



Increase accuracy in your organization before sharing surgical infection data

Prevent inaccurate data with work 'on the front end'

(Editor's note: This is the first of a two-part series on surgical infection prevention. This month, we address ways to improve core measure data. Next month, quality leaders share strategies to reduce surgical infections.)

If your organization was found to have a high rate of surgical infections, you could expect to face bad publicity, potential malpractice lawsuits, and major problems with the Joint Commission. But are the data telling an accurate story?

In July 2004, the Joint Commission, the Centers for Medicare & Medicaid Services (CMS), and the Hospital Quality Alliance introduced a standardized set of surgical infection prevention (SIP) measures designed to help hospitals continually assess and decrease surgical infections.

Several pay-for-performance programs now are giving payment incentives for lower surgical infection rates. These include the CMS/Premier Hospital Quality Incentive demonstration project and also some programs in the private sector.

"Pay-for-performance creates incentives to achieve high rates of performance on all of the quality indicators that are part of the demonstration projects," says Dale W. Bratzler, DO, MPH, principal clinical coordinator for the Oklahoma Foundation for Medical Quality, based in Oklahoma City, and immediate past president of the American Health Quality Association. "These demonstrations have also brought close scrutiny to the specifications of each performance measure."

To ensure your organization's core measure data include only infections actually acquired during surgical procedures, take the time upfront to identify whether there was a diagnosis of a potential infection at the time the patient came into the hospital, or if the infection was developing during the hospitalization but prior to the surgical procedure, recommends Frank Zibrat, JCAHO's associate director of ORYX implementation.

"If it was not an infection acquired from the surgical procedure, you need to exclude those to get valid data," he underscores.

"We don't want hospital staff held accountable for something they had no control over as it relates to the surgical procedure," Zibrat points out. "That has the potential for making an organization look worse than

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they might otherwise look.”

Surveyors will want to see that you have determined whether infections were acquired before or after the patient was admitted, says **Darlene Christiansen**, director of JCAHO’s standards interpretation and office of quality monitoring.

“The surveyors will look globally across the continuum about where that infection initiated from and what the follow-up analysis was,” she explains.

The Joint Commission currently is working with third-party vendors that provide patient-level data,

asking them to perform interrater reliability analysis to make sure the data collected by the organization are valid.

“In fact, we are going to be asking them to submit to us the results of the data reliability analysis, because we want to be assured that the data are accurate,” says Zibrat.

SIP key focus during JCAHO surveys

There is increasing demand from consumer organizations for more transparency in health care, and surgical infections are a key focus.

“Some are calling for public accountability for infection rates. Others are promoting transparency related to the processes of care shown to reduce infections,” Bratzler says.

The Hospital Quality Alliance has called for voluntary public reporting of the three SIP performance measures starting later this year: Prophylactic antibiotic administered within one hour of incision, discontinuation of antibiotics within 24 hours, and whether the agent used was consistent with published guidelines.

Surgical-site infections are the second-most common cause of hospital-associated infections, according to the Centers for Disease Control and Prevention, and are a major cause of mortality and morbidity for hospitalized patients.

Of 15 million inpatient surgeries each year, about 300,000 patients develop surgical-site infections, at an estimated cost of \$1.5 billion.

If there is a trigger for the surveyor to review surgical infections based on the organization’s Priority Focus Data, that may be one of the initial patient tracers they conduct during the survey, Christiansen says.

However, even if infection control is identified as a Priority Focus Area, that doesn’t necessarily mean the organization has a risk issue in that area — it could simply mean there is the potential for risk based on the patient population cared for, she adds.

If surveyors detect infection control issues during patient tracers, a system tracer for infection control will be done, and surveyors will want to know the surgical department’s role in the overall hospitalwide infection control program, points out Christiansen.

JCAHO surveyors will be looking for the following:

- **Staff know how to protect patients and staff from infections, with knowledge not only about infection control processes but also**

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Editorial Questions

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about the specific patient they are caring for.

Although surveyors will not go in and interrupt a surgical procedure, they will observe from a doorway to make sure processes are being followed, as identified by staff.

“The surveyor may not have looked at the actual written policies, but after speaking to staff about what their process is, they will observe to see that what the staff described is what is actually being done,” Christiansen says.

If any discrepancy is noted, the surveyor may ask to see written policies and procedures, so they can speak with leadership about their observations.

- **Appropriate processes for central sterilization are followed after a surgical procedure is completed.**

“They will take a close look at those procedures to make sure safe practices are in place to prevent recontamination,” Christiansen notes.

Surveyors will want to see that use of flash sterilization is minimized, with risk areas identified and staff appropriately trained.

- **Appropriate protocols are followed by environment-of-care staff when cleaning rooms for the next patient.**

At some organizations, problems have been identified involving failure to follow appropriate protocols because housekeeping staff feel pressured to turn rooms over quickly, she reports.

“In several cases, they said that the physician likes the room turned around in 10 minutes, and as a result, they weren’t following the policies for appropriate decontamination,” Christiansen points out.

- **Staff are aware of the chain of command to follow if they’re not comfortable with infection control practices.**

“All professionals have equal autonomy in the surgical area, because that is one of the most critical areas in reduction of infection,” she says.

“So at any point, anyone has the authority to put a halt to a procedure until they are comfortable that all the processes have been followed,” Christiansen notes.

- **Ancillary services and all professional staff with access to the operating suite areas follow infection control practices.**

“Sometimes, we are so geared to the caregivers taking care of the patient that we don’t consider all the other ancillary departments who may not be as knowledgeable about infection control, including pharmacy, laboratory, and radiology,” she says.

- **Action is taken if data reveal opportunities for improvement.**

The main thing surveyors will want to know? What your organization actually is *doing* with the data once they’re collected, Zibrat says.

The problem was that some organizations were focusing on data collection but falling short in terms of corrective action, he explains.

“But this is getting significantly better,” Zibrat continues. “The focus has moved from ‘I’m doing the best I can to collect the data’ to ‘Now that I have it, I better start looking at it.’ Organizations are now really starting to sit up and take a look at their data because it’s being publicly reported.”

He points to the Joint Commission’s Quality Check web site (www.jcaho.org/quality+check); Hospital Compare, a web site created by CMS and the Hospital Quality Alliance (www.hospitalcompare.hhs.gov/); and a growing number of health insurers that are factoring quality data into reimbursement.

SIP measures used internally

Not many hospitals actually are reporting SIP data to the JCAHO currently, Zibrat reports.

Organizations were required to report data for a third set of core measures as of Jan. 1, 2004, so a third core measure set already had been selected before the SIP measures became available on July 1, 2004.

He also points to Medicare’s pay-for-performance initiative, Reporting Hospital Quality Data for Annual Payment Update. The program — part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 — gives hospitals financial incentives to submit data on 10 quality indicators, which didn’t include SIP.

“So there have been disincentives for picking up SIP, but when we increase our requirements for the use of a fourth core measure set, we will see a lot of hospitals picking this up,” Zibrat predicts.

The additional requirement is expected to become effective by the beginning of 2006.

However, even if hospitals aren’t submitting SIP data to JCAHO, many are collecting and tracking the measures internally, he says.

“This is a key focus for organizations; they have been waiting for the SIP core measure set for a long time. They liked what they saw, and they are using the measures. But until we up the requirement, there is not much of an incentive to

them to submit the data to us," Zibrat adds.

Collecting data internally gives organizations a chance to fine-tune their data collection processes to ensure accurate data, he emphasizes.

"This gives them breathing room to put together the processes internally to be sure they are collecting reliable data, so the analysis is valid pertaining to their actual infection rates," Zibrat says.

"There are approximately 35 pages on antibiotics to look at, and also 30 pages on different infectious processes that might be going on prior to surgery," he continues.

Strategies to improve SIP analysis

To improve your analysis of SIP data, use these effective strategies:

1. Do a careful analysis when a surgical-site infection does occur.

When a patient develops a surgical-site infection, audit the chart to see if all known practices that can prevent surgical-site infections were done, Bratzler says.

If everything was done right, the infection should be termed "apparently unavoidable," but if some processes were missed, such as the antibiotic dose not given until after incision, then the infection was "potentially preventable," he points out.

2. Use real-time data.

SIP measures currently publicly reported on the Hospital Compare web site reflect events in the first and second quarter of 2004, notes **Terry Hill**, MD, medical director for quality improvement at San Francisco-based Lumetra.

"As excited as I am about the site, quality managers need data that is closer to real time," he says.

"Real-time data collection is important to identify the vulnerabilities in processes for giving antibiotics. It doesn't have to be research-quality data, and sampling is perfectly appropriate. But in order to make credible suggestions to medical staff, you need enough data, and it needs to be pretty close to real time," Hill explains.

Once the medical staff know that data will be publicly reported and are given a credible amount of data to show their performance is less than optimum, they are likely to take dramatic leadership action, he says.

"The role of the quality manager is to be a champion for change and to give enough credible data to the surgical leaders to make a difference," Hill adds.

3. Identify problems and take appropriate action.

The following actions were taken based on analysis of SIP data at Louisiana State University Health Sciences Center in Shreveport, says **Leisa Oglesby**, assistant hospital administrator of quality:

- Pocket cards listing core measure indicators were given to all residents and faculty.
- New guidelines were implemented for ordering antibiotics preoperatively, with antibiotics given at induction of anesthesia. Inservices on the guidelines were given to involved staff and departments.
- Quarterly updates were sent to inform involved department chairs of results, with action plans to be implemented when thresholds are not met.

Developing an action plan

When problems are identified, an action plan is developed and implemented to improve performance, Oglesby says. For example, inadequate nursing documentation was addressed by giving inservices, "bathroom blitzes," and ongoing monitoring to improve performance.

"They have also included this in the nurses' self-learning packet, which must be completed annually," she notes.

The process also revealed that Code 99 forms were not being completed; or in some cases, the documentation on the form was different from what was found in the medical record.

To address this, quality leaders asked a team to review the entire process and make recommendations for improvement.

These included revising orientation for nursing staff, educating physicians and members of the code team, defining responsibilities for all code team members, redesigning the form, revising policies, and establishing ongoing monitoring.

The first step is to identify who owns the process of making sure antibiotics are delivered, then determine how problems occur, notes Hill, who gives the example of one hospital where anesthesia residents sometimes gave antibiotics before they knew when the surgery actually would occur.

"They were very eager to do the right thing and were going down their checklist, but they didn't really know whether the incision was about to happen," he adds. "As a result, the antibiotics often wound up being given further out than they should have been."

The quality manager's role is to trace the steps that occurred and explain what went wrong with the process, Hill explains. "You need to make it clear, in a very simple and visual way, that the process either has redundancies, lack of ownership, or other problems."

Getting a description from one or two people or observing on one occasion can be enough to draft a flowchart, which the quality manager can then use to facilitate further individual or group discussions, he says.

"People will generally be quite willing to point out vulnerabilities or common variations in the process," he says.

Good opportunity for an FMEA

4. Do a failure mode and effects analysis.

"This is a wonderful opportunity to take a look at current processes from when the patient is admitted until they are discharged from the [post-anesthesia care unit] to whatever unit they are going into," Christiansen notes.

"This can become very burdensome if you try to look at everything at once, but if you strictly take a look at the processes within the surgical area related to infection control, you can identify where the gaps are. Then you can begin to evaluate how to correct that and implement new strategies," she adds.

Recommended reading

- Bratzler DW. Use of antimicrobial prophylaxis for major surgery: Baseline results from the national surgical infection prevention project. *Arch Surg* 2005; 140:174-182.

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Surveyors zero in on life safety code compliance

Life safety code is key focus during patient tracers

Are you worried about the certified health care engineer surveyor who will be scrutinizing your organization's life safety code compliance during your next JCAHO survey? If so, be aware that the attention paid to life safety and Environment of Care (EC) may be even more intense than you expect.

"Throughout the survey, the team looked at EC issues wherever they went," reports **Kerri Anne Scanlon, RN, MSN, ANP**, associate executive director of quality management at North Shore-Long Island Jewish Medical Center in New Hyde Park, NY. The organization had an unannounced JCAHO survey in April 2005.

"A lot of hospitals are nervous about the engineer, but it wasn't just the engineer," she says.

"The administrator actually took a lead in doing the EC. He did the formal three-hour EC interview and was very educated in his approach. Your building safety program is just as important as any other safety program," notes Scanlon.

A 2004 report from the Government Accountability Office (GAO) was critical of JCAHO's ability to ensure quality care. The report found that JCAHO surveyors did not find deficiencies in 123 out of 500 hospitals, including failure to adequately protect patients and staff from fire-related disasters.

The report found that of 167 serious deficiencies that were not detected by JCAHO, 87 were related to a hospital's physical environment, which includes life safety code standards for fire prevention and safety.

At that time, JCAHO acknowledged that it needed to improve its assessment of life safety code compliance. As of Jan. 1, 2005, a certified health care engineer was added to the survey team for hospitals with 200 or more beds, and additional training in life safety code compliance was given to surveyors of smaller organizations.

"In my experience, smaller organizations are often in need of qualified engineers for consultative and educational purposes, as they are unable to afford to hire those folks or attract them to small and rural areas," says **Ann Kobs**, senior vice president for accreditation and standards at

TUV Healthcare Specialists in Cincinnati.

Those surveyors will look closely at the standards in the EC chapter, she adds.

“It would be most beneficial for staff in quality to become conversant with the National Fire Protection Association code, the Statement of Conditions, and the standards, which have been left up to the in-house engineers in the past,” Kobs says.

As of Jan. 1, 2005, several of the EC standards no longer require a Measure of Success (MOS) if the facility is not meeting the intent of the standards. “This does not mean that they are any less important,” says **Susan Mellott**, PhD, RN, CPHQ, FNAHQ, CEO of Houston-based Mellott & Associates.

When developing an MOS, there must be a numerator and a denominator in the measure, and both need to be easily measurable and reportable.

“One common mistake is that the indicators selected really cannot be measured or do not really pertain to the area of noncompliance,” she says.

As a quality manager, you need to work with the EC staff to establish MOS that meet the criteria, Mellott explains.

“You must then assure that the MOS are being monitored and improvements are being made and reported as appropriate,” she says. “Quarterly reporting of the MOS to the quality manager should be required.”

Ensure EC compliance

To ensure compliance, do the following:

- **Do an EC tracer on stained ceiling tiles.**

“This is a perpetual problem,” Kobs says. “What usually happens is that organizations order crates of ceiling tile and keep replacing the stained ones. Instead, they need to see if there is a leaky pipe above and fix the leak.”

She advises removing a stained tile, tracing the leak to its source, and having the appropriate person fix it. “It could be their entire system may need repair or replacement instead of fixing one pipe,” Kobs says. “In the meantime, if it’s growing mold, or Legionnaire’s, it’s unhealthy for workers or for patients.”

She recommends answering these questions: What is staining the tiles? Where is the leak coming from? Why isn’t the leak fixed? Is there mold? Who is responsible for plumbing? Are they qualified? Were they oriented? How were

they deemed competent?

Mock EC tracers should consist of two separate tracers: one focusing on the life safety aspects of the EC standards that the life safety specialist will look at, and a second focusing on the remaining EC standards, Mellott says.

During this second tracer, the EC records that correspond with the standards should be reviewed, she adds.

“There should also be interaction with staff, to assess staff knowledge about the high-risk areas for each of the seven plans,” Mellott continues. “For example, does the staff know what to do if a bomb is possibly in the area? What does the staff do with medical equipment that is not working properly?”

Are your documents accessible?

The tracer also should include evaluations of the fire and disaster drills and assess whether necessary changes were made, she says.

- **Have documents accessible.**

On the first day of a JCAHO survey at a hospital Mellott consulted for, the administrative surveyor was looking at EC documents while the life safety specialist was touring the building with the plant operations director.

“This had a great impact on this survey because the plant ops director had only been at the facility a little over a month, and the position had been vacant for four months prior to his arrival,” Mellott points out.

The new plant operations director wound up fielding questions from both surveyors and was asked to provide some documentation that the secretary did not have, she notes.

“This created an issue when the administrator could not find the information he was looking for,” Mellott says. “It is imperative that the plant ops director has the documents in an accessible place for the administrative surveyor that first day.”

That includes risk assessments and annual evaluations for each of the seven EC plans, the EC/safety committee minutes, and evidence of reports regarding the EC being shared with the governing board for the past four quarters.

- **Review the seven EC plans annually.**

“The surveyors are looking for demonstration of the effectiveness of each of the seven EC areas,” Mellott explains. “This is the area where the quality managers can have the biggest impact during

(Continued on page 127)



PATIENT SATISFACTION PLANNER™

A 'NOD' to patient needs boosts satisfaction rates

Proven strategies from other industries used

New York City may have a reputation as a fast-paced metropolis where most people are too busy to give you the time of day, but the emergency department (ED) at Jack D. Weiler Hospital, one of three EDs in Bronx's Montefiore Medical Center, has won over patients with an approach focused on friendliness and TLC. A 2001 Press Ganey Associates patient satisfaction survey ranking the facility against its peer hospitals in New York City showed the ED to be in the 25th percentile in 2001; by 2004, it had reached the 70th percentile. In 2001, 5.2% of registered ED patients "eloped" (left without being seen).

In 2004, under a new fast-track system, only 1.5% of ED patients eloped. During that same period, community visits to the ED have jumped 15% and hospital admissions from the ED have soared 30%, while hospital ED visits in the Greater New York region have remained relatively flat, according to data from the Greater New York Hospital Association.

There were many factors that led to the turnaround. One was high staff turnover. "First, we had to replace nursing and physician leadership, which we did in 2001," recalls **Peter Semczuk**, vice president of clinical services at Montefiore. "Then we wanted all board-certified emergency medicine docs; we ended up hiring 50 for our three EDs."

A five-tiered triage system, including a separate fast-track wing to give patients immediate care, also had an impact, says **Alice Corbett**, RN, administrative nurse manager at the Montefiore ED. "Without the process changes, the other initiatives would not have enabled us to handle the volume and acuity, but all of these things working together have made a huge impact on the department."

In light of the poor Press Ganey numbers, the whole ED management team (the medical director, assistant medical director, the unit manager, and several nurse managers) sat down to determine why customer satisfaction was so poor and to devise a plan to turn things around. During their discussions, they turned their attention to concepts that had proven successful outside the health care setting.

One of those concepts was the NOD (name, occupation, duty) approach used by the Disney organization. Now, whenever staff members come in contact with a patient, they always share that information. "They might say something like, 'Hi, my name is Bonnie. I'm the manager of the department, and I'm here because I heard you needed to see a manager,'" Corbett offers. "Any staff member approaching any patient needs to introduce themselves and say what they are about to do."

The other key concept involves a commitment to avoid any patient being "hungry, angry, lonely, or tired. In order to increase communication with people in the waiting room, we started to have a food cart come around," she says.

This teatime cart is brought around just before dinnertime, "when everyone is hungry and cranky and we are most packed," Corbett notes. The cart contains coffee, tea, hot chocolate, juices, muffins, fruit, and yogurt, and has magazines on the bottom shelf. "If a mom shows up with kids in tow, we make sure to give them PB&J," she adds.

The department has a standing order of cold sandwiches, including peanut butter and jelly, which arrive fresh twice a day. All of this is free of charge. The dietary service doesn't charge for the food, and an ED service associate passes around the cart. After about a year, the director of food services approached the ED and offered a morning tea-cart service, manned by a food service associate.

This also is not charged to the ED. The food service department prepares the morning and afternoon teatimes. During teatime, as with regular mealtime, the MDs and RNs let the server know which patients can eat. The servers will provide for visitors but will not give food or fluid to any patient unless OK'd by the clinical staff.

Joseph Braverman, MD, medical director of the ED, says, "To the extent that the patient is angry and hungry, and when other factors like a long wait take their toll, when you go in to see them you are already in a hole, and you have to dig yourself out. This approach makes that a rare

event." Upon each visit, physicians also are encouraged to prop up patients with pillows.

Another key strategy at Montefiore is the solicitation of input from the patient, to ensure care is satisfactory, or determine the cause if it is not.

For example, the physicians call a small sample of seen-and-discharged patients the next day, he says.

"It's always reassuring to double-check on their condition," Braverman explains. "If they feel they need be reevaluated, you can encourage them to see their doctor or come back; or if they were unhappy with their waiting time, it presents an opportunity to mend those fences."

Patients who receive these calls are very surprised and appreciative, he adds. "All of the thanks you may not get when the patient is in pain and stress in the ED, you sure get then." ■

Hospital cuts overall length of stay by 1.3 days

A series of multidisciplinary initiatives has resulted in a 1.3-day decrease in length of stay (LOS) at Hackensack (NJ) University Medical Center (HUMC).

"With the help of case managers, the average length of stay has significantly decreased without adversely impacting quality or outcomes. In today's economic atmosphere, you must be able to positively impact the length of stay as well as maintain our high standard for quality of care," says **Pat Eason**, RN, BSN, administrative director for case management services at HUMC.

HUMC is a private, not-for-profit teaching hospital serving the New York City metropolitan area. The hospital has grown from a 12-bed community hospital to a nationally recognized 683-bed university-affiliated medical center that runs at a 92.5% occupancy rate.

The administration at HUMC established a care coordination committee several years ago to develop strategies to integrate performance improvement principles with LOS and resource management procedures and programs.

"The administrators realized that increases in chronic illness, shorter lengths of stay, complexity of care, and expansion of technology resulted in changes in the delivery of health care. The rising cost of care, the demand to control costs, and changes in reimbursement necessitated the

provision of the most cost-effective quality of care. These changes translated into the need for better coordination of patient care across disciplines and services, especially for high-risk groups of patients," Eason says.

One of the major initiatives HUMC has undertaken is multidisciplinary care coordination for the delivery of patient-centered care that begins at the unit level. "We are dedicated to providing health care services of the highest quality, providing the patient with the right care at the right time and the right setting," she adds.

A key component of the initiative is daily multidisciplinary care coordination rounds, led by a physician, on all units Monday through Friday. In addition to participating in the multidisciplinary care coordination rounds, case management services undertook departmentwide initiatives that have contributed to the decrease in LOS and an increase in patient satisfaction, Eason notes.

Among the initiatives are case management or social worker visits to 100% of medical-surgical patients within 24 hours of admission, personal visits by case management services team members to patients who have been discharged to other facilities, and direct conversations with insurance companies instead of faxing information or leaving messages on voice mail.

The multidisciplinary team participating on the care coordination rounds includes physicians, case managers, social work professionals, nurse managers, advanced practice nurses, staff nurses, pharmacists, nutritionists, physical therapists, and others as needed. "These rounds provide a forum for the multidisciplinary team to collaboratively review and facilitate the patient's plan of care and share this information with the attending physician," Eason says.

The purpose of the rounds is to ensure the appropriate care plan is in place for the patient's acute problems; assist attending physicians in providing timely services in the appropriate setting; and collect, trend, and report data on service delays to the respective medical directors, departments, and multidisciplinary teams, she explains.

"When a variance in care or a barrier to moving a patient through the continuum is identified, the appropriate team member is assigned to address the issue and remove the barrier. Having a group of people with advanced clinical skills involved with the patient's care results in a well-coordinated plan of care," says **Theda Gunsher**, RN, MA, operations manager for case management services.

Case managers and social work professionals are an integral part of the multidisciplinary rounding team on each unit, Eason adds. They are involved with the patient and family from admission to discharge and are responsible for keeping the team updated on the discharge plan and resource needs of each patient.

They work with ancillary services, ensuring that testing and reporting are done in a timely manner. For instance, if a patient is scheduled for an X-ray at 3 p.m. and could be discharged pending the result, the case manager works with the radiology department to have the X-ray done earlier and ensures the results are communicated to the physician in a timely manner.

Case management services at HUMC include RN case managers, social work professionals, RNs who work on denials and appeals, and analysts. The organization has an integrated model of case management that includes utilization review and management, discharge planning, and in some situations, transitioning patients to rehabilitation hospitals or other post-acute facilities. Case managers are unit-based with assigned caseloads based on the size and acuity of the unit. Some case managers may be assigned more than one unit, while high-acuity units may have two case managers.

The overall LOS on each unit is a good indicator of how many case managers are needed to staff the unit, Gunsher adds. For instance, the orthopedic unit has a rapid turnover, with 10-plus admissions and discharges on a daily basis. That unit needs more case managers than a unit where patients stay several days.

The target case ratio is one case manager to every 15 patients when the case manager performs three roles: utilization review, discharge planning (setting up home care, durable medical equipment, and infusion therapy), and transfers to rehabilitation facilities. For case managers performing two roles — utilization review and discharge planning — the target case ratio is one case manager to 20 patients. The hospital's high census makes it difficult to always maintain these target ratios, Gunsher says.

Social work professionals are responsible for transitioning patients to extended care facilities, crisis intervention, substance abuse and mental health treatment, and patient advocacy as well as referring patients to entitlement programs such as Medicaid, pharmaceutical programs, and other community resources.

When case managers transition patients to rehab facilities, they meet with the family to

develop an appropriate discharge plan and often provide a list of area facilities for families to visit. Once the patient and family have decided on a facility, the case manager arranges transportation, develops the plan for the transfer, and works with the case managers at the receiving facility.

The hospital strives to cluster similar-type cases in certain diagnoses. For instance, one unit is dedicated to stroke and CVA patients, and another is dedicated to heart failure.

"When the census is as high as ours usually is, you have to assign beds where they are available. Some units have more patients than others. The highest unit has the capacity for 33 patients, with the lowest being 14," Gunsher says.

Case managers at the medical center work staggered hours, with the first group arriving at 6 a.m. and the last group arriving between 9:30 and 10 a.m. They rotate being on call from 4:30 p.m. to 8 p.m. Monday through Friday. Two case managers and one social worker are on-site Saturdays, Sundays, and holidays. During the week, a full-time case manager and social worker are assigned to the emergency/trauma department.

Every patient in the medical-surgical unit receives a visit from a case manager or social worker who gives them a brochure explaining what case management is and what services they offer. "Seeing the patient within 24 hours of admission is truly beginning the discharge process on admission and has contributed significantly in reducing the length of stay. The case managers are able to pick up on potential problems they might not find in the medical record and can intervene much faster," Eason says.

For example, while talking to a patient, a case manager may discover that the patient is not capable of taking care of him- or herself at home or that the patient needs community services or help paying for medication. In other cases, the case manager may find that the patient has frequent admissions or visits to the emergency department and can intervene to prevent continued hospitalizations.

"We can decrease the length of stay when we address these issues early on rather than waiting until discharge to find that the patient does require some interventions," Gunsher adds. Visiting with every patient has increased the hospital's patient satisfaction. "We found through our patient satisfaction surveys that some patients who didn't require care at home or a facility felt we were not involved in their discharge planning. Now, either a social worker or a case manager assesses each

patient and addresses questions they may have regarding their discharge, she explains.

In a new initiative piloted over the past several months, a case manager or social work professional visits each patient who has been discharged to an extended care facility to ensure a smooth transition to the next level of care. "It is reassuring to our patients to know we are concerned that they receive the appropriate post-hospital care, Eason says.

Visiting the extended care facilities gives staff a better understanding of the type of care that is provided and helps them provide feedback to physicians about which facilities would be appropriate for particular patients, she adds. If a patient is discharged to home with home health care, durable medical equipment, or by ambulance, the case manager follows up by telephone the next day to make sure the patient's needs are being met.

"Both patients and families seem pleased with our post-hospital monitoring, and it also gives the case manager the opportunity to take corrective action if the patient is having problems. We haven't been doing this long enough to know if we have cut down on readmissions, but that is part of our goal," Eason says.

At HUMC, the case managers do not fax information to insurance companies or leave messages on voice mail. "The case management services' practice of talking to insurers one-on-one has had a positive impact on denial of payment. There is no misunderstanding about what is actually occurring with the patient because the staff speak directly to the insurance case manager and can provide additional information or answer questions as needed," she notes.

The practice has significantly decreased the number of phone calls between the HUMC case managers and the insurance companies, Eason adds. "Our case managers and the insurance case managers have gotten to know each other very well, and we now have current information on a patient's status instead of waiting for decisions."

The hospital's finance department is working with the insurance companies to change contract agreements on how frequently the case managers are required to review a case with the insurance company, she adds.

HUMC tracks all payer LOS and breaks out LOS for Medicare and managed care by both noncase mix-adjusted and case mix-adjusted length of stays. LOS is broken out by unit as part of a unit report card containing financial, clinical, and satisfaction indicators. ■

CE questions

9. Which is accurate regarding JCAHO surveyors and assessment of procedures related to surgical infection prevention?
 - A. Surveyors will interrupt surgical procedures during all tracers.
 - B. Surveyors will assess compliance strictly from written policies.
 - C. Surveyors only will observe surgical procedures if written policies are inadequate.
 - D. Surveyors will observe surgical procedures to make sure processes are followed.
10. Which is an example of compliance with JCAHO requirements for surgical infection prevention?
 - A. Frequent use of flash sterilization.
 - B. Protocols may be altered to allow housekeeping staff to make beds available quickly.
 - C. Any staff member may intervene if infection control processes aren't being followed.
 - D. Ancillary staff are exempt from adhering to infection control practices.
11. Which is true regarding JCAHO surveys and life safety code compliance?
 - A. The 7 EC plans aren't required to be reviewed unless an organization has a deficiency.
 - B. Only managers and unit directors will be questioned about life safety code compliance.
 - C. Frontline staff, including housekeeping and receptionists, will be questioned by surveyors.
 - D. Only the engineer surveyor will be asking questions about life safety compliance during the survey.
12. Which does a JCAHO Sentinel Event Alert recommend to improve the safety of the chemotherapy dispensing process?
 - A. Dilute IV vincristine in a volume that prevents administration via the intrathecal route.
 - B. Never dilute IV vincristine.
 - C. Conduct timeout only if syringe is unlabeled.
 - D. Avoid labeling vincristine syringes.

Answer Key: 9. D; 10. C; 11. C; 12. 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 in that issue and return it in the reply envelope provided to receive a certificate of completion. ■

(Continued from page 122)

the survey, in regards to the EC standards.”

The administrative surveyor was impressed with North Shore-Long Island Jewish’s annual evaluation process, says Scanlon. “He said all levels of staff were very knowledgeable about life safety and could speak to this. They could see it’s part of everyday practice here, not just for the survey.”

The objectives, scope, performance, and effectiveness of each of the EC management plans need to be reviewed, so develop your plans for each of those areas and then list the evaluation of each area in the annual evaluation, Mellott says.

“This lets the surveyor know that you are aware of the requirement to have and evaluate these areas,” she explains. “Of these, however, the effectiveness is the most important.”

The indicators used throughout the year, as well as any MOS that have been monitored, should be discussed in the effectiveness section, Mellott notes.

If a request to the administration and/or board for implementation of an improvement has been requested, this should be discussed in the context of the appropriate plan evaluation, says Mellott. “The annual evaluation should then set the stage for what will be the priorities and monitored during the upcoming year,” she adds.

- **Do unit-based EC rounds.**

The surveyors at North Shore-Long Island Jewish did not find any EC deficiencies, which Scanlon credits to the organization’s ongoing EC and building maintenance program.

“The program is under the direction of the director of safety and reports up to our quality program,” she explains. “They do unit-based rounds using a designated tool for EC, which covers the seven plans and also has a staff knowledge component.

“The rounds were key, because we had to assess whether we were in compliance or not, and this facilitates the momentum of the ongoing program,” says Scanlon. “However, you need some type of scoring grid to report that information back. Otherwise, it becomes very subjective.”

Staff are interviewed on EC compliance, with scores reported to unit managers on a monthly basis.

“All of that information gets aggregated and gets reported to the quality committee, up to the board of trustee committee on safety,” says Scanlon.

“That information allows us to objectively measure our improvement over time,” she says.

The organization’s administrative team for EC consists of Scanlon, the vice president of nursing, associate executive director for facilities and clinical services, director of engineering, director of housekeeping, and director of safety.

“We do rounds on all the units and all the services, identify any real-time opportunities to fix things then and there, and also reinforce staff knowledge,” she says.

The team also assesses which units are failing to correct problems or submit corrective action plans.

- **Educate frontline staff.**

At North Shore-Long Island Jewish, the surveyor spent a lot of time talking to unit staff, including housekeepers and receptionists, about fire drills, disaster codes, infant and pediatric abduction, and security, notes Scanlon.

“It was really frontline staff that they wanted to speak to. We were able to demonstrate our emergency management program, which was linked to many patient tracers,” she says. “They observed practitioners doing actual clinical procedures in the patient rooms. It was a very different EC review.”

Fire and life safety code was their biggest focus, says Scanlon. “They asked staff about the evacuation plan for exiting in a fire and then tested it, and also asked about oxygen and how it relates to this,” she says. “They were very interested in the actual fire life safety program, including what disaster drills we run and if staff were aware of them.”

- **Have a thorough building maintenance plan.**

At North Shore-Long Island Jewish, the organization’s building maintenance plan covers the seven EC plans, including fire life safety codes and utilities management.

The administrator opened every fire door in all three hospital buildings, says Scanlon. “He was extremely thorough, even more so than the engineer,” she says. “They opened up ceiling tiles and went into every nook and cranny. It was a five-day survey, so they were able to cover that much more ground, and there were several more surveyors this time.”

The engineer surveyor validated and verified the plan, looked through emergency department records, and did the building tour, Scanlon explains. “From the first day, surveyors had a good understanding whether our building was in good shape or not,” she notes. “That set the stage

for how the rest of the survey would go.”

The director of engineering accompanied the JCAHO engineer during the survey, which was helpful because they could “speak the same language,” Scanlon says.

- **Work closely with engineering.**

You may need to begin by finding out exactly who is responsible for EC, says Kobs. “I don’t say that to be facetious, but somehow in some organizations, they just haven’t crossed paths,” she says. “Getting to know these persons is a good start.”

Ask these individuals to walk you through the building to demonstrate how the Statement of Conditions are addressed and kept current, she recommends.

“Have them explain about the composition of the roof, future plans to upgrade old facilities, and what makes some areas not suitable for patient occupancy any longer,” Kobs says.

At Baptist Hospital of Miami, the safety officer and director of engineering are co-leaders of the organization’s EC team, which is part of the JCAHO readiness team.

“Quality leaders really don’t have the level of expertise for this — engineering does. I think with the addition of the life safety engineer, we need to rely on their expertise even more,” says **Faith D. Solkoff**, RN, BSN, MPA, director of performance improvement.

“As a quality leader, we can ask the right questions and ensure that the EOC standards are being met; but at the end of the day, you need your engineering folks to ensure that the building is safe,” she adds.

A good way to prepare is to review your organization’s life safety findings from your state audits, Solkoff says.

“If you see that there are many issues, then you should recommend to your CEO that a consultant life safety specialist or engineer be brought in,” she adds. “Thanks to the life safety leaders in our organization, we impressed JCAHO with our staff’s knowledge of the EC, as well as the safety of our structures.”

Here are key areas of focus for life safety code compliance during the hospital’s recent JCAHO survey:

- **Document review was thorough.**

“The surveyor had a list that he ran down and checked off as it was reviewed,” says **Jeff Zohn**, director of engineering services at Baptist.

“He looked at our documentation especially hard to make sure we were testing at all of the

appropriate intervals — monthly, quarterly, semi-annually, and annually.”

Fire protection components were looked at especially closely, such as fire sprinkler testing and inspections, fire alarm testing, fire drills, and smoke damper inspections and maintenance.

- **Documentation on generator and transfer-switch testing was checked.**

“Make sure you have documentation that all automatic transfer switches are tested in the designated time frame,” Zohn advises.

- **Surveyor looked for penetrations.**

“The surveyor spent a lot of time above the ceiling,” he says. “He asked for every electric room door to be opened and looked for penetrations in them. He also checked numerous fire doors for latching as we toured the building and looked for clutter in the corridors.”

- **Fire protection in the kitchen was reviewed.**

The surveyor made sure the fire suppression system was inspected and up-to-date, that staff knew how to activate it and what type of fire extinguisher to use, that nozzles were positioned over the cooking areas, and asked staff what they would do if there was a grease fire.

- **Surveyor checked whether flammable material was contained, stored, and labeled properly.**

“During the building tour, he asked employees about their role in the event of a fire, and asked several nurses about who can shut off oxygen,” Zohn adds.

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FMEA prevents chemo dispensing process errors

New recommendations in Sentinel Event Alert

Tragic errors caused by administration of vincristine into the subarachnoid space of chemotherapy patients continue to occur, even though these “wrong-route” errors are preventable, according to a recent Sentinel Event Alert issued by JCAHO. Although only a single case has been reported to the JCAHO’s Sentinel Event database, with the error resulting in permanent paralysis of the patient, numerous cases have been reported by the U.S. media in recent years, including several fatalities.

That suggests health care organizations are failing to voluntarily report these errors to the Joint Commission or the U.S. Pharmacopeia, possibly due to concerns over legal discoverability of the related information, according to the alert.

JCAHO’s recommendations include: Diluting IV vincristine in a volume that prevents administration via the intrathecal route; labeling each vincristine syringe: “Fatal if given intrathecally. For IV use only. Do not remove covering until moment of injection” — never dispensing IV vincristine in a manner that would permit it to be administered at a time and location where intrathecal medications are administered and conducting a timeout with at least two health care professionals to independently verify and document drug, dose, and route.

At Gwinnett Health System in Lawrenceville, GA, the chemotherapy dispensing process was chosen for a proactive risk assessment, using failure mode and effect analysis (FMEA) tools to conduct the assessment. “We identified a number of opportunities to improve our dispensing process to reduce the likelihood of error,” says **Suzanne Compau**, BSN, MHSA, director of patient safety and quality resources.

Any medication safety alerts from JCAHO, the Institute for Safe Medication Practices, or the Food and Drug Administration are addressed through the organization’s Medication Error Reduction Team. In this case, the alert also was addressed by a multidisciplinary chemotherapy team, which was formed specifically to conduct this analysis, working with Compau and the organization’s pharmacy performance improvement coordinator.

“We are currently implementing our corrective action plan,” Compau reports. “The team has

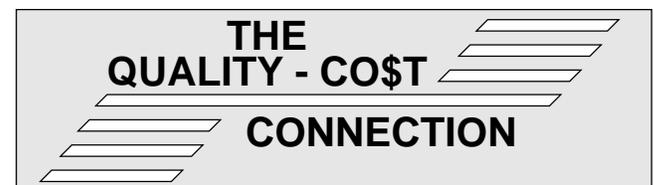
decided to continue meeting through the next fiscal year and will be conducting a proactive risk assessment of the chemotherapy administration process at the bedside. I will also facilitate that review as the representative from the quality resources department.”

The same team will review JCAHO’s recommendations and determine which actions or monitoring, if any, would be appropriate, she notes.

The chemotherapy team consists of a group of physicians, nurses, and pharmacists who have been performing the FMEA on the chemotherapy dispensing and administration process. “So we thought this team would have some good insights on how to proceed with the JCAHO recommendations as well,” Compau adds. “We already follow the labeling precautions discussed in the alert and will see if the other recommendations can be incorporated as well.”

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- To see a complete list of JCAHO’s recommendations, go to www.jcaho.org. Click on “Sentinel Events,” “Sentinel Event Alert,” and under “Preventing vincristine administration errors,” click on “Complete Text.”] ■



Maintain accountability in patient safety efforts

Make sure each person fulfills responsibilities

By **Patrice Spath**, RHIT
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Focusing on a blame-free environment to promote a culture of patient safety is important; however, it also can have an unintended and undesirable effect on accountability.

Hospitals have ultimate responsibility for the safety of patients, and everyone in the organization must share responsibility for certain elements of safety. An accountability system is essential if all the hard work and effort you spend in designing safer patient care processes is not to be lost. Accountability must be inherent in any patient safety improvement effort.

The aim of a health care organization's system of accountability is to ensure that each person fulfills his or her responsibilities. An effective accountability program teaches managers, supervisors, and staff to take personal responsibility for their actions and the subsequent effect of these actions on the patient.

The purpose of an accountability program is to help all employees understand how critical their performance is to the safety of patients and to teach them how to minimize the risk of errors. Accountability ensures your patient safety improvement program is not just a paper tiger with no real power to achieve improvement goals.

Set departmental objectives

Patient safety improvement objectives for departments should be based upon performance measures. These are indicators that tell you whether the person or department performed as expected. The following considerations will help you set reasonable objectives:

- **Aim your objectives at specific areas of performance that can be measured or verified.**

"Improve patient safety in my department next month," is too general an objective to be useful. A better objective would be, "Reduce patient falls by 10% over the next month." Even more measurable are those objectives over which the manager or supervisor has complete control, such as, "Hold 30-minute patient safety meetings for all employees in my department every Monday afternoon."

- **Objectives should be realistic and attainable but also should represent a significant challenge.**

—Appropriate authority is necessary. Example: A patient safety director's objective to reduce medication administration errors is not directly attainable, because achievement is dependent on the performance of the nurse managers and staff members. An objective to determine specific patient safety training needs for members of the nursing department, develop the training, and notify supervisors of

its availability is within the bounds of the patient safety director's authority and, therefore, is achievable.

- Adequate training is necessary. Example: A supervisor's objective is to investigate all near-miss incidents that occur in his/her unit and ensure future prevention. This objective may be unattainable if the supervisor has not received training in incident investigation and process improvement techniques.
- Appropriate resources must be available. Example: A manager's objective is, "Ensure that all equipment is safe to operate." That objective will be unattainable without an appropriate budget for replacement parts and capital improvements. Similarly, if the housekeeping supervisor is held accountable for clean nursing unit areas at the end of each day shift but is not given enough staff to complete all tasks and finish the cleanup, an objective of clean nursing areas at day shifts' end will be unattainable.

- **Objectives need to be understood by all concerned parties.**

Use clear, understandable language that leaves no doubt what someone is required to do. Example: An objective is, "Investigate near-miss incidents to determine multiple causation." This may be unclear to a supervisor. "Investigate near-miss incidents to determine all causes and take corrective action within 48 hours of the accident," is a clearer, more specific objective.

- **Objectives should be agreed to by those with responsibility for achieving them.**

Even when managers and staff appear to agree on most issues, it is important for managers to openly discuss patient safety performance objectives and secure staff agreement or cooperation. Give a copy of the performance objectives to employees and incorporate them into future performance discussions with employees.

Determine the safety role of positions

What role do you want each position or group of positions to play in your patient safety program? What level of authority will the person holding this position need? While authority is built into managerial and supervisory positions, you may want to make changes specifically relating to your patient safety program.

Here are some examples of patient safety roles:

- **The board and CEO:** Establish and provide the leadership and resources for carrying out the

stated patient safety policy.

- **Managers and supervisors:** Maintain patient-safe conditions within their respective jurisdictions.
- **Employees:** Exercise care within their work area to prevent errors and unintended patient harm.
- **Vendors and subcontractors:** Comply with all patient safety requirements while on the premises.

Some individuals may have some additional general duties. For example:

- **Patient safety department:** Be fully responsible to the CEO (or other senior leader) for the direction and day-to-day operation of the patient safety program.
- **Biomedical engineering:** Ensure all biomedical equipment that could affect the safety of patients is selected, installed, and maintained in a way that eliminates or controls potential hazards.
- **Purchasing:** Ensure equipment and supplies are purchased in a timely manner and new supplies and equipment are analyzed for potential patient safety hazards so preventive measures or controls can be implemented.

It may be useful to combine all these written statements of patient safety responsibilities into a single document, then post it or circulate it to all employees involved. Discuss the responsibilities in face-to-face meetings with the staff members who will be responsible for meeting the expectations. Keep a copy of this document and periodically refer to it when meeting with individuals for performance reviews.

Review performance

Managers periodically should review the patient safety performance objectives to make sure the desired performance and results are being achieved. For instance, if a supervisor meets the objectives but the department continues to have too many incidents, too many close calls, or no improvement in safe outcomes, then

the objectives need to be revised. Performance evaluation can be verbal, written, or both.

An effective evaluation will include the following critical elements:

- **It should be performed at specified intervals.**

As managers and staff become accustomed to working toward defined patient safety performance objectives, the intervals between evaluations can be lengthened. The evaluation can become an opportunity to provide encouragement and refresher training.

- **The evaluation always should be performed against a backdrop of previously defined patient safety objectives.**

There should be no surprises to the person being evaluated regarding what was expected. Should problems develop, it may be necessary to modify the objectives to ensure they are understandable, measurable, and achievable.

- **Ideally, the evaluation is an opportunity for exploring ways of improving both the system and the performance of the individuals in the department.**

Negative attitudes, such as refusal to listen to one another, animosity, blaming one another, or fear and intimidation will limit the evaluation's usefulness.

- **The goal of evaluation should be to encourage personal responsibility and the individual's efforts toward improving the safety performance of the team.**

Give positive reinforcement for a job well done.

- **If the evaluation determines that patient safety performance did not meet expectations, changes must be made.**

Sometimes, the required changes will be obvious. In other cases, it will be necessary to carefully explore the reasons for the objective not being met and discuss possible solutions.

- **Perhaps the wrong person was assigned a particular responsibility.**

A simple change in assignments may alleviate the problem. Perhaps the level of authority of the assigned person needs to be increased.

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The objectives themselves may need to be modified and employees helped to develop capabilities or skills that they do not presently possess.

- **There must be a point where some predetermined consequences for unacceptable patient safety performance begins.**

Some task monitoring may be necessary to support the performance evaluations. For example, monitor a supervisor's investigations after each near-miss incident until it is clear that the supervisor has developed the necessary evaluation and process improvement skills.

Set consequences

Consequences need to be appropriate to the situation. Firing a manager for the first poorly conducted near-miss incident investigation is an obvious example of overreacting to a problem. Gradually, though, the consequences of poor performance should be increased. One common disciplinary system consists of:

1. verbal warning;
2. written warning;
3. suspensions;
4. (as a last resort) termination.

Eventually it may be evident that an individual is not capable of handling the assigned patient safety responsibilities, and the maximum degree of consequence must be enforced. Otherwise, other employees will conclude that consequences for unsafe acts or failure to adhere to performance expectations are not to be taken seriously or do not apply equally to everyone.

That belief among managers and staff will destroy any chance for an effective patient safety accountability program. ■

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