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Terrorists posing as JCAHO surveyors? Act now to make your security airtight

Disturbing incidents at hospitals call for increased vigilance

It's 3 a.m., and a well-dressed man and woman approach a clerk at a nurses' station, official-looking clipboards in hand. They claim to be surveyors from the Joint Commission and demand to be taken to the pharmacy to inspect medication storage areas. In reality, they're impostors seeking unauthorized access with motives unknown.

If this occurred at your organization, would these individuals be given carte blanche access? Or would they be asked for identification and told to wait while administration and security were notified?

Unfortunately, the above scenario is not just a hypothetical situation from a disaster drill or failure mode effect analysis. Hospitals in Boston, Detroit, and Los Angeles have reported that impostors posing as Joint Commission surveyors have attempted to gain access to their organizations. In every case, the impostors were questioned by security or hospital staff and left the premises. In addition, several other hospitals have reported individuals posing as federal law enforcement, inspectors, and physicians. **(See related story detailing recent incidents, p. 75.)**

Both the number of incidents and the behavior of the impostors point to a chilling possibility. "I believe that the events described do not carry the common hallmarks of simple criminal activity," says **Joe Cappiello**, JCAHO's vice president of accreditation field operations. "Maybe the criminals have become more sophisticated, but you cannot in good conscience rule out the possibility of terrorism. Sept. 11 broadened our thinking, and we would do ourselves a disservice to dismiss this possibility."

Although surveyor impostors aren't unheard of, past incidents typically have involved an obvious motive, such as patients trying to get preferential treatment from staff. The recent incidents were markedly different, with individuals demanding information about the inner workings of hospitals and asking for access to specific areas.

"What raised our concern was the similarity of the incidents in L.A. and Boston and the fact that they took place at such an odd hour, and the impostors were asking odd questions — questions that I would not think criminals trying to 'case' an organization would ask," Cappiello notes.

Alarmed JCAHO officials contacted the FBI and have met with federal anti-terrorism experts. "We became engaged with Homeland Defense and

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other federal agencies when we reported the impostor incidents to the FBI," he says. "Through interagency cooperation and coordination, other agencies were informed, and they followed up with us directly."

The Department of Homeland Security (DHS) is calling on U.S. hospitals to take steps to prepare for unauthorized individuals trying to gain access or obtain information.

The DHS advises encouraging staff to confront all suspicious individuals, maintain control over entrance points, monitor exit points, and review security procedures. (For a complete list of the DHS recommendations and JCAHO's bulletin, go to www.jcaho.org. Click on "Accredited Organizations," "Security Notice Updates — To all Joint Commission accredited organizations.")

Hospitals always have been viewed as possible targets for terrorists. In a spate of other incidents, individuals have been caught taking unauthorized pictures of hospitals, asking for hospital blueprints, requesting information about the whereabouts of medicines that would be used in biological attacks, and inquiring about the institutions' capacity for cardiac care, trauma care, and helicopter access.

"Terrorism has always been a real possibility, even before 9/11," stresses **Ann Kobs**, senior vice president for accreditation and standards at Cincinnati-based TUV Healthcare Specialists. "That is the purpose of having your emergency preparedness plan. Quality managers should work in concert with their environment-of-care experts to address this."

At Round Rock (TX) Medical Center, quality managers promptly shared the JCAHO and DHS alerts with administrators and directors. "We put the word out and had a meeting with our regulatory compliance committee," says **Pamela R. Voss**, FACHE, FASHRM, director of risk management. "We also made a printout of what the JCAHO ID badge looks like, front and back, from the web site."

Department heads were advised to instruct staff not to provide information or access to nonpublic areas of the hospital, especially sensitive areas such as pharmacy, radiology, laboratory, and engineering, to people without authorization from administration or risk management, she says.

If surveyors arrive during off-hours, staff are instructed to immediately contact the administrator and risk manager on call and contact security for assistance, Voss notes. "Any time inspectors from an external agency arrive, staff are to direct them to administration and risk management immediately. Our processes would be the same whether we thought it was terrorist activity or a prank by someone."

The Joint Commission now is recommending the following steps be taken when surveyors arrive at your facility:

- Ask to see their identification badges.
- Ask to see a letter addressed to the head of the organization signed by Russell Massaro, MD, JCAHO's executive vice president of accreditation operations, explaining who they are and why they are there.

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JCAHO surveyors follow a number of ground rules, even for unannounced inspections, Cappiello notes. "We do a number of unscheduled events every year, such as responding to a complaint, so there may be cause for us to arrive that the organization doesn't know about. But our surveyors are instructed to present themselves and ask to be escorted to the CEO," he says. "They are not trying to talk to a low-level security person and go places on their own."

Surveyors always will announce themselves to administration and present a letter identifying themselves and the explicit reason why they are on-site unannounced. "Our surveyors wouldn't be at all put off if someone said, 'I see your badge but I'd like another form of ID.' That's a reasonable

Feds warn of suspicious activity at hospitals

The Department of Homeland Security (DHS) recently issued a special bulletin that warns of an increase in suspicious activity at hospitals.

DHS warns the impostors may be terrorists and "U.S. hospitals offer easy public access and would be recognized by terrorist planners as easy, accessible targets. Known targeting of such facilities would instill great panic and fear in the general public."

The DHS bulletin outlines these recent incidents:

- In October 2004, two hospitals in the Phoenix metropolitan area reported suspicious activity, including photography, requests of building layout, inquiries regarding the location of the pharmacy, and computer fraud.
- Three men inquired as to the location of the pharmacy at St. Joseph's Hospital in Phoenix. These men previously had visited hospitals in Texas and Indiana. All three hospitals are distribution points for the antidote medicines for biological attacks.
- On Feb. 7, 2005, at approximately 10 a.m., two individuals who identified themselves as special agents representing the Department of Defense and the CIA entered the emergency department at Middletown Regional Hospital, NY. The subjects requested to see the charge nurse and presented identification badges. They asked the nurse a series of questions concerning capacity for cardiac care, trauma care, heliport, and private rooms. As the hospital staff's suspicion of the subjects increased, they left the building. The hospital staff did collect a business card from one of the subjects, and it appears to be fraudulent.

Repeated visits at one hospital

The DHS bulletin notes that on March 27, 2005, a New Jersey hospital experienced its fourth separate incident in a six-week period. "Three male subjects in their 30s and 40s, possibly of Middle Eastern descent, spoke fluent, unaccented English and presented themselves as physicians from" the Joint Commission, the DHS bulletin explains.

In addition, an advisory prepared by the New Jersey Office of Counter-Terrorism and disseminated to law enforcement agencies and select health care providers by the Office of Counter-Terrorism, Office of the Attorney General, Department of Law and Public Safety, states, "counterterrorism analysts remain concerned that terrorist organizations may attempt to target U.S. medical infrastructure in order to cause immediate casualties and disrupt health care and emergency medical services."

This is an excerpt from the advisory:

Feb. 26, 2005, at approximately 3 a.m., a Caucasian man and Caucasian woman posing as JCAHO surveyors arrived at a Los Angeles hospital.

The man is described as mid-30s, dark hair, approximately 6-feet tall, and dressed professionally. The woman, also in her mid-30s, has dark reddish hair. A security guard at the hospital believed he saw the two individuals wearing badges similar to those used by genuine JCAHO surveyors. The impostors exited after they were stopped by hospital security.

In the second incident, on March 3, 2005, at 3 a.m., a man described as 35-40 years old, of South Asian descent, 6-feet tall, and with a short black beard and mustache, demanded to inspect a medical facility in Boston. The man left the premises after being questioned by hospital staff.

In the third incident, in the morning of March 10, 2005, a Caucasian woman described as mid-40s, 5-feet 7-inches tall, 160 pounds, with blonde hair, entered a Detroit hospital through the maternity ward and began wandering around the facility. When hospital staff questioned her, she stated that she was a JCAHO surveyor. After further questioning, she fled the premises.

Suspicious events have occurred in the past year at New Jersey medical facilities that appear unrelated to the three incidents described in this advisory.

These suspicious events have included irregular inquiries, incidents of surveillance, and suspicious employees and patients. In particular, on March 11, 2004, an adult male of Middle Eastern appearance entered the emergency department of Warren Hospital in Phillipsburg Township at approximately 4 a.m. and directed several atypical and evidently prepared questions to the duty nurse relating to the hospital's bed capacity and the means by which care is delivered to patients. ■

thing to ask," Cappiello points out.

When surveyors arrive, they must be wearing JCAHO-issued ID badges and carrying the signed letters, Kobs adds. "Announced or unannounced, it is the organization's right to request both of these items from the surveyors," she stresses.

To be clear about your rights, Kobs recommends reading the accreditation policies and procedures section of the JCAHO accreditation manual. "So many organizations jump right to the standards and agonize over a phrase or a word, but the meat of the survey process is rarely read or understood," she says. "This spells out an organization's rights and responsibilities."

New problems with unannounced surveys?

Continuous preparation for unannounced surveys is in high gear at most organizations, with staff keenly aware that surveyors have the right to look at patient records, confidential documents, and inspect any area of the hospital they choose without prior notice. In addition, survey teams have been known to arrive in the middle of the night when investigating a complaint. Will impostor surveyors take advantage of this and attempt to convince someone working the night shift to provide immediate access to sensitive areas?

Not if procedures are followed consistently by all staff, Voss explains. During routine employee orientation, the procedure to follow when regulators from JCAHO or any other agency come into the facility is reviewed, she says. Even if surveyors were to arrive during off-hours, staff are instructed to follow the same procedures.

"It's very unlikely that a surveyor from any agency would be there at 10 p.m. on a Sunday, and staff are to call security immediately," Voss says. "Remember that it's our facility, and we have a duty to make sure that only people with appropriate credentials have access to the organization. Even police officers or law enforcement don't have the right to just come in and take over. Just because they're wearing a badge or suit doesn't mean they can walk in and get whatever they want."

JCAHO surveys about 1,700 hospitals a year, with approximately 300 visits currently unannounced, but all surveys will be unannounced as of Jan. 1, 2006. Those plans are unchanged, Cappiello underscores.

"When we go to fully unannounced, it will present some other problems, but not insurmountable problems," he says. "First of all, unannounced means unannounced. We are not going to give organizations a day's notice."

Unannounced surveys are not a new phenomenon in health care, stresses **Patrice Spath**, BA, RHIT, a health care quality specialist with Brown-Spath & Associates in Forest Grove, OR. "Several state health departments have been using this model for years for surveys of nursing homes as well as hospitals," she notes.

JCAHO surveyors still will arrive in the morning during normal business hours, except for the small number of surveys done for cause, driven by a complaint. "It may be that the best time for us to evaluate the environment in which that complaint took place is outside of normal business hours, such as, perhaps, an issue with staff on the night shift," Cappiello says. But even in those cases, surveyors still will follow the procedure of showing badges and a letter stating the reason they are there, he says.

In response to the incidents, JCAHO will give organizations a foolproof way to verify the identity of surveyors — by posting photos of the actual survey team. This information can be accessed on your organization's secure, password-protected extranet site at midnight, central standard time, on the morning the team is to arrive. "So at 7 or 8 a.m. when the team arrives and you want to make sure, you can go and find their pictures and bios," says Cappiello. "We are working on the ability to do that in preparation for 2006. We are also looking at some internal things, including badges, to see what we can do to make it more difficult to impersonate someone from the JCAHO."

"This just goes to prove how important it is for *everyone* at the hospital to request the reason a person is in a certain area and, in many instances, the name of a person found wandering their hallways, regardless of how official they may look," says **Kathleen A. Catalano**, RN, JD, director of regulatory compliance services for Dallas-based PHNS Inc. "Any way in which the hospital quality manager can thwart threats would be warranted."

Staff at the hospitals handled the impostor situations very well, and no one was able to gain access, she notes. "I am extremely impressed with the security guards who asked for more information. When staff see someone who shouldn't be there, they should question them, regardless of how busy they are," Catalano says. "It will make the impostor think twice and, as has been seen, throw them off their mission — whatever that may have been."

Individuals arrive at a hospital unannounced for a variety of reasons, Spath says. "They may want a copy of their medical record or bill, or to speak with someone in a particular department," she adds. "JCAHO surveyors are no different than any other customer who arrives at the hospital's doorstep. You find out what they need and direct them to the appropriate place."

To assess your "customer validation" procedures, Spath recommends using a "secret shopper" approach. Ask someone who is not known to hospital staff to dress in professional attire and request confidential information such as a copy of a patient record, or have them say they are from the Joint Commission, she suggests.

"You can see how your validation process is actually working," Spath says. "No matter who the customer is or why they are at the hospital, we need to be certain that we have confirmed their identity. Just like we would not give someone a copy of a patient record without verifying their identity, so should we not begin the survey process without verifying the surveyors' identity."

To develop a more secure customer validation process, solicit input from your health information management department or staff in the hospital nursery, Spath suggests. "They must deal with ID validation quite frequently," she says.

The incidents put a spotlight on a larger issue — that of overall security at your organization, Cappiello notes. "This is a really good time for hospitals to reflect on their internal security plans in general. If you're going to do something to address this, you should use that energy in a bigger context." He suggests looking at access points, how your organization monitors who comes and goes, and your system for validating the identity of anyone claiming to be from an accrediting body or organization. "This event occurs, and we all get excited about impostors, but there are issues hospitals face every day with people trying to gain access who shouldn't be there. There are all kinds of bizarre things that you have to be prepared for, such as identity theft and infant abductions."

Access points also are an important component of disaster preparedness, Cappiello adds. "For instance, if there is some sort of chemical spill or a biochemical weapon is used, you would need to limit access and lock down and secure the medical center. So this is not just an issue about impostors — it's an issue about security in general and also about emergency preparedness."

In responding to this or similar incidents, your organization's security systems are key, explains **Michelle Pelling**, MBA, RN, president of the Propell Group, a Newberg, OR-based health care consulting organization specializing in JCAHO compliance and performance measurement. "There is no reason these individuals should gain access."

Quality managers must advocate a thorough review of security management for their organization, Catalano says. "You should assist in creating a monitoring program to help keep security on its toes, and monitor so that corrections made can be recorded and reported as appropriate."

Surveyors will be testing organizations to make sure they have adequate systems to assure security of patients, visitors, and staff, and that there are systems to prevent this kind of thing from happening, Pelling says.

Surveyors will ask about your security system and how its effectiveness is tested, Cappiello notes. "They may ask what the hospital has done in response to the alerts."

Hospital leaders should put systems in place so that these individuals do not gain access and communicate these expectations to staff, Pelling emphasizes.

"We have alerted staff about this possible situation, but hospitals should be checking all after-hours visitors for security and safety reasons anyway," says **Darlene Adams**, RN, MSN, director of quality management at United Regional Healthcare System in Wichita Falls, TX. "Possibilities for impostors trying to gain access include obtaining information illegally, terrorism, and competitors looking for information." The organization allows security badge access only for all doors after business hours, with a security monitor by the main entrance. "We have visitors to the ED sign in after 9 p.m. with security," she says. "Anyone saying they are inspectors are held in security until the house supervisor and administrator on call are notified. If an impostor is identified, both police and JCAHO are to be notified."

Quality managers and safety officers should monitor compliance with security procedures through performance improvement and emergency preparedness drills such as patient abductions, Voss says. To identify areas for improvement, monitor staff's ability to follow procedures when suspicious people are encountered and critique drills involving security issues.

"What we have done is tied safety and security to quality and service," Adams says. "Employee badges with bar codes give us audit trails to review if there is a breach in security. As we renovate our

medication rooms, we are assuring secure storage and badge access."

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Have you implemented a rapid response team?

Lower mortality rates, fewer in-house codes

How do you think quick access to a team of clinicians with critical care expertise for patients in crisis would affect your hospital's mortality rates? The Cambridge, MA-based Institute for Healthcare Improvement (IHI) recommends that organizations create rapid response teams (RRTs) to bring immediate help to the patient's bedside or wherever it is needed.

More than 1,800 hospitals have signed up for the IHI's 100,000 Lives campaign, with participating hospitals implementing specific care interventions to prevent avoidable deaths, including forming RRTs, with the goal of saving 100,000 lives between now and July 2006 and every year thereafter.

"According to the literature, benefits of RRTs may include a reduced incidence of in-hospital cardiac arrests, decreased bed utilization following cardiac arrest, and lower overall in-hospital mortality," says **Terri Simmonds**, RN, principal of Safe and Reliable Health Care and director of the IHI.

"We have found that when you provide nursing staff a reliable and efficient mechanism for bringing immediate resources to the bedside, the nurses are more likely to call for help in a crisis," says **Michael DeVita**, MD, associate professor of critical care medicine at University of Pittsburgh (PA) Medical Center. "Their sense of empowerment and safety increases."

Their ability to care for other patients in the unit also improves because resources are brought to the bedside to avoid "domino code" syndrome, with everyone caring for one patient and neglecting others, he adds.

"We have changed the culture at the bedside. People are trying to prevent crisis instead of preventing death," DeVita explains. "Most of our nurses now could not imagine working in a system that does not have this." By analyzing the event leading up to a crisis, you can generate extremely precise quality improvement data.

"When you look at a crisis, you are able to track the type of errors that are particularly dangerous, so you can target those," he says.

You also can target particularly dangerous combinations of events, such as use of patient-controlled analgesia (PCA) and sleep apnea. "We have found that patients who have a risk for sleep apnea have an extremely high risk for respiratory events," DeVita adds. "So we can target interventions for particular subpopulations of patients and treatments. You can't do that with a normal error system. We have found a whole series of problems that are not errors in the normal sense of the word, but are things you want to avoid to prevent a crisis from occurring."

After a problem is identified, that problem then can be classified as an error, he explains. "It's not an error today to have a patient with a history of sleep apnea on a PCA without monitoring, but in three years it will be," he says. "Four years ago, treating low glucose with a glass of orange juice was not considered an error, but today it is, because we've established a norm."

After the RRT had responded to several incidents of hypoglycemia, it was discovered that low blood sugar was being treated inconsistently. "We put together a task force to work on the problem and developed a hypoglycemia protocol so that every person gets treated the same way," DeVita notes. "Our rate of crises has gone way down."

(Continued on page 83)

PATIENT SATISFACTION PLANNER™

Reduce chaos to see satisfaction scores rise

Knocking on doors makes patients feel welcome

Patients and their families want to feel comfortable, informed, and respected when they come to your facility for surgery, and your ability to make them feel that way is reflected in your patient satisfaction scores.

Improving patient satisfaction usually doesn't require major changes in the way you treat patients but does require paying attention to little things that affect a patient's perception of your facility, according to winners of the 2004 Compass Award for improved patient satisfaction scores from Press Ganey Associates, a South Bend, IN-based patient satisfaction benchmarking company.

"It was easy to improve our patient satisfaction scores when I arrived, because our processes for handling same-day surgery patients was chaotic and confusing," says **Susan M. Sherman**, former director of surgical services at Gila Regional Medical Center in Silver City, NM.

No one reviewed charts prior to the day of surgery, she says.

The lack of prior review meant that missing labs or X-rays were not discovered until the patient arrived at the facility, which resulted in delayed or rescheduled procedures, Sherman explains.

"This was not only inconvenient for the patient, but also for the surgeon," she says.

The chaos continued when patients entered the pre-op area, Sherman adds.

"There were no restrictions on who could go back to the small, open pre-op area, so families and patients were standing in the hallway that led to the operating rooms, often having to move out of the way as patients were moved into surgery," she points out.

There was no privacy for the patients, Sherman says. "It was hard for the patient to concentrate on instructions from the nurse because of all the activity in the area, and it was stressful for staff," she adds.

The first step Sherman took to address the problems was to move the pre-op area to a room across the hallway from the surgery department. It is not an ideal situation to have to cross a public hallway to return to surgery, she adds.

"We are planning a renovation this next year that will move pre-op back into the surgery department," Sherman continues. "This is, however, better than our previous situation because we have curtained areas that do provide some privacy for the patients as the nurse conducts her pre-surgical assessment and answers the patients' questions."

The hospital also prohibits family members or friends from accompanying patients to pre-op unless the patient is a child or an older adult who needs a caregiver with him or her, Sherman points out.

"This rule not only reduces the noise and confusion in the area, but also further protects the patient's privacy in case there are sensitive issues to discuss," she adds.

Another change for the same-day surgery program was the addition of a pre-admission nurse who calls patients prior to the day of surgery to provide instructions on preparation for surgery and to conduct a pre-op assessment by telephone.

Patients can discuss surgery concerns

The biggest advantage to adding the pre-admission nurse is that patients have a chance to ask questions and talk about their surgery prior to the day of surgery, Sherman notes. "This makes the patient a lot calmer and better prepared."

The pre-admission nurse sits next to the scheduler so the two can coordinate preparation of charts, she says.

"The pre-admission nurse reviews the charts prior to surgery and makes sure that all history and physical information, lab work, and other diagnostic tests ordered by the physician are on the chart," Sherman adds.

This move has made cancellations of surgery almost nonexistent, she says.

"We have called physicians' offices to get power of attorney forms for children when their grandparents are bringing them in for surgery

prior to the day of surgery because the pre-admission nurse found out in her initial call that parents would not be bringing the child," Sherman says.

The changes at the same-day surgery program at Sacred Heart Medical Center in Spokane, WA, were not as drastic as adding staff and moving the pre-op area, but they were effective, says **Denise Dominik**, RN, BSN, CPHQ, director of performance improvement at the hospital.

"Our first step was to send our performance improvement team throughout all areas of the hospital to observe how we communicate with patients, visitors, and family members," she says.

Smiles improve overall attitudes

One of the things the team noticed was that employees throughout the hospital, including those in same-day surgery, hurried from place to place without making eye contact with visitors or other employees, Dominik notes.

That discovery, as well as other examples of poor communication, were used to develop staff education programs that addressed the importance of making visitors feel comfortable, she adds.

The first step in educating staff members to make others feel welcome was to institute the "10-foot rule," Dominik says.

Whenever staff members are within 10 feet of another person, they are to smile and say hello, she explains. "The person can be a visitor, another staff member, a physician, or anyone," Dominik adds.

Smiles are contagious, she continues. "I've seen greetings put smiles on people's faces, and then they've gone on to greet the next person," says Dominik.

If a staff member notices someone who appears to be lost, it is that staff member's responsibility to stop and help the person find the way, she notes.

In addition to feeling welcome, privacy also is a significant issue for patients, says **Connie Wechtenhiser**, RN, manager of outpatient surgery at San Jacinto Methodist Hospital in Baytown, TX.

For that reason, same-day surgery staff members always keep the sliding doors in the pre-op and recovery areas closed, she says.

"We also respect privacy of patients in different cultures," Wechtenhiser says. "For example, we allow Indian women to keep pants on to maintain their sense of modesty until right before we take them into the operating room."

At Sacred Heart Medical Center, staff members throughout the hospital are required to knock on a patient's door before entering the room, but the same-day surgery department has curtains separating patients rather than doors, Dominik notes.

Knock first

Curtains, however, don't change a nurse's responsibility for knocking, she adds. "Our staff members stop at a closed curtain and say 'knock, knock' before entering," Dominik says with a laugh.

Sometimes improving patient satisfaction is as simple as letting patients know who cared for them during their visit, Wechtenhiser points out.

Perhaps the most successful activity implemented at San Jacinto is the greeting card that the same-day surgery department prepares for each patient.

The card thanks the patient for entrusting San Jacinto with their care and wishes them a speedy recovery, she explains. The card is placed on the chart and as the patient moves from area to area, the staff members, including the physicians, sign the card.

"Not only does this increase the sense of accountability for staff members, but patients have mentioned the card in follow-up phone calls made by staff members as a highlight of their experience," Wechtenhiser says.

A bonus to having all staff members sign the card is that the patient now knows everyone who provided care, she says.

"We've always had patients send thank-you letters that named their pre-op nurse, but now patients thank every person who cared for them because they know who cared for them, even when they were under anesthesia or drowsy in recovery," Wechtenhiser says.

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Offer elderly reclining chairs, not gurneys

Decrease pain for ED patients

Would you like a simple way to reduce pain and increase satisfaction of elderly patients? Allow them to sit on reclining chairs instead of gurneys, suggests **Scott Wilber**, MD, FACEP, director of the emergency medicine research center at Summa Health System in Akron, OH.

Researchers placed 132 patients age 65 or older in a reclining chair or gurney, and their pain levels and patient satisfaction were assessed one and two hours later using a 0-10 scale.

"What we found was that even though more patients in the chair group reported pain at the onset, that group had a substantial drop in pain levels to almost zero at two hours, whereas the gurney group had a steady increase of pain levels," says Wilber.[1]

At the same time, patient satisfaction increased by 2 points for the chair group at the two-hour mark, with an average score of 8.1 compared with 6.0 for the gurney patients.

"We decided to study this because we observed that a lot of older patients, as the ED stay gets longer and longer, complain of pain while in a gurney," he says.

While in a gurney, the patient's hips are flexed between 45 and 90 degrees with legs fully extended, which can worsen pain from chronic back problems, Wilber explains.

"Placing them in that position is bad, but you can't lay them down flat looking at the ceiling, either," he adds.

The researchers were able to borrow the chairs needed for the study from hospital inpatient floors, closets, and storage areas, but the ED will purchase six new reclining chairs at a cost of $800 each (3-Position Deluxe Adult model, Invacare, Elyria, OH).

"We were able to demonstrate to administrators that this is something we can do to improve satisfaction in this population, which is cheaper than hiring an extra nurse or physician," says Wilber.

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Reference

1. Wilber ST, Burger B, Gerson LW, et al. Reclining chairs reduce pain from gurneys in older emergency department patients: A randomized controlled trial. *Acad Emerg Med* 2005; 12:119-123. ■

Technology, planning key to successful programs

While the Centers for Medicare & Medicaid Services (CMS) introduces new programs designed to address the care of chronically ill patients, home health agencies continue to find innovative ways to provide care to diabetic and congestive heart failure (CHF) patients — two of the most common diagnoses identified as chronic illnesses.

"We provide care to 4,000 patients, and half of them are considered chronically ill," says **Ray Darcey**, vice president of Sentara Home Care in Chesapeake, VA. "The most common diagnoses are diabetes, CHF, and chronic obstructive pulmonary disease [COPD]," he says.

After identifying CHF patients as the group for which costs were increasing and reimbursements were decreasing, Darcey's agency evaluated different ways to continue providing quality care at a lower cost.

"We do have standard protocols that we follow for all of our chronically ill patients, and those do streamline our care. But we wanted to see if telemedicine would help us reduce our labor costs," he notes.

The telemedicine program for CHF patients was introduced four years ago. "The program involves a combination of telemedicine and nursing visits," Darcey explains.

"The telemedicine visits are designed to supplement — not completely replace — nursing visits. Our program is a live, interactive video that requires a computer screen and a telephone line," he says. "The patient's unit has a blood pressure cuff, a scale, and a stethoscope that are used during the telemedicine visit with the results appearing on the nurse's screen," Darcey points out.

Although the program has reduced staff costs because nursing visits to the home can be reduced,

it also has produced some other significant results, he says. "We've seen a 70% reduction in hospital readmissions, a 78% decrease in emergency department visits, and a 50% improvement in activities of daily living for our CHF patients on the telemedicine service," Darcey notes.

The 60 patients on Sentara's telemedicine program are between 65 and 80, and none of them were apprehensive about the use of the telemedicine equipment, he says. "There was no hesitation, and we've discovered an unexpected bonus to the telemedicine program," Darcey adds. While the patients were not nervous about the equipment's digital camera sending their image to the telemedicine nurse, they especially are careful about their appearance during the telemedicine visits, he points out. "When nurses go to the home to see these patients, many of them will still be wearing their pajamas.

"For the telemedicine visit, the patients dress up, put on makeup, and fix their hair," Darcey laughs. Their attitude also is different, he adds. "They take their responsibility for their care between visits very seriously, and they are diligent about recording the information the nurse will request during the telemedicine visit."

The telemedicine patients see this program as a way for them to participate in their care, and their attitude and approach to self-care have improved greatly, he adds.

Although Sentara did experiment with the use of the same nurse for both the telemedicine and the in-home visits, Darcey notes it was not an efficient use of staff time. "Some of our patients live over 100 miles from the office with the telemedicine equipment."

Scheduling the nurses who cover these distant areas to come to the office to make telemedicine visits wasn't effective, he explains. "Patients don't mind two different nurses overseeing their care, and patient satisfaction scores for this group of patients have increased."

In addition to having their own CHF program that includes comprehensive protocols and patient education, Sta-Home Health Agency in Jackson, MS, has targeted diabetic patients as one group to receive special attention to reduce complications and the need for hospitalization.

"We have a team approach to caring for diabetic patients that includes nurses, diabetic educators, and dietitians to make sure our patients receive the best education and care," explains **Michael T. Caracci**, chief executive officer. "All of our nurses are familiar with the potential complications and the neuropathy of diabetes, and we have seven certified diabetic educators on staff to serve as resources for the nurses and to visit patients."

In addition to comprehensive patient education for his agency's own home care patients, Caracci's staff offer foot-care clinics through physician offices. The clinics are held in the physician's office for patients of that practice.

"One of our nurses, along with the physician, will talk to the group of patients about foot care in general for diabetics. Then our staff will work with each patient on an individual basis to trim toenails and check feet," he explains.

To avoid any Stark violations, the physician pays the agency on an hourly basis to provide the education and the foot care, he adds.

Because Caracci's agency covers a wide geographic area with 40 offices and more than 4,000 patients, it is not possible for diabetic educators to see every diabetic patient on a regular basis. That doesn't mean that nurses don't have access to the diabetic educators as a resource, he points out. "Although our nurses are well trained in the care of diabetic patients, there are times they may need advice," Caracci says.

Not only can nurses reach the diabetic educators by phone or e-mail but, if they are concerned about a patient's skin breakdown, nurses can give accurate information about the patient's condition with pictures. "We don't use telemedicine at this time, but we do have digital cameras in each of our offices that nurses can use to photograph a patient's wound and transmit the picture to the diabetic educator," he says. "This makes it possible for the educators to determine if the patient should be seen by another clinician or themselves for other treatment," he adds.

While technology such as digital cameras is affordable for most agencies, Darcey admits that telemedicine requires a significant investment.

"The cost of training nurses to use and set up the equipment in the patient's home is not much, but the equipment and software can add up," he admits. "We are fortunate that we are part of a larger health system with several hospitals. The reduction in readmissions and emergency department visits, and a shorter length of stay when hospitalization is needed for CHF patients combined to make a strong argument in favor of the investment in telemedicine," Darcey adds.

"We are planning to expand our telemedicine program to include COPD this year, and we expect to see positive results for those patients as well," he says. ■

(Continued from page 78)

One-third of events are not preventable, one-third have an error linked with them, and one-third have no errors linked to them but clearly are preventable, he says. "We don't use the term error at all — instead we say 'process inefficiency' or 'process issue,' to capture both the mistakes and the preventable processes," he explains. "Our credo is to not only prevent this patient from dying but get clues to prevent the next 10 patients from dying."

The process doesn't replace traditional quality improvement efforts, DeVita says. "But this is another way of finding areas of concern, and helps focus effort on high-risk areas," he says.

Quality professionals already have the skills to troubleshoot problems, such as doing a root-cause analysis and investigating and correcting errors, DeVita says. "But they will have to gain the ability to deal with a new data source," he says. "The RRT patient analysis is more fruitful data collection because it's more focused. I don't see it replacing current process improvement strategies — but it will become an important adjunct to them."

All five hospitals in the Mercy Health Partners network in southwest Ohio, are participating in the IHI's campaign. "We have charged the associate medical directors at each hospital to be accountable for the implementation of these protocols and processes," says **Robert Strub**, MD, the organization's interim chief medical officer. "We have given them the freedom to do this the best way for their facility, since you can't make a cookie-cutter implementation — it varies according to the different cultures and service lines."

The goal is to decrease morbidity and mortality rates for each of the hospitals, improve overall quality of care, shorten length of stay by preventing complications and catastrophic events, and provide more cost-effective care, he says. "Sick people with complications consume a significant amount of health care resources and dollars," he adds.

When implementing an RRT at your organization, consider the following:

- **Determine the best structure for the team.**

One potential challenge is the allocation or reallocation of resources to staff the RRT, adds Simmonds. "Many organizations are using critical care and respiratory therapy charge persons, who are functioning in an administrative role during a given shift, to staff the RRT," she says. "These individuals may be free of direct patient care responsibilities and thus able to leave the unit to respond to a RRT call."

The University of Pittsburgh now has six different types of specialty RRTs, DeVita says: a medical emergency team that responds to any crisis, a stroke team, a chest pain team, a trauma team, and a blood administration team.

"If you've got a hospital that has open-heart surgery and a high-risk newborn nursery, you will need a different mix of professionals than a general med/surg hospital," Strub says. The basic RRT team consists of an intensive care unit (ICU) nurse, respiratory therapist, and an intensivist or hospitalist. "That is your basic team, although you can have an ICU nurse and respiratory therapist as the initial response for a smaller hospital, and then they would call the next level of specialized care as needed, such as an IV team or anesthesia," he says.

- **Establish criteria for when the team is called.**

"This is a challenge we have faced and will vary by the service line," Strub says. "Each facility needs to ensure that all employees know when it is appropriate to summon the team. Waiting too long to call is just as dangerous as calling too often when it is unnecessary."

IHI suggests using criteria such as a staff member being worried about a patient, or acute change in heart rate, systolic blood pressure, respiratory rate, oxygen saturation, conscious state, or urinary output.

- **Provide education and training.**

"The team needs to know what they are supposed to do, how they are supposed to do it, and what to do differently," Strub says. "This requires a whole re-education of staff to a degree, with a never-ending training and retraining process."

The goal is for the procedures to be hardwired in staff, he adds "This is what happens every time, and it is not something you have to think about. It's just done. It should take only five minutes from the time somebody is notified to mobilize the team and hopefully less."

- **Create a data collection tool.**

The quality manager needs to be involved upfront in creating an appropriate data collection tool to document the time of the event, demographics, what happened that resulted in the call to the RRT, and what interventions were needed, Strub explains.

He recommends using the sample documentation forms posted on the IHI web site as templates and customizing these for your own organization. He suggests having the data

recorded by a floor nurse, since the team caring for the patient also can't be documenting.

"Examining the medical records of patients who've suffered cardiac arrests for evidence of clinical deterioration in the hours prior to the arrest may help organizations demonstrate the need for the RRT," says Simmonds. "Once the RRT has been implemented, data should be collected on the incidence and location of in-hospital codes, hospital mortality, and utilization of the rapid response team."

- **Measure effectiveness.**

To evaluate the impact of your RRT, the IHI recommends using these key measures: Codes per 1,000 discharges, codes outside the ICU, and utilization of the RRT. Other possible measures are post-cardiac arrests, ICU bed utilization, and percent of coded patients surviving at discharge.

"You need these data to evaluate how the patient came to need this care," Strub says. "The ultimate goal is to analyze it and come up with ideas as to how this could have been prevented in other patients. If postpartum patients are having problems with hemorrhaging, what are we doing to decrease risk for patients with a bleeding problem?" After the data are collected with an initial assessment, they should be presented to a quality and safety committee, with both good and bad outcomes discussed. "We will be looking to improve the measurable data that we're getting now and moving that number in the right direction. This is a part of how we will improve our core measure data," he adds.

After policies are put into place, fewer patients should be transferred to the ICU from the floor, and the number of full-blown codes in the hospital should decrease, but this will vary according to your hospital's volumes, Strub says. "If you have one less code, that may be a 10% drop for some hospitals, so you may have to look over a longer period of time. The stuff you see on *ER* should be the exception and not the rule. We will hopefully look at resuscitations on the floor as a thing of the past."

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- *For more information on rapid response teams, go to the IHI's web site at www.ihi.org. Click on "100,000 Lives Campaign," "Rapid Response Teams."]* ■

Learn to use a 'What-If' patient safety analysis

Assemble an experienced review team

By **Patrice Spath**, RHIT
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"What-If" analysis is a structured brainstorming method of determining what things can go wrong and judging the likelihood and consequences of those situations occurring. The answers to those questions form the basis for making judgments regarding the acceptability of those risks and determining a recommended course of action for those risks judged to be unacceptable. An experienced review team can effectively identify major patient safety concerns in a process or system.

During a What-If analysis, the team assesses what can go wrong based on past experiences and knowledge of similar situations. At each step in the process, What-If questions are asked and answers generated. To minimize the chance that potential problems are overlooked, the team doesn't make any improvement recommendations until all of the potential patient safety hazards are identified. The review team then makes judgments regarding the likelihood and severity of the "What-If" answers. If the risk indicated by those judgments is unacceptable, then a process improvement recommendation is made by the team.

The first steps in performing an effective What-If analysis include picking the boundaries of the review, involving the right individuals, and

assembling the right information. The boundaries of the review may be a single task, a collection of related tasks, or a complete process. The narrower the review focus, the greater the likelihood of explicit improvement recommendations. When the review boundaries are too wide, the team's findings and recommendations tend to become more general in nature.

Assembling an experienced, knowledgeable review team probably is the single most important element in conducting a successful What-If analysis. Including individuals experienced in the day-to-day tasks is essential. Their knowledge of performance standards, past and potential errors, as well as task difficulties bring a practical reality to the review. Consider also including recently hired staff members on the review team to gain their perspective.

Once the team is assembled, the next step is conducting the analysis. An experienced patient safety review facilitator should be chosen to lead the group through a series of "What-If" questions. In addition, the team should be provided with clerical support to take notes of the review.

With input from the team, a list of What-If questions is formulated. The questions could address situations such as:

- Failure to follow procedures or procedures followed incorrectly
- Procedures incorrect or latest procedures not used
- Staff inattentive or not trained
- Equipment failures
- Workplace influences such as lighting, noise, staff fatigue
- Combination of events such as multiple task failures

Team members who are knowledgeable of past process failures and likely sources of errors should be able to quickly develop these questions. For

Example of Completed What-If Analysis Form

Division: Nursing **Date:** 9/2004	**Description of Task:** Nurse entry of physician medication orders into computer			
What If?	**Answer**	**Likelihood**	**Consequences**	**Recommendations**
What if the wrong medication is chosen from the pick list?	• Wrong drug ordered • Delay in medication administration if error caught by nurse before giving the medication	Possible	Serious	Change pick list to include "Tall Man" letters and color coding to assist in differentiating between medication
What if the lighting makes it difficult to see computer screen?	• Wrong drug chosen from pick list • Unable to input orders into computer	Unlikely	Minor	No action recommended at this time
What if the wrong patient name is entered in computer?	• Drug ordered for wrong patient • Delay in medication administration if error caught by pharmacy or by nurse before giving the medication	Possible	Serious	Reinforce pharmacy checks to catch these types of errors prior to dispensing medication
What if the wrong strength, unit, or dosage form is chosen from the pick list?	• Wrong strength, unit, or dosage form is ordered • Delay in medication administration if error caught by pharmacy or by nurse before giving medication	Quite possible	Very serious	Nurse to confirm medication strength, unit, and/or dosage with written order prior to administration of first dose
What if physician's written order is illegible?	• Nurse asks another nurse what the order reads • Nurse contacts physician for clarification • Delay in medication administration	Quite possible	Minor	No action recommended at this time

example, consider the task of selecting medications in a computerized order-entry system. Some typical What-If questions that could be generated by the team are listed below:

- What if the wrong medication is chosen from the pick list?
- What if the lighting makes it difficult to see the computer screen?
- What if the wrong patient name is entered into the computer?
- What if the wrong strength, unit, or dosage form is chosen from the pick list?
- What if the physician's written order is illegible?

As the What-If questions are being generated, the facilitator should ensure that each member of the team has an opportunity to identify potential errors or failures. Don't stop during the generation of the question list to answer the questions; otherwise, the team may not spend enough time on question generation. The facilitator should assess if the team has really looked at all of the possibilities before going to the next step of answering the questions. It can often be helpful to break up the analysis into smaller pieces of the process if it appears that people are too quickly moving ahead to answering the questions.

After the review team has exhausted the most credible What-If scenarios, the facilitator then has the team answer the question, what would be the result if that situation actually occurred? For example, what would happen if the wrong patient name is entered into the computer? If done correctly, reviewing the possible process failures and human errors can point out the opportunities for patient safety improvements as well as efficiency improvements. As each What-If scenario is discussed, the team also judges the likelihood and severity of the situation it is describing. The discussion of the situation leads naturally to recommendations for improvement.

The team continues the analysis question by question until the entire process has been analyzed. At this point, the team should step back and review the big picture to determine if it has inadvertently missed anything.

Once the hard work of conducting the analysis has been completed, a report of the project should be prepared for the patient safety committee or other management group. The leader of the review team can create a cover memo that details the scope of the review as well as the major findings, recommendations, names of people who have been assigned responsibility to take actions, time frame for completion, and measures of success.

CE *questions*

21. Which is recommended when surveyors from Joint Commission arrive at an organization?
    A. Staff should allow surveyors access to any area of the hospital.
    B. Surveyors should be asked for identification, and administrators contacted.
    C. For unannounced surveys, surveyors must be allowed to proceed unescorted.
    D. Staff are required to answer any questions, even before the survey officially begins.
22. Which procedures will be followed by JCAHO surveyors for unannounced surveys?
    A. Surveyors often will arrive during off-hours and night shifts.
    B. Surveyors will no longer present identification.
    C. Surveyors always will show identification and a signed letter.
    D. Surveyors will expect to conduct surveys without any notification of administration.
23. Which is an expected outcome after implementing a rapid response team?
    A. increased incidence of in-hospital cardiac arrests
    B. increased bed utilization following cardiac arrest
    C. more inpatients transferred to the intensive care unit
    D. lower in-hospital mortality rates
24. Which change resulted in decreased mortality rates for hip fracture patients at Staten Island University Hospital?
    A. developing specific criteria for privileging of medical staff for preoperative evaluations
    B. using only cardiac intensivists for preoperative evaluations
    C. allowing all attending physicians to evaluate patients before surgery.
    D. prohibiting attending physicians from performing assessments of high-risk patients.

Answer Key: 21. B; 22. C; 23. D; 24. A

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 this issue, you must complete the evaluation form provided** and return it in the reply envelope provided to receive a certificate of completion. ■

This cover memo can be attached to the completed What-If Analysis Form. **(See box, p. 85.)** A periodic report should be generated to summarize the present status of each of the recommendations and measurement results.

The What-If analysis technique is simple to use and can be applied effectively to a variety of patient care and business processes. No specialized tools or techniques are needed. Individuals with little hazard analysis training can participate in a full and meaningful way. The results of the analysis are available immediately and usually can be applied quickly. On the other hand, the technique does rely heavily on the experience and intuition of the review team. It is somewhat more subjective than other methods, such as failure mode and effect analysis (FMEA), which require a more formal and systematized approach. If all of the appropriate What-If questions are not asked, this technique can be incomplete and miss some hazard potentials. It may be better to do a more rigorous FMEA on high-risk processes or those with known patient safety problems. ■

Protocol reduces mortality rates for hip fracture 80%

Administration overcame physician resistance

In 2000, quality professionals at Staten Island (NY) University Hospital reviewed the perioperative death of a 78-year-old woman undergoing hip fracture surgery. During a root-cause analysis of this sentinel event, a key area for improvement was identified: Medical staff lacked specific privileging for preoperative evaluations of high-risk patients.

Even though the organization's mortality rate of 4.9% was less than the state average of 5.1%, quality leaders set a goal to reduce mortality by developing criteria-driven pre-op assessment privileges requiring specific training and experience.

A defined privilege was developed for medical staff to assess and preoperatively clear high-risk hip fracture patients to ensure competency and reduce variability. A cadre of physicians was identified who could continue doing the pre-op assessments, consisting initially of pulmonary or cardiac intensivists, and later, 20 hospitalists. In addition, emergency department physicians were asked to give earlier notification of hip fracture patients so medical evaluations can be initiated sooner.

"The medical management of the surgical patient is becoming a specialty field unto itself, and we relied on this research to form the basis of our hypothesis," says **Joseph Conte**, MPA, the organization's vice president of quality and risk management. "We did not know that it would be validated by the outcomes until they were measured over time."

There was considerable resistance from attending surgeons who didn't like having to ask a privileged physician to do preoperative assessments for their patients, Conte says. "The JCAHO medical staff standards do call for privileges to be defined in the department the practice is going to be delivered, so this was the underpinning for the authority we needed to go forward," he says.

Resistance was addressed by making it clear that patient safety was at stake and offering all medical staff who previously did preoperative clearance for hip fracture patients the opportunity to apply for preoperative assessment privileges.

"This was contingent on them taking the continuing medical education class, either internally or externally at an approved center, agreeing to proceed with the evaluation within 12 hours, and most importantly, that they continue monitoring the patient postoperatively throughout the stay," Conte adds. A four-hour evidence-based graduate medical education program was developed and offered to the medical staff so they could become privileged, with approximately 55 of 400 eligible physicians choosing to pursue it.

Outcomes data were shared showing marked improvements, which motivated orthopedic surgeons to become advocates for the new process.

"They saw immediate benefits to their patients. They began using the new approach for assessment on all their patients age 65 and older having any kind of surgery, even though it was not

required. This was very powerful," Conte says. The dual effect of reduced mortality and improved continuum of care overcame any remaining resistance within months, he adds.

Over the next three years, mortality rates for high-risk patients undergoing hip fracture repairs decreased nearly 80% — from 4.9% down to 1%. "The first year, it was reduced to 2.7% and the second year was the same. But the third year was a breakthrough year, with 1% mortality for over 200 patients, and so far we have held at that same level," Conte explains.

The impressive results resulted in the organization receiving both JCAHO's Ernest A. Codman Award, which recognizes excellence in the use of outcomes measurement to achieve improvements in the quality and safety of health care, and the New York State Hospital Association's Pinnacle Award for Quality Improvement.

The project has led to a credentialing revision for all categories of preoperative assessment for in-house surgical patients, Conte reports. "This process is being phased in starting with high-risk procedures in June of this year," he says. Since nearly 25% of patients die within one year of a hip fracture, the organization now is looking at post-op mortality for hip fracture patients following discharge. "We have developed a protocol that will follow patients post-discharge through a home visit program, including medical and physical therapy follow-up," he reports.

The organization's root-cause analysis was the key factor in identifying areas for improvement, Conte adds. "We were able to dig down into issues related to competency training and variance and what happened in previous cases, which is not something generally done in morbidity and mortality review, when you are looking at an individual practitioner," he explains.

However, root-cause analysis only is effective when there is no preconceived notion at the initiation of the process, Conte notes. "Often, organizations go through the motions and back into a preconceived solution that is not a proximate cause of the event. If you do not make the hard decisions about competency, training, and performance, the process will not be fully effective."

Blaming an individual for inadequate performance does little to prevent recurrence, when in fact the underlying issues are often systematic and rooted in long-held practices that are difficult to change, both operationally and politically, Conte adds. "Using evidence-based medical information often satisfies the physician's need for a scientific basis for change and improvement," he says.

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CE objectives

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

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- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions.

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