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JCAHO's 2006 National Patient Safety Goals: Handoffs are biggest challenge

Surveyors will zero in on the way caregivers communicate

Is your organization still struggling to comply with the Joint Commission's existing National Patient Safety Goals? If so, you may be bracing yourself at the thought of additional requirements, while at the same time, recognizing the need to address high-risk areas. With its new 2006 goals, the Joint Commission apparently struck the right balance, according to quality professionals interviewed by *Hospital Peer Review*.

"I think they added what was needed and pushed us where we needed to be pushed. But they weren't unreasonable — they were sensitive to the requirements and how difficult it is," says **Kim Shields**, RN, clinical systems safety specialist at Abington (PA) Memorial Hospital.

The Joint Commission decided not to increase the total number of requirements from 2005 to 2006, with no more than two new requirements added, says **Richard J. Croteau**, MD, JCAHO's executive director for strategic initiatives. "We made a decision early on in the process to limit the number of new requirements," he says. "It's a matter of keeping the focus on those areas considered to be most important. We believe very strongly that we can accomplish more by focusing on a small number of expectations than by flooding the field and trying to do everything at once."

Two goals were retired, including the goal regarding free-flow protection on all general-use and patient-controlled analgesia intravenous pumps, as well as the requirement to assess and periodically reassess each patient's risk for falling and address identified risks.

"Although they are retiring two goals, they still require maintenance to ensure continued compliance with the processes established in previous years," says **Mary M. Owen**, RN, MPA, director of outcomes case management at University of California, Irvine Medical Center in Orange.

Compliance with the retired goals still is necessary, since the requirements are incorporated or implied in existing standards. "So they didn't really go away, but it was nice to see the list not keep growing and growing," says **Missi Halvorsen**, RN, BSN, senior consultant for JCAHO/regulatory accreditation at Baptist Health in Jacksonville, FL.

JCAHO's focus on patient safety has changed the landscape of performance improvement in health care dramatically, Owen says. "It has scripted organizations on their quality work plans for the year. But in that change,

it may disempower organizations to identify internal opportunities for improvement without adding additional manpower resources."

With the cost of health care increasing at the bedside, whether from nursing ratios or technology advancements, resources for performance improvement are lower priority, Owen explains. "A complex paradigm shift is occurring. We need to ensure the shift is balanced so that these excellent patient safety initiatives are effective and not a landslide," she adds.

Here are the new requirements for 2006, with strategies for each:

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Editorial Questions

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- **Implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions.**

This goal was "right on the money," Shields says. "I think we all hated to see it because it is a difficult fix. When we start looking at this, we will recognize that the problem is even bigger than we thought it was. Everybody just needs to take a deep breath and understand that whatever process may be in place, anything we do is an improvement from what we are already doing."

Misinformation or ineffective communication at handoff points is one of the most common causes of adverse events, Croteau warns. "Two-thirds of all of our sentinel events are related to breakdowns in communication, and most of that is at handoffs," he says.

Every organization will have to take an in-depth look at handoffs and how to improve communication, Halvorsen emphasizes. "I'm glad to see this one — this has always been something that's been a concern, and we could all do better. This is really a very, very dangerous process in a patient's care, and it's extremely important that we do it right."

The challenge for organizations will be designing the right infrastructures to support the needed actions, says **Christine Macaulay**, RN, MSN, CEN, a Philadelphia-based consultant specializing in accreditation compliance and health care quality.

"Communication handoffs have been a challenge in all my 20-plus years experience," she says. "Getting point-of-care staff to assume leadership in patient safety is easy. But without formal mechanisms in a blame-free environment — one that focuses on process rather than finger pointing — the outcomes may not be realized."

Surveyors will want to see that your organization has a defined process for how information will be communicated. You'll need to identify which handoffs to address — which typically will include nursing change of shift and physicians going off duty and transferring responsibility to another physician — and determine what information needs to be communicated.

"In addition to having a defined process that addresses those things, we will want to know that those expectations have been communicated to all the staff who are involved in handing off, and through direct observation and interviews, determine that this is actually being done consistently, which is the most important piece," adds Croteau.

Whenever a patient moves from one area to another and new caregivers are involved, there is an expectation of transferred information, and if something isn't clear, you need a system to ensure it can be clarified immediately.

That will call into question the practice of making audiotapes of change-of-shift reports for nursing staff, which commonly is done at many organizations. "That will not be an acceptable way of meeting this requirement," Croteau explains. "If the nurses have any questions, and they often do, they either make their best guess or call nurses from the previous shift at home, which they're often reluctant to do."

Real-time communication

Face-to-face communication is ideal; if this is not possible, real-time communication also can be done over the telephone, he says. "This really isn't about written communication, it's more of a real-time communication, because we're taking care of patients in real time," Croteau stresses.

Patients are put at risk during busy periods and changes of shift when caregivers don't take the time to ensure a safe transfer process, adds Halvorsen.

"I've always felt it was best to have a face-to-face approach to transfers and discharges. When we are at a high census or extremely busy, the use of transfer sheets with written information is probably not the safest way to communicate," she explains. Transfer and discharge forms should include an opportunity to ask questions face to face, and if that's not possible, then a telephone conversation should take place. "We often get in a hurry and rely on written communications — but if I'm on the receiving end and don't understand something they wrote, I should be able to follow up and ask questions."

Make sure that forms are conducive to communication about the care of the patient, Halvorsen explains. "We had to do the same thing for medication reconciliation, so this goes hand in hand with that. We are currently reviewing all of our transfer and discharge forms and making necessary changes, including adding appropriate prompts for information gathering."

With JCAHO and other quality agencies requiring ongoing monitoring of many indicators, facilities have been pressed to add extra staff, especially since a lot of the monitoring has to be done manually. "To monitor this particular process would require observation of transfers and discharges, or retrospective data collection on forms, both of which requires more staff," she notes.

Electronic records are one solution to the handoff requirement, but the cost and implementation of a software program to support communication can be a major barrier. In addition, few software vendors can meet the needs of all the different venues in the communication loop such as the physician office, home care, satellite care center, hospitals, long-term care, and rehabilitation centers, Macaulay says. "Many health care systems are going down the road to full computerization but are still in the half-electronic and half-paper system," she says.

Create a checklist noting information that should be exchanged during a handoff, including the reason for handoff (such as following a procedure or test, prior to a procedure or test, or movement of patient from one unit to another), condition of patient, any complications, and the time and place of the handoff, recommends **Kathleen A. Catalano**, RN, JD, director of regulatory compliance services for Dallas-based PHNS Inc. "The quality manager is going to need to monitor the effectiveness of any mechanism put into place," she adds.

Abington Memorial currently is implementing an electronic medical record for orders and lab test results, but nurses are not yet documenting electronically, Shields says. "Physicians can access the information from inside or outside the hospital, which certainly helps, but it doesn't address the problem of when patients are outside of the institution."

Computerized discharge instructions are being developed so information can be printed out for laypeople or using medical terminology, depending on whether the patient is being discharged to home or a nursing home, with copies sent to the patient's primary physician or specialist. "That is one way we are going to improve communication on the discharge end," she continues.

However, in smaller hospitals, a paper system can work very well, as long as everyone documents in a single place, Shields says. "Organizations shouldn't be discouraged just because they don't have an electronic system. A good paper system, with everybody using the same tool, can be very effective," she says. "No one has the time to look at other places, and that's how we tend to miss things."

A medication reconciliation sheet is being developed so clinical professionals can document on a single form. "Right now, nurses and doctors document the patient's medication history on

separate forms. Physicians may be unaware of additional medications the patient told the nurse about, if they do not reference the nurse's medical history list," Shields says.

The goal's requirements are very broad, since handoffs occur so frequently in the organization as patients move through the continuum of care.

"It doesn't have to be transferring the patient from one hospital to another, or a different level of care of service; it could be something such as the patient going for a procedure or test," Halvorsen says. "It's important to talk to people down there and give them a report on the patient. There has to be communication between care providers anytime there is a handoff in providing care."

For example, lab results may fall through the cracks when patients are going from the inpatient to outpatient setting. "Lab or radiology test results not documented on the patient's chart prior to discharge may fall into a black hole where no one ever follows up on the results, because the outpatient physician is unaware that the tests were ordered," Shields notes.

To address this, at Abington, instructions were added to the discharge sheet stating, "Make sure that all lab tests and radiology results have been reviewed prior to discharge. If not, make sure you let the doctor know there are test results pending."

Set up discharge instruction sheets in a checklist format, Shields recommends. "Some organizations have generic discharge instruction sheets with a lot of space for narrative notes, but without a checklist, you may forget to address important discharge instructions," she says.

Ensure information is shared with all the physicians involved in the patient's care, Shields advises.

"We have to make sure that handoffs aren't going to just one doctor. If you have electronic records, make sure everybody involved gets a copy of the discharge instructions. If you have a paper system, set up a faxing system to make sure discharge instructions go to all doctors involved in the patient's care. Again, you don't have to have an electronic system to make this doable," she underscores. "When the patient is discharged, the unit secretary can fax it to all the doctors involved. It is more work, but it certainly is worth it."

- **Label all medications, medication containers, or other solutions on and off the sterile field in perioperative and other procedural settings.**

"What we're looking for is pretty simple — we're looking for labels on all medications, period," Croteau says.

Even though JCAHO's standards already include a requirement that all medications should be labeled, there has been a longstanding practice in surgery to have medications available for anesthesia without labeling them, he notes.

"Unfortunately, we've had some horrendous adverse events, including children dying, as a result of injecting something someone thought to be a medication and turned out to be cleaning fluid or another substance, simply because it was there and wasn't labeled," Croteau adds.

Anesthesiologists often will draw up medications to be administered during surgery, and there may be two or three unlabeled syringes that can get mixed up, he says.

"We put it into the safety goals to call attention to this and put a spotlight on it. We will be surveying it more intensely, specifically for surgically invasive procedures," Croteau says, adding that surveyors will use direct observation and interview staff to determine compliance.

"The medication labeling goal is already in effect within our organization and was a point of emphasis during our accreditation survey last year," Owen says. "Anesthesia has been the key to this improvement."

When medication labeling was addressed at Baptist Health, anesthesiologists were resistant at first, Halvorsen explains. "That was a real culture shift for them; they set up the same field every time they do a case, and that's when errors are made," she says. "We identified a few anesthesiologist champions for change to address this in anesthesia departmental meetings."

There is no system fix to assure that medications aren't labeled incorrectly — you have to rely on the practitioners to do the right thing, Shields says. "If we were doing the right thing all along, this wouldn't have to be a goal," she adds. "Most importantly, this involves leadership buy-in. It has to start at the top, and there has to be zero tolerance for not doing it. Otherwise, people will go back to their old ways."

Practitioners don't start out with the mindset that they are going to make an error. In their minds, they feel their method of preparing medications is safe, Shields notes. "They feel they are so busy and this is one additional thing to do," she says. "But there continue to be reports of medication mix-ups, with patients getting the wrong medication."

The best way to educate staff is through stories about adverse outcomes that occurred at your organization because of mislabeled medications, Shields adds. "That really brings it home without

making it seem punitive. Staff have to understand that not only is it the right thing to do, but now we're required by an outside regulatory body to be compliant."

A cultural change in behavior is needed, she emphasizes. "It's not just educate and forget. You need tracking mechanisms and metrics to measure improvement. Studies show that it takes anywhere from 12 to 18 months for behavioral culture changes to occur in an organization. You can't just throw it on there as the flavor of the month and move on to another project."

To monitor improvement requires direct observation of cases, Shields says. "You hate to use the word policing, but someone needs to go through ORs or procedural units to observe staff compliance with labeling syringes before procedures," she advises. "Pick one day a week when you go through five or six units. To look at the entire house would be too overwhelming, so start small, do a sample, and that's your baseline. The most important thing is to give feedback to the practitioners."

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Make your next mock tracer more effective

Tracers can make or break your next survey

Mock patient tracers probably are a key aspect of preparedness for unannounced JCAHO surveys at your organizations. But do yours really identify problem areas and help to prepare nervous or uninformed staff members?

Staff preparedness at Baptist Health in Jacksonville, FL, has improved dramatically as a result of mock tracers, reports **Missi Halvorsen**, RN, BSN, senior consultant for JCAHO/regulatory accreditation. "The more frequently you do them, the less anxious they will be during a real survey," she says. "I start off by telling staff, 'You can't have a wrong answer; maybe there is a better answer, but we are here to help you.'"

Continual tracers make staff far more comfortable answering questions about processes and the care they deliver, says **Wendy H. Solberg**, CHE, director of quality resources at Gwinnett Hospital System in Lawrenceville, GA.

"The process also allows our leadership team to get a 'real' sense of how we are doing with continual compliance," she says. "We are able to interact with staff and communicate with those delivering the care."

Patient tracers are done weekly, with smaller, more focused tracers being conducted on a unit level, such as tracing a congestive heart failure patient through his or her stay. "The concept has really been found to keep a handle on compliance as well as monitoring the care delivered to our patients every day," Solberg explains.

During a recent unannounced JCAHO survey at Long Island Jewish Medical Center in New Hyde Park, NY, mock surveys proved invaluable, says **Kerri Anne Scanlon**, RN, MSN, ANP, associate executive director of quality management. "By the time the JCAHO got here, no one was frightened to speak to them," she adds. "The staff actually came looking for the surveyors and came right up and welcomed them to their units."

"The primary nurses really knew their patients, and we didn't have one nursing care-related issue," Scanlon reports. "I credit that to the tracers we've been doing. The staff felt so comfortable because they had been doing this in front of us for so long."

To make the most of mock surveys, do the following:

- **Do system tracers.**

System tracers routinely are done with Baptist Health's leadership, including infection control and competency assessment, Halvorsen says.

"They need practice just like staff do," she says. "If the surveyor identifies an issue during the system tracer, they can follow up with a patient tracer activity to assess the impact of the process deficiency on patients and staff."

For example, if the surveyor has a concern about infection surveillance or prevention activities, the surveyor might ask to do a tracer on a patient diagnosed with a community-acquired infection.

- **Focus on hot topics during tracers.**

At Tifton (GA) Regional Medical Center, an

employee handbook lists "hot point" JCAHO questions, and provides information on failure mode and effect analysis (FMEA) and the status of current patient safety initiatives, says **Angie King**, BSN, CPHQ, CPHRM, quality management director. "This is given to all employees in orientation and is updated approximately every six months," she says.

The JCAHO hot points are then covered during mock tracers, including life safety code compliance, the "first-dose" requirement, patient identification, timeout procedures, and strategies implemented as a result of FMEAs. "The confidence of the staff was evident in their ease with survey questions, chart review knowledge, and familiarity with patient issues," King says. "Staff who were previously afraid of making a mistake or blanking out are now more confident."

Solberg refers to a master list of areas that need to be covered during patient tracers, with patients picked randomly once the "surveyors" arrive on the floor, focusing on patients with complicated care and/or high-risk conditions or procedures, such as inpatients receiving chemotherapy.

- **Conduct tracers on the unit level as well as organizationwide.**

At Gwinnett Hospital System, each member of the 17-member leadership council must conduct at least one tracer monthly, with almost all departments visited within a year. "In addition, our leadership council members have passed on this expectation to managers of various units," Solberg explains. "The managers of the units can do tracers to better refine their processes internally and be more prepared for when we come through."

The importance of the tracers at a unit level is that the staff and the unit managers are more involved and use the tracer methodology as a continual improvement tool, she says. "The widespread use also has allowed staff to be a lot more comfortable when the blue suits come around to do their tracers."

Topics are based on a number of elements that need improvement or reinforcement, gleaned from open medical record audits, patient safety rounds, or the needs of the specific unit.

For example, one unit has focused on core measure data, with a tracer conducted for congestive heart failure and pneumonia patients; and a surgical unit has focused on looking at consents prior to procedures to be sure that they are complete, as well as other typical surgical tracer elements such as history and physical.

"We are able to give but also receive great feedback," Solberg notes. "On a recent tracer, a nurse on our orthopedic floor was questioned on cultural diversity and mentioned that we needed a vegetarian liquid diet on the menu for ordering. We are working to print new menus as we speak and to get this into the system. So the road does go two ways."

At Long Island Jewish, quality managers and nurse and physician leaders all are involved in mock tracers, Scanlon says. "About a year and a half ago, we put in a very different approach, with myself, the nurse executive, and the medical directors doing tracers and rounds on every patient care unit," she adds. Every week, a different area is chosen to focus on, such as the National Patient Safety Goals, emergency department throughput, open medical records, and communication.

- **Address problems identified during tracers.**

An effective communication structure is key to ensuring that, once identified, problem areas actually are addressed, Scanlon says. The organization's "captains" responsible for each of the JCAHO standards follow up on any issues identified during tracers and mock surveys. These issues also are addressed in administrative leadership meetings with directors and at a weekly senior leadership meeting.

At Gwinnett, data captured from mock tracers are used to identify potential areas for improvement, Solberg says. "We have had several processes that we have identified through this methodology and have seen a dramatic change of events," she reports.

For example, tracers revealed a need to improve nursing documentation of patient comorbidities, both active and nonactive. "Once this was identified, our nursing leadership was able to direct very specific education to our units, and we have seen a dramatic improvement," Solberg says.

Another issue that came to light during tracers involved case managers lacking enough space to adequately document the discharge plan, particularly for lengthy admissions. "As a result, we are working with our medical records committee to create a discharge planning tab and document that ties to our clinical pathways and provides ample room to communicate this type of information," she says.

While walking through a unit during a mock tracer, if you see medications sitting on a cart that aren't supposed to be accessible to the public or observe staff failing to follow hand-washing

(Continued on page 99)

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Project examines why patients don't take meds

New tool measures 'adherence intention'

A pilot project under way at Arnot Ogden Medical Center in Elmira, NY, is assessing how likely patients are to adhere to their prescribed medication regimen, with the ultimate goal of helping them to become more compliant, says **Tina Davis**, RN, MS, CNS, senior director of continuum of care.

The project is based on new guidelines issued in fall 2004 by the Case Management Society of America (CMSA), which the Little Rock, AR-based organization has described as "the first national evidence-based algorithm to assist case managers."

At Arnot Ogden, a student working toward a master's degree in social work is interviewing patients to determine where they fall on a grid that illustrates two categories: medication knowledge and understanding the importance of therapy, and willingness to change behavior, Davis explains. "We have this tool to help identify: Is it a motivation deficit, and why? What are the issues, so we can have a set of interventions to help patients?

"Patients can have different levels of adherence based on their motivation and knowledge — so someone can have a high knowledge level and a low motivation level," she says, or any other combination of low and high.

A patient who is assessed as being "low" in both motivation and knowledge, Davis adds, will be in Quadrant 1 of the grid, which shows the adherence intention is low. Someone whose knowledge is low and motivation high, is in Quadrant 2, which shows the adherence intention is variable, while one whose knowledge is high and motivation is low is in Quadrant 3, she says, which shows the adherence intention is variable.

"If the person is in Quadrant 4, the knowledge is high and the motivation is high, which shows the adherence intention is high," Davis notes.

The assessment can be done surprisingly quickly, she points out. "We've found that it takes about 15 to 30 minutes, which is not a lot of time. If [the result] will be increased adherence to the medication regimen, it will be time well spent."

The pilot project began the first week of April 2005 and is to continue through August 2005, involving the patients on one nursing unit, Davis says. Those who have just had surgery or who are confused, are excluded, she adds. "Confused people won't provide good data."

Davis says she is very excited at the potential — through use of the CMSA tool — for being able to "put our arms around" an issue with which clinicians have struggled for years.

One of the challenges, she points out, has been that — without the advantage of an evaluation tool — nurses and case managers may not have realized a particular patient would have a problem with medication compliance. "The person might look as if he or she would be adherent.

"Medications are one of the most difficult things to deal with for our patients," she adds. "I think it's going to give us excellent information as nurses to intervene and improve adherence, to be able to identify the actual problems — what we need to help the patient with."

So far, Davis notes, patients interviewed at Arnot Ogden have fallen into all of the quadrants except Quadrant 3, the one that indicates a high

level of knowledge with low motivation. "We're waiting to see if that's a pattern as we continue to evaluate patients."

In addition to the tools needed to evaluate patient adherence, the algorithm developed by CMSA includes guided interventions to help address patient adherence needs. Those suggested interventions, Davis says, include such strategies as patient reminder systems and referrals to home health agencies, which can provide staff to help patients with their medications.

One recommendation, she adds, is to educate patients on the consequences of not adhering to the medication regimen, and to use the "teach-back" method of asking the person to repeat the instructions he or she has been given.

"There can be specific interventions for specific quadrants," Davis notes. "We're not trying to educate the person on everything. If they've scored in a particular quadrant, we know that's where the potential problems are and the interventions to put into place based on the assessment of adherence intention."

The next step for Arnot Ogden, she says, is the meeting of an interdisciplinary team to determine, based on patient scores, the interventions that will be put in place, not only in the hospital, but after the person has been discharged and is back in the community.

That team, Davis adds, will include social workers, case managers, the senior director of nursing, a unit director, staff nurses, and the vice president of medical affairs.

Among other things, she says, the team will look at how to continue the program after the social work student leaves, and at creating a letter that will be sent to physicians as a communication tool to inform them of patients' adherence intention. The idea, Davis adds, is that education efforts can continue in the physician's office.

A potential strategy could be to use the hospital's telephonic nursing program to assist patients who need help with medication adherence, she says. "The referral would come from the inpatient case manager, who would — based on the adherence score — refer the patient to the telephonic program, which would follow up with a designed intervention once the person is home," Davis notes.

The Case Management Adherence Guidelines, known as CMAG-1 because updates are planned on a regular basis, were developed when CMSA created the Council for Case Management Accountability to identify outcomes that should be measured in case management regardless of setting, explains **Sherry Aliotta**, RN, BSN, CCM, president of CMSA. "We did a bit of survey and research with our stakeholders — about 150 different organizations representing the health care field," she says.

"Those groups, which included the American Medical Association, the American Hospital Association, and the Joint Commission for the Accreditation of Healthcare Organizations, came up with three things as being the most important outcomes to measure — adherence, coordination of care, and patient empowerment and involvement," Aliotta continues.

At the behest of CMSA, nurses researched the literature on these concepts "to see if we could have any impact on them," she says, "and with adherence, we saw the strongest link. We could measure, we could predict, we could impact, and there was a cost benefit. So we could improve quality of care, cost of care, and patient health status."

Working with a grant from Pfizer, the international pharmaceutical company, Aliotta says, the CMSA researchers identified tools that could help predict the likelihood of adherence — "adherence intention" — to whatever course of treatment was prescribed.

The CMSA model was based on a white paper by the World Health Organization, which outlined "the key factors to be in place to make lasting behavior change," she continues.

"We identified tools that would address each area — education, behavior skills, and motivation — and packaged them into what is now known as CMAG-1," Aliotta explains.

The organization will be working in the fall of 2005 on CMAG-2, she notes, "which will be enhanced with what we've learned from the application of guidelines and newly identified tools and will be more in-depth in certain focuses."

The tool is free and available for download to anyone who is interested. During the first two months after it was introduced in October 2004, there were 22,000 hits on the web site where the information is offered, she says.

Shortly afterward, CMSA began offering half-day training sessions on the guidelines exclusively to its membership, Aliotta says. "We did 39 workshops around the country that were very well attended and received good feedback."

These classes, she adds, eventually will be available to nonmembers.

Another benefit that at present is limited to

CMSA members is the CMAG Tracker, a web site created to support the new tool that is both an on-line version of the guidelines and a place where data can be recorded and aggregated to look at results, Aliotta explains. "It is a database of assessments and interventions that have been done," she adds.

"It is only through actually documenting results that we will have usable outcomes," Aliotta points out, "so it is important for as many CMSA members as possible to investigate this and if possible participate in research. One person said the situation reminded her of the story of the Little Red Hen — everyone wants a piece of bread, but no one wants to do the work. I encourage people to participate."

Future plans include train-the-trainer sessions, whereby those who have been trained as users can sign up to learn how to be trainers, she explains.

Meanwhile, the organization has a research project under way to evaluate the impact of the CMAG-1 that is open to any case manager who wants to participate, Aliotta says, adding that she and CMSA president-elect Susan Rodgers are co-principal investigators for the project.

'A three-legged stool'

Elaborating on the content of the guidelines, Aliotta says that if one thinks of adherence as a three-legged stool, those legs are:

- **Education/knowledge.**

This would include such information as the benefits of any therapy that is prescribed and why it's important to take a certain medication at the same time each day, or to take it with food, she notes. "If you don't understand why [instructions] are important, it's less likely you will carry them out."

- **Motivation.**

This has to do with discovering if a patient has ambivalence about taking his or her medication, and if so, the reason behind it, Aliotta says. "Mine might be thinking it will make me feel bad, and yours might be that it cost $300 a day."

- **Behavioral skills.**

An example here would be placing the medication where you can see it and remember to take it, she notes.

A technique called "motivational interviewing" is a key skill to master for those using the CMSA algorithm, Aliotta says. Motivational interviewing is described on the CMSA web site as a directive, patient-centered method that requires an atmosphere of collaboration between case manager and patient to identify mutually agreeable goals.

In this model, the case manager spends less time giving advice and more time asking questions and providing information requested by the patient.

"It's different than the typical biomedical interaction that people are used to having, but necessary to help [patients] discover their own internal motivation to change," Aliotta notes.

Davis points out that medication administration, particularly how patients will continue their medication regimens at home, is one of the hot topics of the Joint Commission and that the tool may help address that issue. "If we understand how to affect nonadherence with specific interventions, we may succeed in preventing a number of medication errors," she adds.

"By evaluating all patients and taking a proactive approach, we can address these problems up front, instead of waiting for the patient to come back and finding out after the second or third admission that [medication adherence] is the issue," Davis says. "We're looking forward to being able to roll this out, and possibly give feedback to CMSA about how it works in the field."

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Solutions often found in existing technology

Interdepartmental collaboration key

Collaboration between key hospital departments is crucial to making sure discharge planning starts at the earliest possible point in the patient encounter, and the latest advances in technology certainly can facilitate the necessary interdepartmental communication.

However, there also is much to be said for devising innovative ways to use a hospital's existing technology, says **Katherine H. Murphy**, CHAM,

patient access coordinator for Nebo Systems, an Oakbrook Terrace, IL-based company that specializes in real-time electronic data processing for the health care industry.

"Verifying benefits accurately and in a timely manner is critical to maximizing discharge planning," she says, "as is communicating this information and creating a path of communication among the departments that interface with patient access — medical records and utilization management [UM] . Sometimes, there is a disconnect."

Using symbols

It's important, notes Murphy, a former hospital patient access director, "to take a look and say, 'How can we get our information to the next step in the quickest way?'

"One of the things we created at one of the hospitals where I was access director was an in-house census report that showed financial status," she adds. Prior to that innovation, Murphy notes, "[other departments] would know the patient was there but wouldn't know anything had been done. So we added a column to show that precert had been done."

In another instance underscoring the importance of communication between systems, she points out, access personnel made the initial call notifying the insurance company that the patient had been admitted and took the precert reference number. "Sometimes a patient's account required clinical information and then a handoff," Murphy says, "and communicating that efficiently was important."

The good news was that the departments involved had access to each other's systems, she adds, "so there was harmony there. Utilization management could access the hospital's admission/discharge/transfer [ADT] system, and financial counseling/verification staff could take a look at documentation in the UM system."

The question, Murphy says, became, "How do we best communicate? A lot of times there was a handoff from access to UM that said, 'Here is our preliminary precert number, but UM needs to call back with clinical information.'"

The challenge came when there was a discrepancy at some point, and comments like, "You never let me know that," or "No, I didn't get that voice mail" were traded back and forth, she adds. "Things fell through the cracks."

The solution that was devised through collaboration between access and UM, and with the help of the on-site information technology department, was simple, cost-effective, and made use of existing technology, Murphy explains.

"We created symbols to use in the registration system that would indicate the action that had been taken." Everyone had access to the definition for each symbol, so there was no room for the miscommunication that can occur when someone abbreviates words or uses other shortcuts in language," she adds.

"This was a matter of using the resources we had and creating our own little internal tool, so that there was not a lot of dialogue being keyed in that was subject to interpretation," Murphy points out.

For example, the pound (#) symbol indicated no precertification was required, she says, while the ampersand (&) meant precert was pending clinical information and the insurance company would call UM, or that the call had been transferred to UM. The dollar ($) sign meant precertification was pending clinical information and UM must call the insurance company.

"Using the symbols to communicate with UM allowed for consistency in the format of the message, accurate documentation, and accountability, since the message was stamped with date, time, and user identification," Murphy adds. "We all agreed on, 'Here's what it means; here's how we will use it,' and if something wasn't done, it was easier to pinpoint the breakdown."

For facilities in a position to implement the latest in technology solutions, she notes, there now is software that can interface with the registration system or on a stand-alone basis and will determine up front if patients are charity care or qualify for a financial assistance program.

"The software can determine that the patient qualifies for financial assistance and identify the appropriate [assistance] program," Murphy says. "At the beginning of the admission process, [the screen] is populated with information showing, 'Here's where we are with this patient.'"

That knowledge, when shared with discharge planners, can greatly enhance the efficiency and timeliness of the patient discharge and post-acute placement processes, she adds.

"Certainly, when your patient is being transferred to a different level of care, it's extremely important that you know where they stand financially," Murphy points out. "All of these front-end processes can shorten the discharge process and, potentially, the unnecessary delays that increase length of stay." ■

(Continued from page 94)

procedures, have staff address that immediately, Halvorsen advises.

The goal is to change staff behavior to improve patient care, she stresses. "I tell staff that we don't use alcohol foam because it's a JCAHO standard. We do what we do because we want to protect our patients from infection," she says.

- **Connect patient tracers with process improvement activities.**

In some organizations, there is a disconnect between tracer activity and clinical process improvement activities, notes **Janet A. Brown**, RN, BSN, BA, CPHQ, FNAHQ, president of Pasadena, CA-based JB Quality Solutions. Costly activities initiated to comply with accreditation requirements may involve the quality department but often are structured separately from other quality activities, she explains.

"With tracers, we are once again creating a compliance process that may be separate from, and in addition to, the other ongoing quality methods we use, such as performance measures, data collection and analysis, improvement teams, and monitoring effectiveness," Brown adds.

Tracers must have a purposeful, direct link to performance improvement, she emphasizes. "I assume most quality departments are receiving the tracer data and can aggregate it to look for needed process improvements. But if process is not the focus, then we may tend to fall back to looking at *who* was responsible for a problem, or go for a short-term fix, rather than seek *how* to improve the process for the long term," Brown points out.

She recommends utilizing tracers as one way to monitor effectiveness of a change whenever improvements are made to any clinical process, with relevant performance measures incorporated into the tracer review. "Looking at patient flow through the processes of care is a great way to monitor. I envision a tracer that checks against applicable standards but includes measures for the way things are supposed to flow, coordinating applicable clinical practice guidelines, known best practices, and the results of relevant root cause analyses, FMEAs, and other team quality improvements," Brown says.

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ACCREDITATION
Field Report

Patient flow, life safety code key topics for survey

Unannounced survey is 'intense,' detail-oriented

JCAHO surveyors covered far more ground during a five-day unannounced survey at North Shore-Long Island Jewish Medical Center in New Hyde Park, NY, than accreditation inspectors had done in previous years, reports **Kerri Anne Scanlon**, RN, MSN, ANP, associate executive director of quality management.

"One thing was very clear: If you're not practicing continued survey readiness every day, you're not going to do well in this process," she warns. "The surveyors this time around were such seasoned professionals. They were not punitive but were extremely detail-oriented. This is a very intense process — this was a tough survey."

Surveyors were impressed with patient-focused activities held by the organization for National Patient Safety Week. "We did something different this year, by engaging patients and visitors in patient safety," Scanlon says. A table in each lobby featured a raffle with children's booster seats as prizes, asking the general public for ideas on how to improve safety at the hospital.

In addition, alcohol-free hand-washing gels,

information about the Joint Commission's "Speak Up" initiative, and educational materials on medication management were distributed.

Here are key areas of focus during the survey:

- **Medication management.**

In all patient care areas, surveyors closely observed how staff administered medications and looked to see if staff were washing hands and complying with infection control standards.

- **Patient flow.**

"When they did our Data Use interview, they commented that they loved our indicators and what we were looking at," Scanlon says.

Surveyors liked that the organization wasn't just tracking patient length of stay and the time it takes to get to a bed, but also was looking at clinical indicators that affect patient throughput, such as lab or radiology turnaround.

"When you do tracers, most patients come from the ED [emergency department], so the ED got reviewed more than any other unit in the hospital," she explains. "They were very interested to see how we provided the same level of care for patients waiting for a bed as we would on a floor," Scanlon says. To address this, inpatient and behavioral health nurses were hired to care for admitted patients being held in the ED.

"We also put in two Six Sigma projects to enhance throughput in the ED with good results, so we were able to identify things that were impinging on moving patients through the ED," she says. "This has been a big priority for our institution. They were very pleased with what we've done for throughput. They also liked the fact that we measure those statistics monthly and that they are reported into our performance improvement program."

Depending on the ED's volume, green, yellow, and red zones are used to trigger specific interventions to speed throughput. "They loved that — but anything you show them, they want to see how it works," Scanlon explains. "We were able to demonstrate how we provide the same level of care for patients and move them expeditiously through the house."

Surveyors now expect to see patients in hallways, but they want to see that you are doing something to ensure safe care. The organization added a cardiac short stay unit to move telemetry and cardiac interventional patients out of the ED, hired an ED case manager to improve throughput, and hired physician assistants in the ED to provide better care for department of medicine patients waiting for inpatient beds to become available.

- **Environment of care (EC).**

The EC review was much more in-depth than for previous surveys, says Scanlon. The survey team's engineer looked at life safety code issues for a full day, but even after that, the EC review was not over, she says. "The administrator surveyor did our two other buildings the second and third day, so we had a three-day EC review, and he also did our EC interview," she notes. "They focused very heavily on infection control and general life safety, fire doors, how we respond in emergencies and disasters, how we chose our drills, and how we responded to them. Almost every unit was asked about life safety code, and it wasn't just nurses — it was any staff member."

The safety and engineering department collaborated with nursing units to do weekly EC rounds, which prepared staff to answer those questions, Scanlon explains. During the EC interview sessions on the final day of the survey, one of the surveyors shared best practices they had seen nationally.

"They also told us that we should share the results of our FMEA on how to reduce the potential for blood transfusion-related errors with a patient identification process," she reports.

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Medical liability policy focuses on patient safety

A new public policy report from the Joint Commission argues that the nation's medical liability crisis puts patients at risk by discouraging reporting of adverse events and undermines learning opportunities for safety improvements.

In *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury*, JCAHO urges hospitals to pursue system changes that truly facilitate improvements in patient safety, encourage open communication between patients and practitioners, and strengthen oversight and accountability mechanisms to ensure competency for physicians and nurses.

Many organizations currently are working on

providing objective data to support physician privileges and nursing competencies, says **Frederick P. Meyerhoefer**, MD, a Canton, OH-based consultant specializing in JCAHO and regulatory compliance. "However, at many institutions this is still not yet a mature program that will support this expected oversight."

Quality managers often have difficulty providing such data, even as they assume an increasing importance in the organization, he says.

"It entails taking data analysis to the next level, derived from commonly used larger initiatives such as infection rates and focused performance improvement studies." This will involve a culture shift for many organizations that are not used to providing practitioner-specific data, Meyerhoefer explains. The problem is that many medical staff members still have difficulty accepting evidence-based competency data to support the continued granting of clinical privileges to the practitioner.

"Few hospitals, as yet, have provided the necessary data systems to support internally the initiatives suggested by JCAHO," he says. "Anything that strengthens this process will increase the safety and quality of care provided to the patient."

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THE QUALITY - CO$T CONNECTION

Know how to manage your near misses

Information can help improve process stability

By **Patrice Spath**, RHIT
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A near miss is an event that signals a weakness in the delivery of health care services. If the weakness is not identified and remedied, there could be significant consequences in the future.

Consider the following example: A patient is transferred to the intensive care unit after a particularly difficult surgery. The patient's original post-op orders, written immediately prior to the surgery, were not discontinued, but due to the unexpected intraoperative complications, additional orders were written for the intensive care unit admission.

An order for an oral medication at 30 mg was continued and an order for 50 mg of the same medication was added. The error was noted before either medication was given. Some organizations calls this type of event a "good catch." Whatever the terminology used to describe these events, one thing is clear: A good near-miss management program is essential to patient safety.

Information about near misses can provide a prospective opportunity to improve process stability and avert potentially catastrophic adverse events.

The benefit of having a good near-miss management program is clear. Near misses occur much more frequently than more serious patient incidents. They also are relatively simpler to analyze and easier to resolve. Usually each sentinel event can be linked to a number of near misses that happened earlier.

By addressing the small failures more effectively, the likelihood of a sentinel event is reduced. Just by involving staff in identifying near misses, the patient care environment is likely to be made safer.

Seek out information

Regardless of the type of near miss, information about the event has to be sought after actively. Identification of near misses is not always obvious, and many near misses probably occur that are never recognized as such. It is important for the organization to have a consistent definition and perception of the near-miss event among all levels.

Don't be too restrictive in the definition of a near miss. If the definition is narrow, the organization runs the risk of not gathering safety-related information simply because people don't believe that the observed situations are reportable events.

Disclosure must be quick and simple. Completion of long forms will discourage reporting. Though the follow-up investigation may require a more thorough analysis, a quick summary of the near miss generally suffices for the majority of events.

Remember, even if filling out the disclosure form is a quick process, if retrieving a report form involves going to another room or scrolling through a web site, disclosure rates will decrease. If there is only one method of reporting near misses, people may be discouraged from reporting. Although there is a move in many health care organizations toward intranet disclosure systems, some individuals may not be computer-savvy.

Disclosure must be encouraged through several means. However, most important is that staff members know their reports are acted on quickly by management and the information is used to make needed and long-lasting process improvements.

Follow to closure

It is imperative that health care organizations have a system to ensure that all action items that result from the analysis of a near miss are followed until closure. If safety goals are being met, the process is working. If attainable goals are not being met, other targeted interventions are developed. Information about the process and causes of action plan failure are used to discover the barriers and make plans to decrease them.

Not only is it important to ensure that problems are fully resolved, it is also essential to the success of the near-miss management initiative. If staff members perceive that near misses are not acted on, they will not disclose near-miss information in the future. It is important to track all action plans resulting from the process and communicate them to the staff.

That lets employees know that the near-miss management process is working, and it increases accountability and recognition of the people implementing the interventions. A simple report that lists all the action plans that have been initiated and their status can be posted. Everyone will see that a certain number of interventions have been completed successfully, some are under way and producing results, some are under revision, and some are on hold for a stated reason.

Near-miss database

In addition to management of individual near misses, systems must be in place to manage and monitor aggregate near-miss information.

Near misses provide insight into potential failure points within individual processes and also can highlight weaknesses in the management

CE *questions*

1. Which does the JCAHO's National Patient Safety Goal regarding communication for patient handoffs apply to?
   A. surgical procedures
   B. in-house transfers to other units.
   C. transfers to outside facilities
   D. all of the above
2. Which is recommended for organizations conducting mock patient tracers to prepare for JCAHO surveys?
   A. Avoid doing system tracers before surveys.
   B. Never address problems on the spot in front of unit staff.
   C. Always structure tracer activities separately from other quality activities.
   D. If problems are identified, fix them immediately when possible.
3. Which did surveyors state was in compliance with the JCAHO's patient flow standard during a recent survey at Long Island Jewish Medical Center?
   A. No patients should be held or cared for in hallways.
   B. Organizations should review clinical indicators that impact throughput
   C. A different level of care can be given to admitted patients held in the ED
   D. Only ED staff, not inpatient nurses, should care for admitted patients held in the ED.
4. Which is recommended by JCAHO regarding accountability mechanisms to ensure competency for doctors and nurses?
   A. Provide objective data to support physician privileges and nursing competencies.
   B. Make no changes in physician privileging.
   C. Have medical staff determine competency requirements without use of objective data.
   D. Granting clinical privileges should not be based on practitioner-specific data.

Answer Key: 1. D; 2. D; 3. B; 4. 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 December issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. ■

system itself. As new incidents are added to the database, the organization can learn more about the stability of processes and effectiveness of systems. For example, suppose that a similar near-miss event has occurred in the past.

Suppose further that the previous incident occurred in a different department and the investigation was closed. If, in fact, the analysis of the previous incident was thorough and the right interventions were implemented, this would lead to the suspicion that there may be problems with the dissemination step of the organization's near-miss management system.

Automated, computer-oriented information systems can greatly expedite management of near misses. It also is helpful to have some classification system to assist in the dissemination and processing of incidents.

Systematic collection and analysis of near-miss data should provide information that allows observation of patterns and trends over time. Such information is critical to reducing the frequency of future incidents.

A question that often arises in health care organizations is whether a large number of near misses is indicative of a safe or unsafe environment. It could be argued that a high number of incidents suggest unsafe situations.

However, simply the fact that near misses are *identified* suggests that employees are more safety-conscious and potential unsafe conditions are resolved proactively before a catastrophic event occurs. Hence, a large number of reported near misses are indicative of a safe health care delivery system.

If the organization's senior leaders or groups external to the organization suggest that a high number of identified near misses translates to a high rate of sentinel events, this is likely to suppress the disclosure of near misses, which in turn will increase the risk of catastrophic events.

The goal of the near-miss management program should be effective evaluation and resolution of unsafe conditions, not reducing the number of reported events.

Near-miss management can improve the quality and safety of health care services significantly by identifying and remedying precursors that signal the potential for a significant adverse event.

Staff member involvement in all steps of near-miss management must be encouraged. Near misses often are less obvious than sentinel events and tend to have little if any immediate impact on patients or processes.

Despite their limited impact, near misses provide valuable insight into potential accidents that could happen. To reduce the likelihood of future catastrophic patient incidents and further improve the safety of health care services, organizations need to strengthen their near-miss management activities. ■

Compare quality measures with 4,200 other hospitals

New web site facilitates benchmarking

A new web site launched by the Centers for Medicare & Medicaid Services (CMS) and the Hospital Quality Alliance allows you to compare 4200 hospitals across the country, even by individual departments within hospitals.

The web site Hospital Compare (www.hospitalcompare.hhs.gov) will be updated quarterly with data on heart attacks, heart failure, and pneumonia and reveals that the quality of care varies a great deal even within the walls of a single hospital, such as providing excellent care for pneumonia patients but falling short of the best care for heart attack patients.

The site gives quality managers a national benchmarking database to compare results against other hospitals and identify opportunities for improvement, explains **Nancy Foster**, vice president of quality and patient safety policy for the Washington, DC-based American Hospital Association.

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- What surveyors are asking about life safety code compliance
- How to respond when others question your data's accuracy
- Proven strategies for surgical infection core measure data
- New JCAHO requirements for culturally diverse populations
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"This is a way to identify other hospitals that excel, with which they might wish to consult, with practices that they would like to emulate," she says.

The site currently contains 17 quality measures, but more information soon will be added, including surgical infection prevention measures.

"As we move forward, we will be able to give quality managers comparative data on other aspects of hospital quality that they have not had easy access to before and will find extraordinarily helpful," Foster adds.

The hospital associations involved in the project are looking at ways to help their members improve quality, such as meetings and conference calls, and already have begun to publish information on strategies that high-scoring hospitals have implemented, Foster explains.

"We are not stopping just with the publication of data — we are actively seeking ways to effectively assist hospitals in their quality improvement efforts," she says.

In the coming months, the site will be posting data on patients' perceptions of care using the Hospital Consumer Assessment of Health Plans — HCAHPS — survey instrument developed by the Agency for Healthcare Research and Quality and CMS.

"In some aspects, this should be comparable to data that hospitals have gotten from their own patient survey vendors, but this will expand the number of participating hospitals across the nation," Foster says.

Using publicly reported quality data to compare hospitals hasn't really caught on yet with the general public, she acknowledges.

"There are not as big a number of consumers going to the web site as we would hope," Foster points out.

"But when data on patients' experience of care are posted, we expect that will attract more people to the site. That is more easily understood by people than measures of beta-blockers and aspirin, in terms of their own decision making," she adds.

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- *If you have suggestions for how to improve the Hospital Compare site, go to the American Hospital Association web site (www.aha.org.) Click on "Hospital Quality Alliance," "Contact Us."]* ■

CE objectives

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