharmacy and Therapeutics Committee has developed order-writing standards. These will be distributed in January. It is hoped this will solve the problem.
% of patients at risk for discharge planning problems visited by case manager within 24 hours of admission.	100%	85%	Low rate of compliance is due to insufficient weekend coverage. Still advertising open position for case manager.
% of critical test results communicated to physician within required time frame	100%	76%	Radiology department formed QI team to explore ways of improving compliance. Team started meeting in November and will report process change recommendations in January.

less detailed the reports need to be.

However, it's important that the governing board be provided sufficient information to support their role as overseers of the performance improvement process. In today's competitive health care environment, it is more important than ever that governing board members receive the data they need to adequately judge the quality of patient care in the institution. ■

CE *questions*

9. Which is required to comply with JCAHO's new staffing effectiveness standard?
   A. The same data must be collected for all units.
   B. Data should be collected for units that are most likely to have problems.
   C. A greater amount of data collection will be required.
   D. If staffing numbers are adequate, data do not need to be analyzed.
10. Which is recommended regarding selection of staffing effectiveness indicators?
   A. Organizations always should collect the same indicators for each unit.
   B. Patient falls data should be collected for every single unit.
   C. Only managers should give input about indicators.
   D. Input from clinical staff is required.
11. Which is recommended to comply with JCAHO's medication goal?
   A. Rely solely on primary care practitioners to provide current medication information.
   B. Do pilot projects in one or two units and solicit staff feedback.
   C. Place the burden for medication reconciliation on one individual or unit.
   D. Wait for electronic systems to be implemented.
12. Which is true regarding interactions with staff during a recent JCAHO survey at Winthrop-University Hospital in Mineola, NY?
   A. Surveyors assessed whether staff understood the intent of the National Patient Safety Goals.
   B. Staff were expected to use exact terminology to describe compliance.
   C. Staff were asked to cite specific standards when discussing a patient's care.
   D. Questions about patient care were directed to management as opposed to unit staff.

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

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. ■

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. ■