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IN THIS ISSUE

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Unannounced surveys: What you'll need to do within minutes of JCAHO's arrival

Be ready when the surveyors step foot in your organization

It's the moment of truth: After months of preparation, inservices, and mock patient tracers, you finally get *the* phone call: Surveyors from the Joint Commission have arrived at your hospital.

All JCAHO surveys will be unannounced as of Jan. 1, 2006, and this is at the top of any quality manager's worry list these days. "There is no downtime anymore," says **Paula Swain**, MSN, CPHQ, FNAHQ, director of clinical and regulatory review at Presbyterian Healthcare in Charlotte, NC.

"You need to prepare logistically and think through what an unannounced survey means to your organization, so you are ready when the surveyors step foot in your hospital," she explains.

Presbyterian Healthcare volunteered to pilot test the unannounced survey process, to occur sometime this year.

What you do in the first few minutes after surveyors arrive will affect how smoothly things go thereafter. "A well thought-out plan is equally as important as staff preparedness," says **Missi Halvorsen**, RN, BSN, senior consultant for JCAHO/regulatory accreditation at Baptist Health in Jacksonville, FL.

When Baptist Health underwent an unannounced special issue survey last year, it got a chance to put its processes to the test. "We had a practice run-through," she notes. "We learned that the continuous preparedness processes we had already put into place worked very effectively at a moment's notice."

Draw upon disaster planning

Utilize the same principles in your hospital's disaster plan to formulate an effective approach for unannounced surveys, recommends **Catherine M. Fay**, RN, director of performance improvement at Paradise Valley Hospital in National City, CA.

"When the surveyors arrive, it will be necessary to assemble many resources from the management team to disseminate information and put plans into action," she explains. "Your existing disaster plan can be scaled down to meet specific needs for on-the-spot survey preparation."

This will eliminate the need to start from scratch in developing a method

for managing unannounced surveys, Fay notes.

For the off-hours when administration and the leadership team aren't present, the process can be adapted mirroring the way a disaster plan is modified, she adds.

Establish a command center as with disaster planning to effectively manage the survey with an organizationwide focus, Fay says. "You may want to establish the center in a location different from the surveyors' base."

Personnel manning the center should be members of the hospital leadership team who don't have direct responsibility for patient care services, she continues. "Managers and directors for patient care services will be most effective by remaining in their areas to oversee their department's preparation and to receive instructions and information about the survey."

Presbyterian Healthcare used the communication system developed during disaster planning as a model to notify staff about an unannounced survey.

"We are very active in our disaster preparedness and do disaster drills twice a year, so we used the same structure," Swain points out.

Repeatedly practicing the survey notification process actually improved the organization's disaster notification process, she reports.

"We have now tested our emergency notification text paging process many times during our mock surveys, and it has gotten better every time," Swain adds. "So when we do have a disaster, we now have a really accurate list."

Although there is tremendous focus on JCAHO unannounced surveys, the systems you develop can be used for other types of unscheduled surveys as well, Fay says.

"Department of Health, CMS [the Centers for Medicare & Medicaid], and EMTALA [the Emergency Medical Treatment and Labor Act] surveyors could arrive unannounced as well — so it is important to prepare in the same way for all these possibilities," she adds.

At Gwinnett Medical Center in Lawrenceville, GA, preparations for unannounced JCAHO surveys were tested during a CMS validation survey. "Any type of unannounced survey benefits from this type of coordination," explains **Wendy H. Solberg**, CHE, director of quality resources.

"Essentially, you need a plan to coordinate multiple surveyors in your system in a flash. Within 30 minutes of the CMS validation surveyors arriving, we had some of them on their way to points throughout our system with a guide. The initial thought is daunting — but it falls into place with this type of planning," she adds.

Here is a step-by-step process for what will occur during the first few hours of an unannounced JCAHO survey, with recommendations to improve preparedness:

1. Escort the survey team to administration.

The very first step is for someone to bring the survey team from the front door of the hospital to the administrative offices, Swain notes.

"We will activate our policy on external surveyors and have trained staff to bring surveyors

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to the administration area," she says.

The policy stipulates that no manager will undergo a survey alone. "We support all types of surveys and expect all staff to notify administration and my office that a survey is about to begin," says Swain.

Surveyors may feel comfortable bypassing the information desks in the hospital entryways, especially if they're familiar with the hospital.

"If that occurs, staff still have to call our office," Swain notes. "We then join in the survey, assess the credentials of the surveyor, and arrange to have the appropriate people surround the surveyor and support the process."

Training of all management staff is done routinely as the policy is revised, she says. "Also, because we are surveyed frequently by so many agencies, we have the opportunity to reinforce the training as surveys occur."

Immediately after surveyors arrive, a telephone list will be activated by the administrative assistant, and everything will be put into motion. The surveyors will be brought to a videoconferencing area for an orientation with the two other hospitals in the network that will be surveyed at the same time. "We've got between 8 a.m. and 9 a.m. to get them settled and our orientation process done," Swain says.

Be on alert for impostors

Recently, JCAHO notified organizations that impostors posing as surveyors have shown up in several hospitals and were stopped by staff as they tried to get access to a floor. The matter currently is being investigated as a federal offense.

"Surveyors should go to administration first and shouldn't be going directly to the floors, so that in itself should make you suspicious," says Halvorsen.

"They will show you a letter and ID badge and inform you how many surveyors there are and how many days they'll be there." To be on the safe side, you should contact your JCAHO representative to verify that surveyors are scheduled to be on your campus, she suggests.

2. Alert staff that surveyors are on-site.

As soon as you hear surveyors are present, that's when your notification plan should go full speed ahead. "I sent out an e-mail to our leadership and employees," Halvorsen notes. "Draft that e-mail ahead of time, so all you have to do is sit at your desk and hit 'send.' The word spreads very fast at that point."

Some organizations make announcements with overhead pages using codes such as "Dr. Jayco," but it's better to be up front, she points out.

"I told our organization to announce 'Baptist Health welcomes the Joint Commission' several times during the day. That lets your people know there are surveyors here, and welcomes them at the same time, instead of being secretive about it," Halvorsen adds. "They understand that we have to let everyone know they're on campus, and that's fine."

The first step is to list who in the organization will be notified and how, including directors and department managers up to vice presidents and senior leadership, Swain notes.

First, a mass e-mail is sent out stating that JCAHO is in the facility, providing a "heads-up" for staff. The next e-mail sent covers everyone on the organization's "Emergency Notification" list, stored in Microsoft Outlook, advising managers where to meet and at what time. The third notification is sent out from the command center.

"As the survey progresses, the command center is activated and all staff who will be in roles of escort, support, and review are notified via the command center communication process," she adds.

During mock surveys, it became apparent that many people who thought they were on the list of contacts actually weren't, so they were added, Swain says.

"We also found that our paging company was slow and had some problems, and found dead spots in the house, so there were lots of reasons why people weren't getting their pages," she points out. "Some pagers were found to be old and inadequate, and others did not support text paging and had to be changed out."

When surveyors arrive unannounced at Gwinnett Hospital System, the chief operating officer and the director of quality resources are notified immediately.

"We then enact our command center, which is very similar to our disaster processes," Solberg notes. "In a nutshell, we have a pager listing and a group page is dispatched along with an e-mail, letting everyone know that we have company."

The command center then will coordinate all communications between staff and the appropriate key individuals. "We will also distribute cellular telephones to facilitate communication during the survey," she says.

3. Show surveyors to their designated workspace.

In addition to designating a command center

for staff, you'll also need to prepare a room for the surveyors to work out of, to facilitate review of medical records, policies, and personnel files.

"We use our boardroom, but a classroom or meeting room would also work," Swain says.

Key members of your organization's leadership team representing functions that cross most hospital services, including safety officer, human resources director, performance improvement coordinator, environmental services director, director of infection control, director of medical staff services, and chief of the medical staff, should join administration and the JCAHO coordinator in the area you designate for the surveyors' opening conference, Fay says.

4. **Anticipate the surveyors' requests for documentation**.

The first thing surveyors will want is an up-to-date census listing of patients by diagnosis, since they will need this information to select which patients will be traced.

To avoid problems, get in the habit of pulling an active daily census listing when you pick patients to trace during your mock surveys, Halvorsen recommends. "It's nice to periodically check the accuracy of your list, instead of just going to the floor and pulling a chart," she says.

Update your policies and procedures

You should be updating your policies and procedures on an ongoing basis and have these available upon request, Halvorsen notes.

"There isn't a document review session anymore, but they do spend quite a bit of time in the survey preparation meeting asking for documentation and looking at things," she adds.

Halvorsen still prepares the traditional document review notebook for the different chapters of the standards, and these are kept updated.

"So when the surveyors come, all I have to do is access those notebooks with no running around. The last thing I want to do is hand over my entire policy and procedure manual — that's like giving them candy," she says. "My notebooks are designed to have the documents that they normally request to see, and that's all."

Similarly, you should keep action plans for your periodic performance review in a separate folder, Swain advises.

"The surveyors already have access to other information about us, and we don't really want them to have our action plans since that is private information," she explains.

5. **Mobilize all the people who will be escorting surveyors.**

These individuals will need to pick up walkie-talkies or cell phones for direct communication to the command center, Swain continues.

The number of people involved depends on the size of your organization, she adds. "We have seven surveyors for five days, so there are a lot of logistics involved, but if you have three surveyors for only three days, you can scale that down."

Additional support people may or may not stay with the surveyor the entire time but can be used as backup if the designated escort person isn't available for any reason, Swain notes.

As an incident commander, you need to stay in constant contact with the command center to avoid losing track of the surveyors, she says. The organization uses cell phones, walkie-talkies, text paging, wireless computers, and telephones to facilitate communication during surveys.

"Tracers take surveyors in every direction. This is a major consideration when the interesting patients are those coming through the ED, then going to the OR and the cath lab," Swain adds. "You can go to the bathroom, and literally you don't know where your surveyors went, because they just take off."

The organization used to pair its JCAHO team leaders with the surveyors, but this was changed recently, Swain says.

"The team leaders may be directors or managers who need to be in the areas being pummeled with tracer interviews," she explains. "We now use surveillance people from infection control, medical resource management, quality outcomes, and folks working with core measure analysis in the support person role."

Vice presidents and directors of services, who have many managers to cover the departments, are used as the actual escorts for surveyors.

"Even at that, we must provide for multiple changes of escorts due to the duration of the survey," Swain says.

Swain remains with the surveyors in their workroom, while the organization's regional standards manager acts as the incident commander at the command center and the administrative assistant in charge of computer notifications, updates, and videoconferencing.

"Each of us can roll up into the other positions,"she adds. "However, we use administration's executive assistants to man the computer, should one of us be gone."

The chapter leaders of Baptist Health's

systemwide accreditation committee were designated "survey ambassadors," as the main contact people accompanying surveyors.

These individuals should have expertise with the surveyor's area of focus, Halvorsen says, such as pairing a medical staff member with the physician surveyor and a nurse leader with the nurse surveyor. "For example, the team leader I pulled in for the infection control issue was our infection control nurse, because she knows those standards and I knew she would be the best person," she says.

A scribe should be used to support the ambassador by recording information for future surveys and making notes on follow-up or policies requested, Halvorsen says.

Runners can act as scouts to alert departments that surveyors are on their way, either in person or with a phone call.

"Surveyors don't know where they're going — they don't have a map. Since they have to rely on you to get them there, you can send the runner ahead," Halvorsen says.

Runners also can obtain a policy or person as needed or make sure that a conference room is ready before surveyors arrive.

"These three positions can alternate as needed," she adds. "As long as they have that knowledge base about the standards, they can swap roles."

Have two backups just in case the primary support person isn't available, Halvorsen recommends. "If I am not here, I have two other people on my team who can function in my role," she says. "We try to stack our support three deep."

It's true that surveyors don't want an entourage controlling their every move, but they will expect to have escorts, Halvorsen notes.

"I try not to intimidate the surveyor with too many people, but you know what? It's our survey, and it's our campus," she says. "Give them plenty of opportunity to interact with staff and don't interfere with that. It's not our role to impede that process — we are there to facilitate it. But we are also there to help staff if they don't understand what the surveyor is asking or help smooth things over a little bit."

Your escort system also can be used for state reviews, behavioral health or transitional care certification, or county health department inspections, Swain adds.

"We don't do this only for the JCAHO. We don't leave *any* surveyor to their own devices; they always have a group of us with them," she says.

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Don't ignore the costs for quality resources

Don't forget to address financial implications

When you submit quality reports to hospital administrators, do you gloss over cost and financial issues or address them head-on? This could be a powerful tool to obtain additional resources for data analysis activities or corrective actions, says **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting based in Metamora, MI.

"Many quality professions don't give any thought in advance to how much it will cost to implement some of the corrective changes they are proposing," she says.

This is key to justifying investments to top leadership and the hospital board, such as clearly explaining how much an educational program will cost and what the expected benefits and outcomes will be.

"If you think you're going to change behavior based only on education — well, who are you targeting, and how will you measure the success?" Homa-Lowry asks.

If you have identified deficiencies through your own self-assessment processes while

completing your organization's periodic performance review, you'll need to demonstrate evidence of standards compliance and measures of success. That means you'll need to be as specific as possible. "You need to give some thought about how much time is needed, who needs to be involved, and the costs involved," she says.

Be up front about costs

Avoid making blanket statements such as "continuing to monitor," without including specifics about what it will cost to do this, which may include a failure mode and effect analysis (FMEA), having teams meet on an ongoing basis, going through committees for approval, and implementation.

"Leadership really needs to have knowledge and input on that, because plenty of resources are going to be spent," Homa-Lowry says. "When it gets down to what we will actually implement to effectively resolve these issues, we are often not real specific as to how we will accomplish that and what the cost is."

Hospital administrators are used to getting proposals that include projected costs for needed resources, she emphasizes.

"But when quality improvement issues come up, we don't always give leaders a good understanding of the cost and rationale and reasons why we need the resources," Homa-Lowry says. "If the investment is made, how is this really going to improve things?"

Your proposals must address the financial ramifications of the corrective actions you're proposing, she notes.

"Leaders need to understand not only the accountability but also the resources to accomplish it so they can make good decisions when these reports come back to them for action," Homa-Lowry points out. "They may say, 'We've invested all these dollars in all these review activities, but are we really getting what we expected from our investment?'"

Leaders need to be given the chance to evaluate operationally what it will cost to implement actions.

"Often, reports are really not specific enough to provide leaders a thorough understanding so they can allocate the resources, or if necessary, take it to the board," she continues.

For example, administrators will need more than just a raw number of patient falls to invest resources in a falls prevention program. They'll want to know the evidence that shows that implementation of a falls risk assessment will actually decrease falls and the cost per patient.

"So you are really doing a cost-benefit analysis in terms of thinking through your corrective actions and presenting them to leadership, so they can make decisions about resources and support," Homa-Lowry notes. "You see a fair amount of soft-pedaling where people don't necessarily present that information. But that's what is really going to pique the interest of the chief financial officer and board of trustees."

Your quality reports should be action-oriented and contain specific recommendations for leadership to consider.

"It's hard to make a decision if you don't have all the facts," she says. "Otherwise, leaders will tell you, 'It sounds nice to do this, but where are the facts as to why I should invest the resources?'"

Steps for incorporating financial aspects

To incorporate financial considerations in your quality reports, do the following:

- **Include a specific work plan.**

Many performance improvement reports or corrective action plans include vague statements such as "continue to monitor," "write a new policy or procedure," or "provide staff education," but lack practical details for how these things are going to be achieved. "Rarely in those corrective actions do you see where it's been clearly put into place as a work plan," Homa-Lowry says.

When you propose a corrective action plan, list exactly who is responsible, how long it will take, and what the cost will be. Quality reports also should include the specific measures that are going to help leadership measure the effectiveness of the strategic plan for the organization, she adds.

- **Do an FMEA on the front end.**

Some organizations still are not doing an FMEA to make sure what they are proposing actually is addressing the identified issues and is workable, Homa-Lowry explains.

"They may be meeting in groups to put together a work plan and then putting it out there as a pilot," she continues. "When it doesn't work, then they have to do plenty of reworking, which gets expensive."

Thorough planning is needed to be sure that your proposal is viable for your organization. "Decide on the front end what you are expecting, instead of finding out at the end, so you don't

end up doing additional work to find the issue as well as the solution," Homa-Lowry advises.

- **Don't overlook input from staff.**

"Sometimes, the quality professionals get so wrapped up in planning that they don't include the line staff who will be dealing with the issue day in and day out. Those are the individuals who can evaluate whether or not they think the solution is going to work," she says. This approach also fosters staff's ownership and acceptance of the new or revised process. It also may help to reduce work arounds.

Sometimes, strategic plans are written at a very high level and may not be meaningful to a staff nurse or unit manager, Homa-Lowry notes. "Resource utilization is a common example — what does that really mean to them, to the person on the unit, so they can become involved in the solutions?"

Your strategic plan objectives should be further expanded, so staff at the managerial level as well as frontline staff understand their specific responsibilities in meeting the objectives, she says.

"Meeting their objectives, derived from the strategic plan objectives, is critical to implementing the actions that will ultimately meet the strategic objectives for the organization," Homa-Lowry explains.

If staff haven't been given the chance to give input for process changes, they likely will start finding ways to work around the problems they encounter. "That will further increase the cost of things and can be expensive in terms of variation of care," she says.

- **Continually examine your processes.**

The bottom line is that as your organization moves into continuous readiness, you need to take a close look at systems and processes and revise them on an ongoing basis, Homa-Lowry notes.

"It may be more difficult to implement this on the front end, but it will cost less in the long term. And you will be able to quantify results since it will be done appropriately," she says. "Otherwise, you may be doing plenty of activities without seeing results, which is very expensive."

- **Know how to obtain financial data.**

Quality professionals often are not aware of all the data that they have available through the hospital's marketing department as well as existing databases, Homa-Lowry explains.

As a quality manager, you should meet with your organization's chief financial officer and the head of information technology to see what information can be accessed, she suggests.

"It will be necessary for the quality management professionals to do some independent calculations concerning cost, along with the data supplied by the organization," Homa-Lowry says.

For example, to calculate some of the costs to justify an education program that would reduce hospital-acquired infection rates, you'll need to find out the number and cost of nosocomial infections in your organization, to present different types of financial data such as the cost of doing a root-cause analysis and/or FMEA for a patient with a nosocomial infection and additional data showing how much it costs to manage a patient with a nosocomial infection.

- **Share quality data with your vice president of operations.**

Performance data should be shared with the organization's vice president of operations, and this individual should be included in the development of the corrective action plans, she advises.

"That isn't happening in many organizations, but it will be critical for ongoing preparedness," Homa-Lowry says.

Operations people can help you determine costs involved in corrective actions, whereas quality leaders can inform the operations side about clinical issues involved in making systems changes work effectively, she explains.

- **Use reliable tools for data analysis.**

If the computerized systems you are using aren't giving you reliable results due to faulty data collection techniques or problems with the way data are being put into the system, you may be unsure as to how to produce the most credible information, Homa-Lowry adds.

"But by the same token, if you aren't using the data that are already available and you aren't doing analysis because people are not comfortable with using the statistical tools you have available, then again, the results will be questionable," she adds. "Every time somebody picks up a medical record and re-reviews, it can be very costly."

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ACCREDITATION
Field Report

Communication among caregivers is a key focus

Questions surveyors asked in one recent survey

What were you told about this patient by the previous caregiver during reports? What are you doing for this patient? What are you going to tell the next caregiver about this patient?

These were three questions JCAHO surveyors asked staff again and again at Eunice (LA) Community Medical Center during a March 2005 survey.

"As one of our priority focus areas, communication among caregivers was a key focus during our JCAHO survey," says **Denel LaFleur**, the organization's JCAHO coordinator.

"The purpose of these questions was to evaluate the continuity of care and caregiver knowledge of the patient."

Surveyors wanted to know how staff members ensured they had all of the information they needed to take care of the patient, since information management was another priority focus area. The surveyor repeatedly asked, "What do you need to know so you can properly care for this patient?" to evaluate the caregiver's knowledge of pertinent aspects of care, such as laboratory and X-ray results.

"He wanted to know how results were reviewed and communicated, especially critical values," LaFleur explains. "They asked this information of every discipline, including the different nursing units, respiratory therapy, and dietary."

The surveyors also wanted to know how new information would affect a patient's care, asking, "What information is important for you to review today for this patient?"

"They wanted to hear about getting lab work or test results back, and how that would modify what they were doing," LaFleur adds. For example, one staff member answered that due to the radiology test results, the patient's treatment plan was altered, and in another instance, due to a patient's lab results, the dietitian was consulted.

The surveyor wanted to see that the patient's chart was available to all caregivers, verified that staff were familiar with what was documented in the physician's admission history and physical, and asked to be told about the patient's comorbidities. "One nurse answered that the reason the patient was admitted was due to noncompliance with her previous medicines, which he had read in the physician's notes," she says. "The nurse added that it was the patient's second readmission for noncompliance."

Surveyors were very interested in the plan of care, how it was implemented, and how different disciplines communicated and kept an eye on the big picture, to ensure that by the time of discharge, all of the patient's needs were met.

"They wanted to see, for instance, that nursing staff knew what the dietitian had been working to accomplish during the patient's stay and what had been achieved, " LaFleur explains. "They basically wanted to be assured that the left hand knew what the right hand was doing."

This is increasingly important as patients are being pushed through the system quicker, she adds. "As a small hospital, we can't afford an extra day in the patient's stay because the respiratory therapist didn't communicate with the nurse — we don't have the resources to absorb wasted time or supplies."

Staffing was another key focus, with surveyors asking managers, "How do you plan for patient needs in your staffing mix and level? How do you measure quality for this unit? How do you know if your staffing is effective?"

Overall, the new process was much more educational and a better measure of true compliance, LaFleur says.

"Everywhere the surveyor went, he said, 'I'm not here to try to catch you on anything, just to measure your compliance against established standards. If you don't understand something, please ask me for clarification,'" she notes. "It was a nonthreatening type of atmosphere from start to finish."

The focus was on real-time delivery of patient care, LaFleur adds. "There weren't any closed charts reviewed during the survey. The surveyor was interested in where you're at now, not 12 months ago."

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THE QUALITY - CO$T CONNECTION

Don't be fooled by the illusion of patient safety

Judge effectiveness with actual data, observations

By **Patrice Spath**, RHIT
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As a part of their overall patient safety program, many health care organizations require that managers submit corrective action reports for every significant incident in their department.

Those corrective action reports may give senior leaders the feeling they are doing something about every identified problem. However, such reports may represent more of an *illusion* of patient safety rather than *reality*.

In some cases, when an incident reveals an obvious equipment problem that can be remedied through repairs, such corrective actions may genuinely contribute to improved patient safety. In other incidents, there may either be no obvious fix that would eliminate the problem that was observed in the incident, or the needed changes may simply be too expensive to implement.

Corrective action reports

In these cases, the requirement to identify a corrective action for each incident tends to result in corrective action reports that are long on promises — such as reducing staff distractions or implementing better maintenance procedures. Such "mother-and-apple pie" pledges of corrective action do not ensure a reduced risk to patients.

Action plans such as those often are hard to enforce, and broken promises may become evident only when similar types of incidents reoccur.

Corrective actions that involve staff counseling or training are equally problematic. Even if the promised counseling is done, it is unclear whether this intervention actually will reduce the risk of similar incidents.

When the corrective action report simply says that the particular employee involved in the incident was "counseled," it presumably means that the employee was instructed not to make the same mistake in the future. Another, similar example of a motherhood-and-apple-pie corrective action is staff training.

If the person involved in the incident is particularly ill trained, then retraining actually might be helpful. However, most likely, future instances of the same type of error will not involve the same employee.

Finding the root cause

If the problem is important, it should be brought to the attention of *all* staff members who could potentially end up in similar situations, not just the particular person involved in the most recent incident.

Without doing a definitive root-cause analysis for each incident, it often is difficult to determine whether the promised corrective action is even relevant to the problem at hand.

For example, a frequent type of human error is failure to use equipment properly, e.g., not programming an IV pump correctly. If this is done purely as a result of inattention, then counseling employees to pay closer attention could conceivably be effective.

However, if the instructions are vague or if the equipment is used only occasionally, it is unclear whether most employees would be able to reliably use the equipment properly. In this situation, providing better labeling and easily accessible instructions are likely to be much more effective than counseling the employees to pay closer attention to their work.

Even when a definitive root-cause analysis is done, this also can give the illusion of patient safety instead of the reality if the root causes are not actually found and corrected.

Incident investigation teams often stop their analysis before the root causes are uncovered. Thus, actions are directed at the significant contributing causes, not the root causes. Take for example incidents involving misadministration of medications in the operating room.

The apparent root cause of many of those events is the lack of an identifying label on the containers used to store drugs on a sterile field (syringes, basins, or other vessels). The corrective action: All containers *must* be labeled with the name of the medication in the container. So why do hospitals continue to have similar types of

medication errors in the operating room if the root cause has been accurately identified and the proper corrective action implemented?

The most likely reason for continued problems is that the underlying latent system failures have not been found and corrected.

In a 2004 survey of approximately 1,600 hospitals by the Institute of Safe Medication Practices, more than 42% reported inconsistencies in their labeling of medications and solutions on the sterile field.[1]

It is the latent system failures that allow for these inconsistencies, not the lack of a defined procedure.

For example, is there inadequate supervision? Are staff members not held accountable for complying with procedures? Are there insufficient resources (e.g., not enough labels)? Do senior leaders have a laissez-faire attitude toward patient safety? Is there a culture of complacency?

Those are the types of latent system failures that often are overlooked during a root-cause analysis. Yet these failures must be identified and addressed; otherwise, they will trigger more patient incidents of all types.

If an incident investigation stops when contributing causes have been identified, the underlying system problems are never addressed.

To get to the root-cause level, the investigation team must ask, "Why was this situation allowed to exist?" Answers to this question will help uncover the latent system failures that represent the true root causes.

The purpose of this example is not to argue that root-cause analysis is undesirable or counterproductive, but simply to point out that the act of performing a root-cause analysis does not ensure that the root causes actually are found.

Leaders can observe that the investigation did indeed take place, but the effectiveness of the root-cause analysis only can be judged in retrospect by the absence of similar incidents in the future.

The existence of a root-cause analysis creates an *illusion* of patient safety; only the absence of future events confirms the *reality* of safety.

It may well be appropriate to require a root-cause analysis for each significant patient incident that occurs just to ensure such events are treated with appropriate seriousness. However, resources may be wasted if there is pressure to find a so-called "root cause" in each incident investigation and implement a corrective action for each identified root cause.

More importantly, this may contribute to the illusion of safety by creating a pretense that the root cause of every significant incident has been found and fixed.

Organizational initiatives intended to ensure patient safety are beneficial in many instances.

The intent of this column is not to discourage root-cause analyses, corrective actions, and other worthwhile processes changes, but rather to point out that the goal of maximizing patient safety is very elusive.

Requiring incident investigations and corrective action reports can give management the false security that something is being done about all identified problems.

However, if only contributing causes are being identified or if corrective actions are mostly motherhood-and-apple pie interventions, the impression of patient safety may in fact be deceptive.

To keep from being fooled by this illusion, organizations must judge the effectiveness of

COMING IN FUTURE MONTHS

- Make your mock surveys and patient tracers more effective
- Streamline the approval process for patient safety initiatives
- How to calculate the cost of your corrective actions
- Eliminate redundant data collection at your organization
- Improve quality dramatically with a rapid-response team

patient safety programs and improvements based on actual data and observations, not solely on the number of incident investigations completed or corrective actions implemented.

Reference

1. Institute for Safe Medication Practices. *ISMP Medication Safety Alert*. Dec. 2, 2004. ■

Are you breaking patient privacy regs with e-mails?

Make sure information privacy is maintained

Have you ever included a patient's personal information in statistical studies on specific diagnoses for JCAHO core measures and shared this with staff via e-mail? Do you ever e-mail colleagues about a patient's outcome if that patient was seen at another institution?

Those are just two scenarios of when compliance with patient privacy regulations comes into play.

"It's amazing how many things might include electronic protected health information," says **Kathleen Catalano**, director of regulatory compliance services for Dallas-based PHNS Inc.

"Most of the time, quality professionals are the first to embrace all of the rules, and if the institution said no e-mails with protected health information, they would abide," she explains.

In addition, although Joint Commission requirements do not address e-mail specifically, management of information standard (IM.2.10) requires

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. ■

CE *questions*

17. According to Paula Swain, MSN, CPHQ, FNAHQ, director of clinical and regulatory review at Presbyterian Healthcare, which is recommended when Joint Commission surveyors arrive at an organization unannounced?
    A. Allow surveyors to go through hospital unescorted.
    B. Instruct staff to escort surveyors to the administrative area.
    C. Have a single manager escort the team throughout the survey.
    D. Postpone informing staff of the survey team's arrival until patient tracers begin.

18. Which is true regarding unannounced surveys, according to Missi Halvorsen, RN, BSN, senior consultant for JCAHO/regulatory accreditation at Baptist Health?
    A. Surveyors will refuse to have escorts during patient tracers.
    B. No advance notice can be given of where surveyors are headed.
    C. Surveyors only will allow a single individual to accompany them.
    D. Two backup support people should be designated before surveys.

19. Which is recommended when developing corrective action plans, according to Judy Homa-Lowry, RN, MS, CPHQ?
    A. Avoid specifying the cost of education programs in corrective action plans.
    B. Do FMEAs to ensure effectiveness of corrective actions before implementation.
    C. Do FMEAs on corrective actions only if problems have been identified with compliance.
    D. Ask for input from unit staff only after a corrective action has been implemented.

20. Which is in compliance with patient privacy regulations regarding e-mail?
    A. Removing all direct identifiers whenever patient-specific information is shared.
    B. Sharing statistical studies with patient information via the Internet.
    C. Exchanging patient information with colleagues at other institutions via the Internet.
    D. Sharing patient charts containing contact information with other institutions.

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

information privacy and confidentiality to be maintained.

If you need to use patient-specific information for various studies, you are required by the Health Insurance Portability & Accountability Act (HIPAA) to de-identify the information by removing 18 direct identifiers, Catalano says.

These include all of the following[1]:

- names;
- street address, city, county, precinct, zip code;
- all elements of dates (except the year) including birth date, admission date, discharge date, and date of death;
- telephone numbers;
- fax numbers;
- electronic mail addresses;
- Social Security numbers;
- medical record numbers;
- health plan beneficiary numbers;
- account numbers;
- certificate/license numbers;
- vehicle identifiers and serial numbers, including license plate numbers;
- device identifiers and serial numbers;
- web universal resource locators;
- Internet protocol address numbers;
- biometric identifiers, including finger and voice prints;
- full-face photographic images and any comparable images;
- any other unique identifying number, characteristic, or code.

The HIPAA privacy regulations do not apply when protected health information is de-identified by the removal of the 18 enumerated identifiers and after obtaining an expert opinion that a statistically small risk exists that the released information could be used by others to identify the subject of the information, Catalano says.

For e-mail, HIPAA requires that security measures are implemented to guard against unauthorized access to protected health information that is being transmitted over an electronic communications network, she explains.

"If the e-mails are within an intranet — it is considered to be safe passage, but the Internet is considered ripe for theft," Catalano says.

If staff are exchanging e-mails between facilities, all with the same e-mail extension, then these messages stay within your network with safe passage, she notes.

"When e-mail is sent outside of the intranet, it is best if it is encrypted. This safeguards the e-mails," Catalano adds.

CE objectives

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. ■

Reference

1. *Fed Reg* 82,818 (Dec. 28, 2000). 45 CFR § 164.514(b)(2)(i).

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