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IN THIS ISSUE

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Disaster preparedness: Lessons learned from the response to Hurrican Katrina

JCAHO wants to see evidence of planning for large-scale catastrophes

Your recent disaster drills may have prepared you for scenarios such as local school bus accidents, an explosion at a nearby plant, or chemical spills at a factory.

But what about a disaster of epic proportions that leaves your hospital structurally damaged, with no power for days? Or a bioterrorism attack that paralyzes every community resource in the surrounding area?

The lesson to learn from Hurricane Katrina: Think big. When doing a hazards vulnerability analysis to determine which disasters are most likely to strike, your organization must consider major catastrophes and large-scale events, says **Robert Wise**, MD, vice president of the division of standards and survey methods for the Joint Commission on Accreditation of Healthcare Organizations.

"I think organizations have been timid in being clear about the hazards that might occur to them," he says. "Because if, in fact, it's decided that they have to prepare for a significant hazard, then obviously there are potentially significant expenses associated with that."

Typically, the hazards most frequently prepared for are those that have already occurred, says Wise. "That makes sense, but at the same time, the catastrophic ones also have to be at least considered," he says.

Every disaster presents a learning opportunity, says Wise, who recently visited the Gulf region to meet with affected health care organizations. "We typically go to the area about six or eight weeks after the disaster, when things have calmed down, and will do this with New Orleans and Mississippi. But it is way too premature to seek lessons learned at this point," he says.

One of the biggest lessons is already readily apparent, however: The more planning an organization does, the better. "All the resources invested in planning will be paid for many times over when the actual disaster occurs," says **Jonathan Weisul**, MD, vice president of medical affairs for Alexandria, LA-based Christus St. Frances Cabrini Hospital. Weisul is responsible for JCAHO compliance for Christus Health's Central Louisiana region. "This was a response of unprecedented dimensions, and the follow-up and after action will be created as we go."

Although the hospital wasn't directly affected by Katrina, over several

days 700 patients were triaged and hundreds were hospitalized. At one point, the hospital's Mass Casualty Incident plan was activated after buses with 100 patients arrived with less than 30 minutes notice. "In that experience, the disaster plan worked extremely well. We were able to triage and place the patients within four hours. That included one fatality that died on the way, but other adverse outcomes could have occurred if the plan hadn't worked as well."

"I don't think quality has been addressed until recently in emergency management," says **Victor H. Kennedy**, MPH, CIH, director and health care system safety officer at UCLA Medical Center in Los Angeles. "The planning and drill efforts didn't go beyond the initial response."

That is changing now, he says, pointing to the Joint Commission's emergency management standards, which state that they reflect "the application of continuous quality improvement methods to the performance of emergency management preparation."

New emphasis on quality

"In the new JCAHO standards, there is a good bit of talk about quality. JCAHO has given justification" to a new emphasis on quality, he says.

This means that organizations will need to "push the envelope" when evaluating drills to ensure that quality has been assessed and maintained, says Kennedy. Drills typically end after three or four hours, but the window of time for evaluation should be expanded to measure the quality of care given to patients, he argues.

"We typically don't talk about the degree of quality care we provide to victims. It is easier to talk about mobilization and logistics — whether you got the lights on — than quality."

Ask these two questions after drills, he recommends: How effective was your response? Did you meet your overall objective of continuing to care for patients, and responding to the health care needs of the community?

"We have been discussing this here," Kennedy says. "First, you need to include individuals who are used to measuring those kinds of outcomes, including quality managers."

One possibility is that the first part of a drill could assess the initial response, while a second part could assess follow-up and quality issues, he suggests. "The earthquake happens, you respond, then you take a break and pretend it's two days later," Kennedy says. "We would follow up with the patients as we do our normal patients. We have a mechanism for that during normal operations, but do we have a mechanism to do that during a disaster?"

He points to the Joint Commission's four required elements for an emergency management plan: Preparedness, mitigation, response, and recovery. "Following up is part of recovery and is only now getting attention in health care," he says.

"In the past, disaster planning was done mainly to maintain accreditation and meet JCAHO standards," says Weisul.

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That is no longer the case, as organizations have made disaster planning a priority and allocated significant resources for drills and planning exercises, says Kennedy. "If something happens, it's not going to be the safety guy in front of the news media, it's going to be the CEO," he adds.

Look outside your organization

However, many organizations still don't participate in disaster planning on a communitywide level, says Wise. "That is one area that continues to be difficult, so we continue to emphasize it," he says. "We are strongly urging — in fact, there is an expectation — that hospitals reach out to the community to find out the role they should be playing."

"If the community is hit by something major and there is no electricity or water or sewage — to have a single hospital prepare for that without having its assets integrated into the overall community plan is not going to make sense," he says.

Participate in community drills, which tend to be tabletops, and invite community planners to your drills, Wise recommends. "It certainly makes sense to invite the community in. We often find, though, that they get invited to so many places they may be more reticent to get involved with individual drills. The expectation is that the hospital gets involved in the community drills."

Organizations can do this by committing their personnel, time, and resources to participate, with involvement of quality leaders, says Weisul. "Participate in the network and establish personal relationships, which are crucial in the time of a disaster," he recommends.

JCAHO surveyors will be asking, "Do you know the names of the emergency management people in the community? Are you participating in meetings? Are you aware of your role in a disaster and how communication will occur?

Use large-scale approach

"These are the types of questions that one would want to be able to answer," says Wise. "If you can't answer those, then you haven't done adequate planning. The time to start exchanging business cards is not at the time of the disaster."

When doing your hazard vulnerability analysis, take into account that other resources in your community may be affected, as with the 9/11 terrorist attacks and Hurricane Katrina. "Over the last several years, we have seen some pretty significant disasters, including the loss of electricity in the Northeast and the hurricanes in Florida last year," Wise says. "We have now seen that organizations may in fact be on their own for long periods of time."

Disaster drills are typically geared toward a short period of time, but your organization may need to stand alone for several days, so you must address emergency power, water, sewage, and personnel issues, says Wise. "To be able to sustain an organization for several days without any outside help and build that kind of infrastructure, is actually quite expensive," he says. "That's why you need to sit down with the community to figure out which medical resources are going to be able to stay up and running, and if organizations need to evacuate, where they would go."

After each drill, an after-action analysis should be done to identify weaknesses and vulnerable areas, says Weisul. "You need to keep asking, What if? What if the backup power went down? What if patients arrive with no notice and helicopters were landing without any contact?" he asks.

At UCLA, every drill generates a written critique and detailed action plan given to the disaster committee, which is chaired by a physician. "It is part of the medical staff executive committee, which gives it a lot more power and makes sure the action plan stays on the agenda until the issues are resolved," says Kennedy. "Then we test them again to see if we actually did fix them."

Identifying backup plans for communication is essential, says Weisul. "Communication during a disaster is crucial," he adds. "One of the difficulties of a true disaster is that information is inadequate or changes by the moment."

During Katrina, cell phones weren't working since the system was quickly overwhelmed. As a result, St. Frances Cabrini developed plans to use two-way radios as its primary form of communication during disasters. "The ability to communicate with the affected hospitals in New Orleans was reduced to ham radios," adds Weisul. "Hospitals should consider having access to ham radio operators and equipment during a disaster scenario."

During Katrina, an incident command center was established early on, allowing the organization to handle internal and external communications through one central source, acquire and access resources, and participate in the statewide response to the disaster.

According to Weisul, "An incident command

center should be a crucial part of disaster planning and drills, because it will become the hub of all communications."

Katrina underscores the need to incorporate evacuation scenarios into your disaster drills. "It does point out to hospitals the need to truly identify and test how you are going to evacuate patients," Kennedy says. "Not just how to move them, but once you get them where they are going, how are you going to continue to provide for their care?"

During a recent drill, the organization used the scenario of a fire down the hall from the operating rooms, done after hours. "We put patient volunteers in each of our 23 ORs and pretended they had five minutes to leave," he says.

During other drills, the organization has practiced moving patients from one wing to another and relocating psychiatric patients. "We try to have a patient movement element to each of our drills," says Kennedy.

In addition, there may be two or more steps involved in moving patients during a disaster, says Kennedy. "You don't just move them from their point of origin to where care will be provided. You may be moving them outside of the immediately dangerous area, then from that staging area to their final destination," he says. "So there may be incremental steps to evacuation."

The organization's disaster plan was updated to address this scenario, by identifying specific departments that will formulate a plan for moving patients at a moment's notice if needed, including bed control, nursing, engineering, central supply, and respiratory therapy. "That group comes together and within five to 10 minutes, they will give the plan to the incident commander about how patients will be moved and where," says Kennedy.

If you know a storm is coming, as many patients as possible should be discharged, says Jeanne Eckes-Roper, RN, director of emergency preparedness for the North Broward (FL) Hospital District. If an evacuation is going to occur, the hospital should make copies of all medical records and be prepared to send all records, films, medications, and anything else needed for patient care to the receiving facility, she advises.

"Appropriate family notifications need to be done in advance of any evacuation, if possible," adds Eckes-Roper. "Patient tracking during evacuation will be a critical key for families and facilities."

Patient tracking is a concern during any disaster, even if evacuation is not required. After multiple victims were brought to the hospital after a motor vehicle crash, Kennedy realized that one patient had four identifiers: a triage number given in the field, a patient identification number assigned upon arrival to the ED, and was referred to as "the boy with the head injury" and "boy with the blue jacket."

"We got together with quality management and said, we can't have a patient with four identifiers, especially if blood or X-ray are needed," says Kennedy. "Now, when a patient comes in, they get an identifier that cross-references them wherever they go."

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New standards coming for disaster volunteers

Standards expected to be finalized by year end

Has your organization ever had volunteers offer help during a disaster but was unable to utilize the extra manpower because credentials could not be verified?

In 2002, the Joint Commission created new standards to address privileges for licensed independent practitioners who offered help during disasters, but it became clear they weren't broad enough, says **Robert Wise**, MD, JCAHO's vice president of the division of standards and survey methods. "We realized we needed to create [this] type of disaster privileges for other licensed practitioners. Nurses are a critical group to keep a hospital running during a disaster."

To address this, the JCAHO has proposed new standards for volunteers during disasters, which would cover other practitioners. The standards will undergo committee review this fall and are expected to be finalized by the end of the year.

"After 9/11, it became very clear that a community or hospital that was hit pretty hard by a disaster might not have enough doctors or licensed practitioners to deal with the kind of casualties they were seeing," says Wise.

In New York City, there was an influx of doctors from all over the country, but they lacked proper credentials and privileges, and the process required can take months. "So we understood that there needed to be some change to allow rapid access to these professionals, but at the same time keeping the risk of loss of quality to a minimum," says Wise.

The new standards will allow for a more streamlined process for volunteer clinicians if two conditions are met: That the emergency management plan is activated and that there are patient needs that the organization is unable to meet.

During Katrina, since a disaster was declared for both Mississippi and Louisiana, organizations could use physicians from anywhere in the country as long as they had a license, Wise adds.

The Louisiana medical board's database was not available to check credentials of volunteer physicians. "But they assigned primary source verification to the Federation of State Medical Boards, which is something we accept in our standards," says Wise. "So if somebody wanted to look for a Louisiana license, they were able to use that database." ■

JCAHO guide helps small facilities with planning

Goal is to help prepare for mass-casualty disasters

Although large organizations tend to have access to major resources and community-wide planning, smaller organizations often find themselves out of the loop when it comes to disaster planning.

To address this, the Joint Commission has published a new disaster planning guide, "Standing Together: An Emergency Planning Guide for America's Communities." The goal is to help small, rural, and suburban communities prepare and respond to mass-casualty disasters such as hurricanes, floods, terrorist attacks, major infectious outbreaks, hazardous materials spills, or other catastrophic occurrences.

"One of the things we've found is that larger cities understand emergency management very well, but smaller ones don't see themselves in the line of fire and often don't do much until something occurs," says **Robert Wise**, MD, JCAHO's vice president of the division of standards and survey methods.

Wise recommends sharing the guide with community disaster planners outside your organization. "I think that the ears of the hospital are often more attuned to JCAHO than the eyes of the community. So by sending this to community planners, they might be able to use it to augment their own planning," he says. (For a complete copy of the Joint Commission planning guide, go to www.jcaho.org. Click on "About Us," "Public Policy Initiatives," "Standing Together: An Emergency Planning Guide for America's Communities.")

Smaller organizations are given specific steps to coordinate resources. "What we are asking hospitals to do is to reach out to the community. Depending on the size of the community, there may be a place for hospitals inside the community planning, or hospitals may in fact find that there is not a distinct place," says Wise. "We've found many communities where the hospital has attempted to reach out, but there is no place for them to sit at the Emergency Operating Center. That actually becomes quite problematic when you have a community disaster such as Katrina."

Whenever a disaster has communitywide impact, it becomes critical to know which resources are viable and to have ongoing communication, says Wise.

"The time to get to know your resources is not when a disaster is on the way," says **Bob Staples**, manager of safety and security at St. Joseph's/Candler Hospital in Savannah, GA.

Quality leaders should be represented on the hospital's safety or emergency preparedness committee and be in communication with the local emergency management agency, public health department, and other area and state hospitals.

"This is crucial — you should be meeting on a regular basis to discuss plans," says Staples. "Know their names and their emergency cell phone numbers, and don't be shy about asking questions."

For years, hospitals have been able to deal with facility-based disasters, such as multi-car accidents or loss of power, says Wise. "The real challenge is when not only their resources are knocked out but so are the resources of many other medical asset, or those of the entire community," he says. "This is when community planning becomes critical. No organization can cope with this single-handedly." ■

JCAHO to look closely at patient handoffs

Communication lapses will be key focus

An emergency department patient is brought in for an X-ray, but the nurse forgets to tell the radiologist about the patient's allergy to contrast dye. During a change of shift, a caregiver doesn't mention that the patient is at high risk for a fall injury. When a patient is transferred, the receiving facility isn't given a complete list of medications the patients is taking.

Whenever patients are "handed off" from one health care provider to another, it is a dangerous time, according to **Peter Angood**, MD, vice president and chief patient safety officer for the Joint Commission's International Center for Patient Safety.

"I think the important message out of this is that the JCAHO has gathered a decade's worth of data related to sentinel event activity — and a common theme that's always at the top is the issue of communication," says Angood. "And one of the most important areas is handoffs. It's a high-risk period, and there is a tendency to under-communicate."

Quality professionals are now being challenged to demonstrate that processes are in place to address all types of hand-off communication, with the JCAHO's new 2006 National Patient Safety Goal #2E. Organizations must implement a standardized approach to hand-off communications, including an opportunity to ask and respond to questions.

You must have processes in place to ensure that information is transferred from one caregiver to the next on the patient's condition, current problems that are active or potentially active, and the stability or potential instability of vital signs or physiologic status.

"What surveyors will be looking for is that institutions have implemented the structure and processes to effectively deal with managing handoffs," Angood says.

Surveyors also will be looking for obvious lapses or processes that contribute to poor communication during handoffs, such as the use of tape recorders, illegible handwriting, use of non-standardized forms, and the inability to contact an individual for follow-up questions.

"We are not being too prescriptive about all this, because there are a multitude of environments out there," says Angood. "Ideally, there should be good face-to-face communication. And if needed, there should be a way to contact people to clarify issues about patient care."

The problem with tape recorders is that there may be a tendency to provide minimal information if the staff person is eager to get off duty, says Angood. "They will occasionally miss information. And you've got the new person coming in trying to settle into their day, listening to the message while patients are arriving, which results in inattentive listening."

Inconsistent communication during patient handoffs has, at times, led to a patient's safety being placed at risk, says **Rita Stockman**, RN, MSA, director of hospital quality at William Beaumont Hospitals. The organization recently implemented a re-engineering process to address handoffs.

"The risk may be due to a gap in information, or perhaps the inability to rapidly locate the information in the medical record," says Stockman. "Variances in the reporting process have been demonstrated over time."

A "Hand Off Task Force" designed and implemented an improved process for transfer of inpatient information. The goal was to ensure that during a patient transport, each team member plays an active role in handing off the patient.

A "Transport Procedure Checklist" documents the transfer of the patient — and responsibility for their care — from one department and caregiver to another.

"Each caregiver involved in this handoff plays a distinct role in ensuring the clinical information is current, actively communicated, and that the patient is safe," says **Jayant Trewn**, PhD, the organization's research engineer.

The project was implemented from March 2004 to July 2005, with five teams, as follows:

- The "Continuity of Care" team designed the hand-off project.

• The "Data Elements" team determined the data elements that were to be included in the hand-off form.

• The "Performance Standard & Transfer of Information" team determined the performance evaluation standards and an information system to access data elements.

• The "Research and Publication" team developed and implemented the hand-off project evaluation methodology and assessed the success of the change.

• The "Education Sub-group" developed and implemented the hand-off training. The project was steered by a core group, with monthly review meetings held. A "Plan, Do, Check, Act" methodology was used, with the following cycle of activities: Evaluation of current hand-off process, redesign of hand-off process, testing of new processes using direct observation and user feedback, redesign of the process and form, implementation of revised form and re-evaluation of change, and ongoing monitoring of the hand-off process.

The evaluation and feedback information was used by the task force to revise the form and improve the hand-off process. During the pilot, emergency department (ED) staff identified the need to include a separate form for their admitted patients, since there were specific data elements that needed to be included.

The hand-off process is being monitored on a monthly basis by the task force, using direct observations on a sample of handoffs as they occur on units.

"The observations recorded relate to the compliance with the established process of handoffs, such as patient identification, communication of information, physical presence of relevant staff during the handoff, and the completeness of the information in the hand-off checklist," says Stockman.

To improve handoffs, **Scott Anderson**, principal of Chandler, AZ-based Quality Systems Group, recommends taking the following four steps:

1. Standardize procedures.

Formalize procedures for handoffs by making expectations clear and consistent, such as what to do when the nurse taking over is not available, says Anderson. "This is especially helpful for float staff if shift change reports are different from unit to unit," he says.

2. Use "what if" scenarios to assess how robust the process is.

Communication lapses become dangerous when a combination of variables occur, such as a patient with an emergent change in condition being transferred at change of shift, with the receiving nurse unavailable to take the report directly.

"What if" questions include: What if the nurse is not available? What if this occurs at change of shift? What if the patient is confused and this isn't communicated in the report?

3. Look at communication when patients are transported for diagnostic testing or procedures.

One common problem is lack of a clear process for handoffs from the ED to diagnostic imaging. In response to a sentinel event, one hospital developed clinical criteria for this, Anderson says. "An important step is formalizing the return handoff back to the ED from the imaging department," he says. "The final step of the imaging procedure is direct communication between the imaging staff and the nurse caring for the patient in the ED."

4. Audit compliance using tracer methodologies.

Ask staff about the process of communication between units or shifts and look for inconsistency in responses, Anderson advises.

Or choose a patient about to change locations and identify a few vital pieces of information such as language barrier, abnormal assessment data, significant co-morbidities, and abnormal vital signs. Then, check with the receiving unit to identify whether the key issues were communicated.

"Also, note whether the communication was directly from the caregiver providing the previous care to the new caregiver," Anderson says. "Measurement is the number of key items communicated to the receiving end, divided by the number of items reviewed."

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ACCREDITATION
Field Report

Surveyors quiz staff with their own prep tools

Survey team thorough with the basics

During a recent JCAHO survey at McKay Dee Hospital Center in Ogden, UT, surveyors used the organization's own preparation tools to interview staff. "We made JCAHO booklets, and the surveyors asked clinicians questions right out of them, saying, 'So what haven't I asked you out of your book?'" says **Bonnie L. Jacklin**, RN, MS, nurse administrator.

Similarly, when surveyors wanted to know how communication from leadership got down to the staff level, they used the organization's own newsletters, flyers, and memos to assess this. "If they saw something laying around, they would just pick it up and read it — including memos they picked up in our break room," says Jacklin. "If they saw something sitting there, they figured it was fair game."

The survey team was very thorough with the basics, looking closely at history and physical, nursing assessment, care plans, pain assessment, medication orders, and processes for verbal orders, says Jacklin. "They would spend from a half hour to three hours on a unit looking at processes," she says. "By the fifth day, we could predict what the surveyor was going to ask for, depending on what they saw during the tracer."

Surveyors were very interested in communication between clinicians and other departments or physicians and spoke with all disciplines that cared for the patient being traced. They also wanted to know how the organization's board members interacted with staff, and how much access staff had to the board.

"They were impressed with the participation of our board members during the survey," she says. "The surveyors were very impressed with our quality reports and how we reported to both the board and staff with the same report."

Quality data are gathered on a monthly basis, and each service line presents its reports quarterly to its departments, the medical executive council, and the quality oversight council. "The quality oversight council includes the medical director and the chief nursing officer," Jacklin explains. "They take these quarterly reports to senior management and the board."

The hospital received only minimal recommendations for simple processes that were not followed completely, such as obstetrics anesthesia using an abbreviated form for history and physical. "This was not acceptable, so we changed to the existing OR anesthesia form, while JCAHO was still here," says Jacklin.

"It is harder to prepare for this type of survey because we could not hand pick who the surveyor would talk to and prep them," says Jacklin. "We had to rely on the staff to retain the information that was given to them through staff meetings, newsletters, and inservices. Not having control was hard, but our staff did great."

Here are questions asked by the surveyors:

- For patients transferred from other facilities, surveyors wanted to know how the transferring hospital communicated with the receiving hospital. They asked nurses how they knew the patient was coming and whether communication between nurses was face-to-face or over the phone.
- They asked about communication during patient handoffs, such as how patient information was passed on to the next shift or when patients are transported for diagnostic testing. "They were asking a lot of questions pertaining to that and said it would be a great thing to do an FMEA on," she says. The organization uses a transfer form when patients are sent to different units, to ensure a standardized process for handoffs.

"Face-to-face communication is always better, but the cath lab may be starting another procedure, so the technician may bring the patient out to the floor," she says. "So we do a lot of communication, and we also use the form. If it's missing any information, nurses do have a chance to ask questions."

- Surveyors asked about the number of times patients were transferred to different units within the facility. "That's one way that errors can occur. The way we have it set up is by providing different levels of care in the same unit. We bring the service to the patient instead of the patient going to the service," says Jacklin.

The organization's cardiovascular thoracic unit provides care to patients that require vasoactive medication, to control blood pressure in patients receiving a pacemaker who will be discharged home in a few hours.

• Surveyors looked at the process for verbal orders in every unit. "Our process is that when a nurse takes a verbal order, they write 'RBO' for 'read back order.' That's how we audit the process," says Jacklin.

• If the surveyors saw a "prn" or range order for medications, they asked how nurses knew how much medication to give. "We have a very detailed policy for prn and range orders," Jacklin says.

• On the mother/baby unit, surveyors went over security in detail. "They really delved into it - it was so intense," says Jacklin. "In previous surveys, they just skimmed the surface. But this time they kept delving deeper until they had no more questions to ask," she says.

• In the neonatal intensive care unit, surveyors wanted to know the process for when the mother was being discharged but the baby was not and chose a patient who lived 100 miles away. "They wanted to know how social work and dietary was involved and spent quite a bit of time on follow-up," she says. "They wanted to see evidence of multidisciplinary care, including psychosocial elements."

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THE QUALITY - CO$T CONNECTION

Move from information transfer to exchange

Improve information exchange by clarifying intent

By **Patrice Spath**, RHIT
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Hundreds of service handoffs take place everyday when patients are transferred between caregivers and units. Ideally, a hand-off transfer of responsibility for a patient occurs without a break in patient care and associated activities. A successful handoff avoids unwarranted changes in patient care goals, decisions, or plans, including dropping or reworking activities that others were told would be done by the previous caregiver. The Joint Commission is encouraging hospitals to improve patient care by analyzing and improving work processes to avoid poor communication during service handoffs. An increasing number of studies show that traditional methods of gathering patient data, organizing it, and communicating it among caregivers may not support high quality patient care. Practitioners must move beyond long-standing practices of information transfer (based on a one-way monologue) and toward a more effective system of information exchange (based on two-way dialogue).

Improving information exchange during service handoffs starts with clarifying the intent. What is considered a handoff and what caregivers are trying to achieve during these handoffs? Handoffs don't only occur at shift change or at transition points (admission, transfer between units, discharge). During a patient's day, there may be multiple patient handoffs — junior resident to senior resident, physician to nursing staff, surgery team to recovery room staff, nurse to nurse handoffs.

What about handoffs that don't directly involve the patient. For example, is there a handoff between staff who draw a blood specimen and the person who runs the lab test? The Joint Commission has not clearly defined what is meant by "hand-off communications"; thus, each organization must clarify the meaning of the term. Don't assume everyone has the same definition of a handoff.

Although there may be hundreds of handoffs that occur during a patient's hospital stay, not all of these situations are critical to patient safety. Common examples of potentially critical handoffs are shift changes for nursing staff and residents and transfer of patient care responsibilities from one physician to another or from one medical team to another, such as after a patient has had surgery and is transported from the operating room to the post-anesthesia recovery unit. Even seemingly routine handoffs, such as transport of an inpatient to the nuclear imaging department, can be problematic if there is poor communication.

For instance, in one hospital, an MRI technician described a situation in which she had a particularly difficult time calming a developmentally

disabled child during a test — only to find out later that the child was deaf. This vital information was never relayed to the technician when the patient was transported from the inpatient unit. Also consider hand-off situations that involve other facilities or post-discharge caregivers, such as when patients are transferred to another hospital or discharged home for home care services. The transfer of inpatient care by a hospitalist to outpatient care by the patient's primary physician is another example of a potentially critical handoff.

Next, describe the meaning of a "safe handoff." This description serves as the basis for setting improvement goals. Some organizations incorporate the description into a policy statement. For instance: To ensure safe and effective communication when patient care responsibility is transferred from one caregiver to another caregiver, the oncoming caregiver should receive information needed to:

- safely and effectively accomplish routine patient care responsibilities;
- resolve potential issues or concerns;
- manage unexpected or non-routine situations.

Caregivers must be discouraged from viewing the handoff as only a transfer of information. The most common deficit in patient handoffs is the tendency to view it as a data transfer rather than a higher level information exchange. The ideal patient handoff should be a discussion, not just an exchange of information. The caregiver that simply rattles off a series of facts about the patient and then leaves has not fulfilled his or her duty.

Once the critical handoffs have been identified and hand-off expectations clearly defined, it's time to prioritize which information exchanges will undergo scrutiny first. The service handoffs that create the greatest risk for errors are the most likely candidates for immediate action. Review data about past incidents to determine where miscommunications contributed to the event and the handoffs involved. Study the details of these incidents to gain a better understanding of what aspects of the handoff were defective. A secondary purpose for evaluating past incidents is to substantiate the need for improving communication among caregivers. Unless there is a compelling case for change, stakeholders will be reluctant to put their hearts into it while enduring a needed change. Failure to develop the case for change will cause communication improvement efforts to lose focus, lose momentum, and be stymied by the traditions of the past.

CE *questions*

17. When doing a hazard vulnerability analysis as required by JCAHO, what should organizations consider?
    A. Small-scale events, such as motor vehicle accidents.
    B. Weather-related disasters.
    C. Major disasters that would require communitywide planning.
    D. All of the above.
18. Under which of the following conditions do JCAHO's new standards for disaster volunteers apply?
    A. Whenever the emergency management plan is activated.
    B. When the emergency management plan is activated, and there are patient needs that the organization is unable to meet.
    C. In all cases when the organization is unable to meet patient needs.
    D. When patient volume exceeds the hospital's capacity.
19. Which of the following is required by JCAHO for communication during patient handoffs?
    A. Communicating all information electronically.
    B. Giving caregivers an opportunity to ask and respond to questions.
    C. Using tape recorders to give change of shift report.
    D. Using written checklists only.
20. Which of the following is recommended as an effective way to improve handoff communication?
    A. Implementation of formalized procedures for handoffs.
    B. Encouraging use of informal communication procedures.
    C. Using written communication only.
    D. Auditing compliance only after problem areas have been identified.

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

Bring everyone involved in a critical handoff together to discuss ways of improving communication at vital points in the patient care transition. For instance, if transfer of a patient from the operating room to post-anesthesia recovery is considered a high-risk handoff, involve surgeons, anesthesiologists, nurse practitioners, bedside nurses, OR nurses, transport staff — anyone who is engaged in information exchange.

Start the discussions by drawing a high-level flow chart of patient flow and identifying the hand-off points. This can be a good time to explore ways of cutting down on the number of handoffs. By changing the process, it may be possible to reduce problems by minimizing or eliminating handoffs.

Next, ask people to define the characteristics of each handoff, taking into consideration the organization's definition of a safe and effective hand-off. For example:

- Who is primarily responsible for ensuring satisfactory information exchange?
- What key communication steps need to be followed?
- What minimal information needs to be communicated?
- How should information be exchanged?
- Who should be involved in this exchange?

It is essential that people work together as a team to identify the minimal set of information that needs to be imparted during the handoff and how best to accomplish the communication. With so many individuals involved in the care of patients, it is essential that everyone agree on minimal standards for information exchange. The communication mechanism may vary from unit to unit or situation to situation; however, the same essential information should be communicated during a handoff. Listed in the box above are categories of information that should serve as minimum components of a handoff.

The specific information to be exchanged in each category will vary according to the situation. When designing hand-off logistics, caregivers should consider research findings and the recommendations of professional groups and "best practice" institutions. At the end of this article are sources of information on how to design better handoffs.

Categories of Information to be Communicated in Handoffs

- baseline information about the patient's physiologic and mental status, current medications, diagnoses, procedures, care requirements
- relevant information about most recent phase of care
- expectations for the next phase of care
- other issues, e.g. discharge plans, family concerns, pending consultations, etc.

Source: Brown-Spath & Associates, Forest Grove, OR

Whatever process changes are made to improve exchange of information during patient handoffs, caregiver training in communication techniques also is important. Safe and effective hand-off communications depend on the ability of caregivers to prioritize relevant information and transfer insights effectively. Practitioners and staff may have received no formal training in hand-off communication; it is often just learned on the job.

No matter how efficient the hand-off process becomes, the proper information exchange won't take place if people don't have the right communication skills.

Additional Resources

Australian Council for Safety and Quality in Health Care. *Clinical Handover and Patient Safety: Literature Review Report*. March 2005. Online document (PDF): www.safetyandquality.org/clinhovrlitrev.pdf

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CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review,* CE participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

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Simpson, KR. Perinatal patient safety: Handling handoffs safely. *The American Journal of Maternal/Child Nursing*. 2005; 30(2): 152. ■

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Quality's power, importance increasing, but so is workload

Pay-for-performance and public scrutiny are two reasons why

The role of the quality professional is more important than ever, agree experts in the quality field interviewed by *Hospital Peer Review*.

"Quality professionals are becoming more and more valuable to organizations when you consider all of the various requirements for monitoring and evaluation that are required by the JCAHO standards, elements of performance, and National Patient Safety Goals," says **Kathleen A. Catalano**, RN, JD, director of regulatory compliance services at Dallas, TX-based PHNS Inc.

That perceived value is being reflected in at least some salaries, according to the 2005 *Hospital Peer Review* Salary Survey, which was mailed to readers in the June 2005 issue. This year's results show that 26% of quality professionals reported an annual gross income in the $70,000 to $79,000 range, with 9% reporting income greater than $100,000.

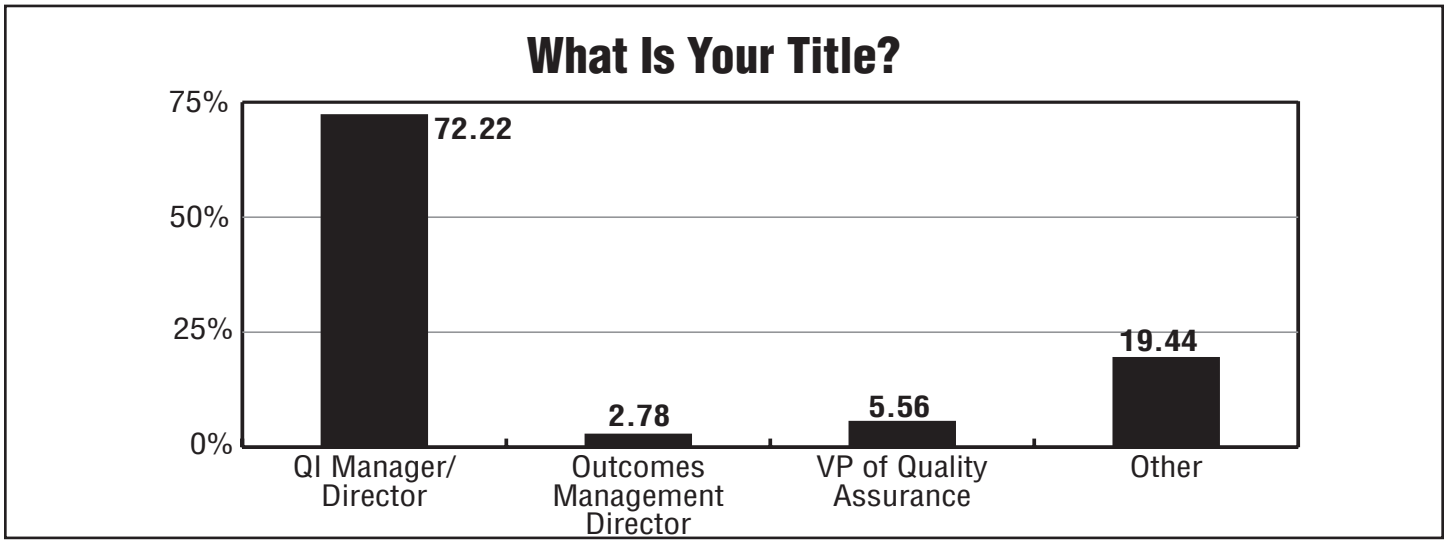
Slightly fewer than half of the respondents reported a salary increase of 1% to 3%; 23% reported an increase of 4% to 6%, while 12% received an increase over 7%.

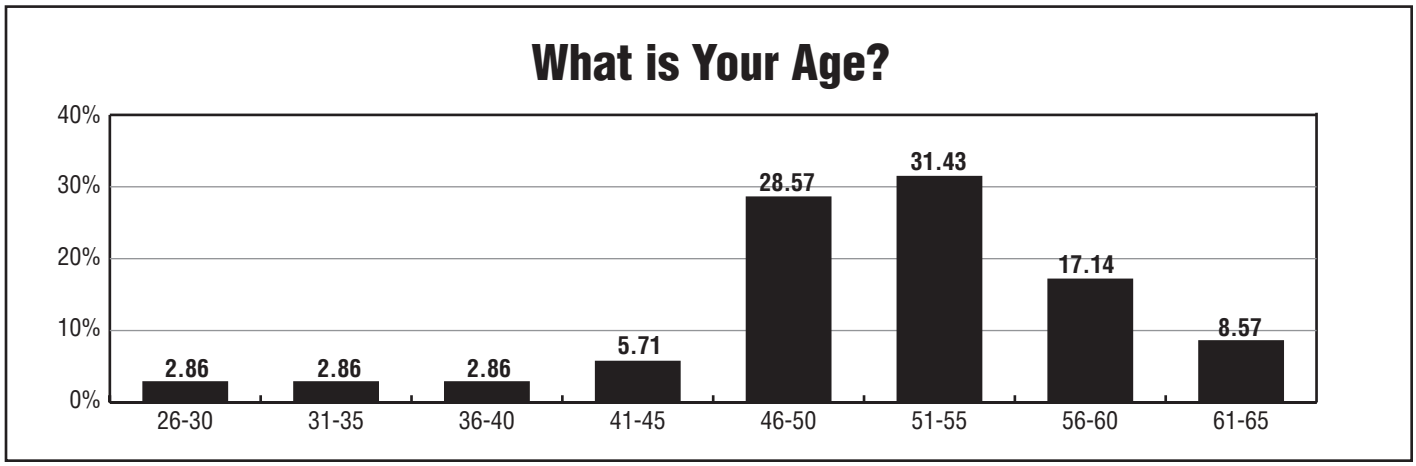
In addition, the trend toward pay-for-performance incentives is giving quality managers more leverage to obtain needed resources."Leaders of health care organizations are concerned that their reimbursement or market share will be adversely affected when performance doesn't meet payers' and/or consumers' expectations," says **Patrice L. Spath**, BA, RHIT, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates.

More hats to wear

As a quality manager, you must be able to provide leaders with performance data that show two things, Spath says: How well the organization is doing at meeting performance expectations, and what improvement opportunities exist.

Increasing demand for transparency and public





reporting of health care performance data has placed more responsibility on quality professionals' shoulders.

"Data gathered for public reporting must be accurate — and data sources, such as patient records, must be well-documented," says Spath. Performance trends must be tracked, and statistical analysis tools used to identify undesirable variation.

In addition, the effectiveness of a growing number of performance improvement and patient safety projects must be evaluated.

"Often, these responsibilities are added to an already over-burdened quality department," Spath says. "The challenge for today's quality professional is how to do more with less and do it well."

Despite these challenges, there appears to be increasing longevity in the quality field. According to the survey, only 14% of respondents worked in quality for three years or less, with 53% working in the field more than 15 years.

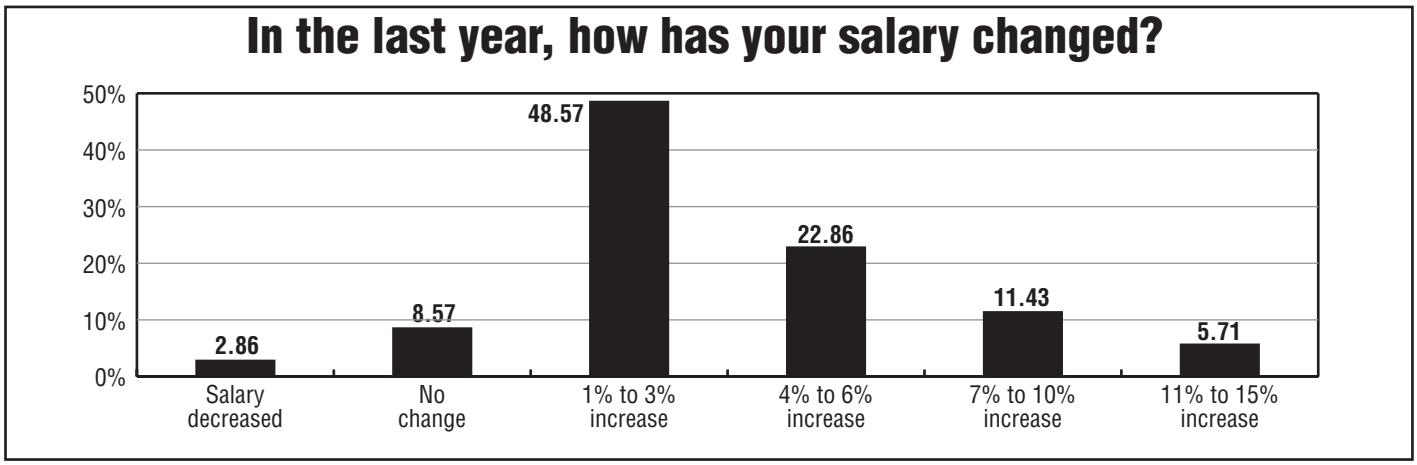
"The reasons for this are not totally clear, but it may be related to the increased recognition of the value of the position to the organization," suggests **Frederick P. Meyerhoefer**, MD, a Canton, OH-based consultant specializing in JCAHO and regulatory compliance. "In spite of all the difficulties, the quality professional may feel the recognition and increased responsibility makes it more comfortable to continue to work in this area."

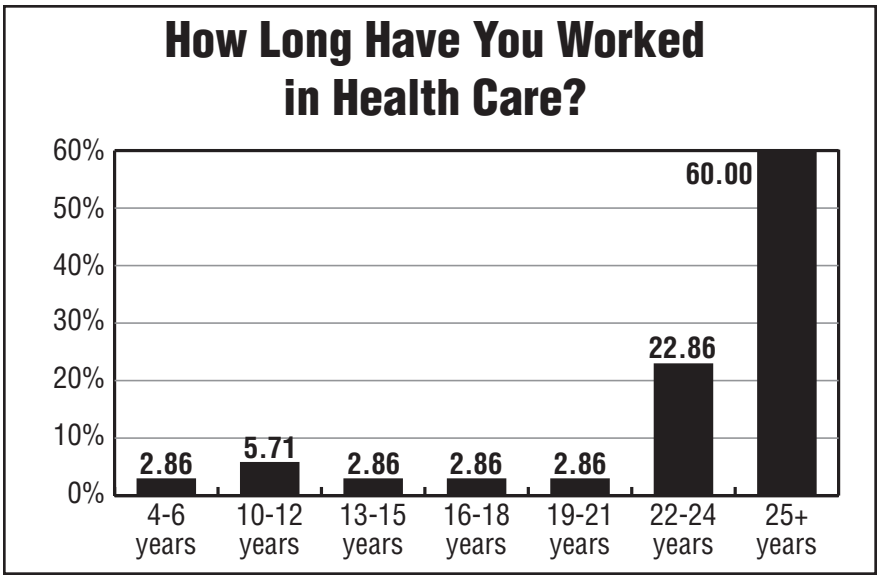
It's true that the importance of quality professionals is growing due to the link between reimbursement and quality.

"On the other hand, more and more work is being piled on to these professionals," says Catalano. "The question to answer is: How long can quality professionals sustain their excellence without increased staff and, possibly, without increased recognition?"

To succeed, quality professionals must determine which tasks are no longer necessary and what can be done to streamline those tasks that must still get done. "The quality department that is not computerized will find it difficult to keep up with the increasing demands of the job," says Spath.

Quality professionals sometimes have responsibility that far exceeds their placement on organizational charts and monetary rewards, says **Judy B. Courtemanche**, president and CEO of Courtemanche & Associates, a consulting firm





specializing in regulatory compliance and outcomes management, based in Charlotte, NC.

"Even though they are viewed as the regulatory watch dogs and trouble shooters for their organizations, less than 6 % are vice presidents or senior leaders with commensurate salaries," she adds.

The survey's results showed that more than half (57%) of quality professionals are working 45 hours or more a week, with 20% working more than 55 hours a week. Just 9% work less than 40 hours, and another 34% work between 41-45 hours a week.

"The increased job duties have added to hours worked, but the salary has not increased commensurate with the job burdens and time," argues Meyerhoefer.

The bottom line is that quality professionals are not considered revenue-enhancing staff in organizations, Courtemanche says. "Rather, they are viewed as an obligatory cost of doing business," she says.

As a result, organizations often limit the resources allocated for quality monitoring. "Organizations can easily lose sight of the need for quality monitoring and performance improvement operations to enhance clinical effectiveness and the bottom line," Courtemanche says. Quality methodologies such as Six Sigma may be too expensive and time intensive for organizations, says Catalano. "They are probably best off sticking with the 'Plan, Do, Check, Act' methodology or simple processes, and do them consistently and well," she says.

Many quality professionals are wearing multiple hats, finding themselves in the roles of quality manager, risk manager, privacy officer, security officer, and patient safety officer. "Some institutions have enough money and are large enough to pay an individual to take on each role, but many cannot," says Catalano.

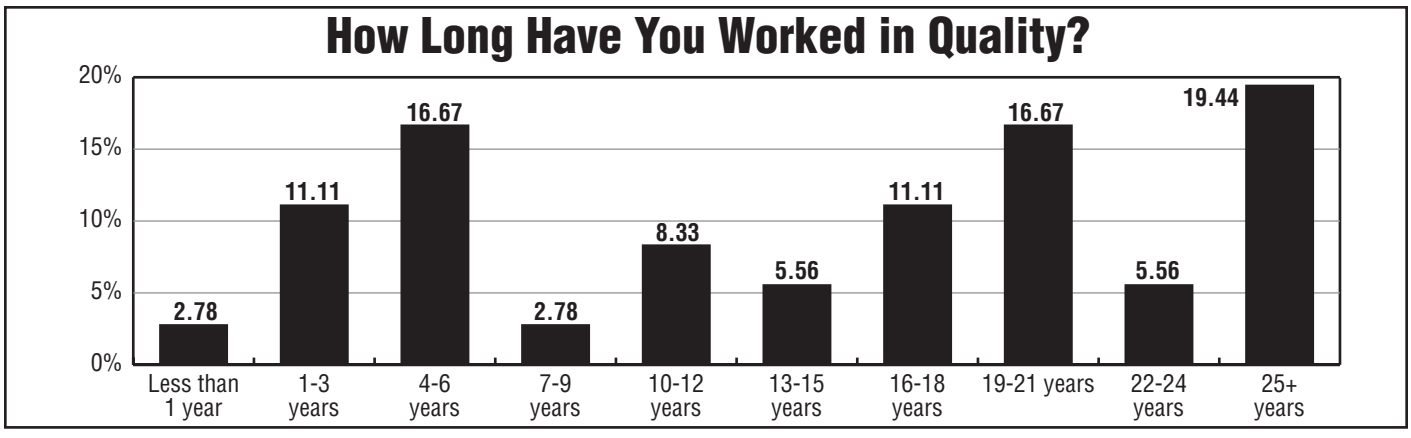
Probably the most common new responsibility for quality managers is that of the patient safety officer, Meyerhoefer says.

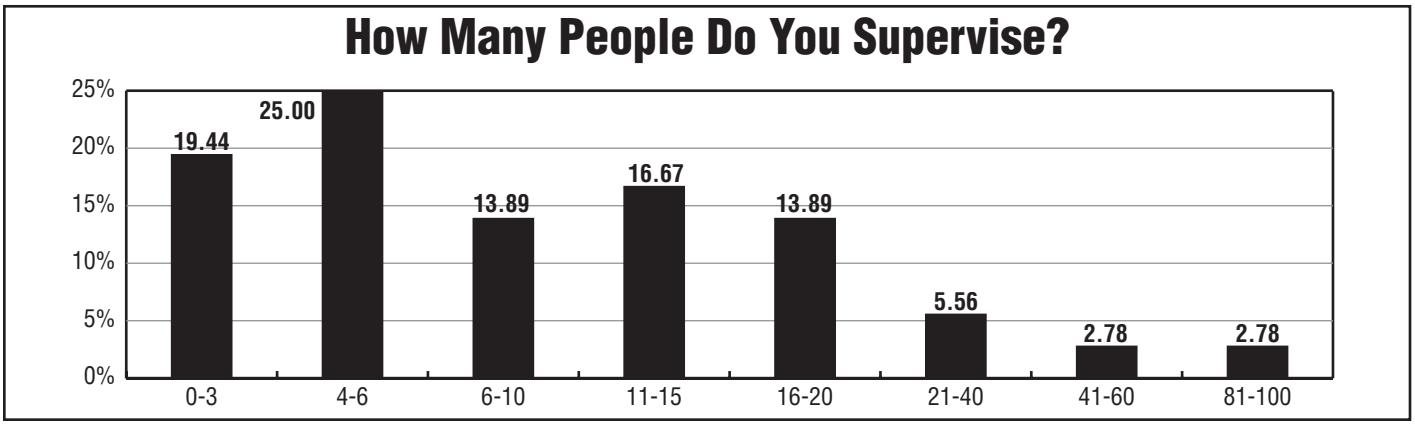
"Other quality managers are also taking on the role of compliance officer," says Meyerhoefer. "As these responsibilities expand, the qualifications for the position also seem to be increasing." The job description now frequently includes different educational requirements such as a master's degree, he adds.

Quality managers need help

To satisfy these added requirements, the quality manager must continue to expand the ability to understand and manage data and information, to satisfy all the internal quality initiatives along with external regulatory requirements, says Meyerhoefer.

"Coupled with these changes is the slowly evolving shift in job title. More individuals





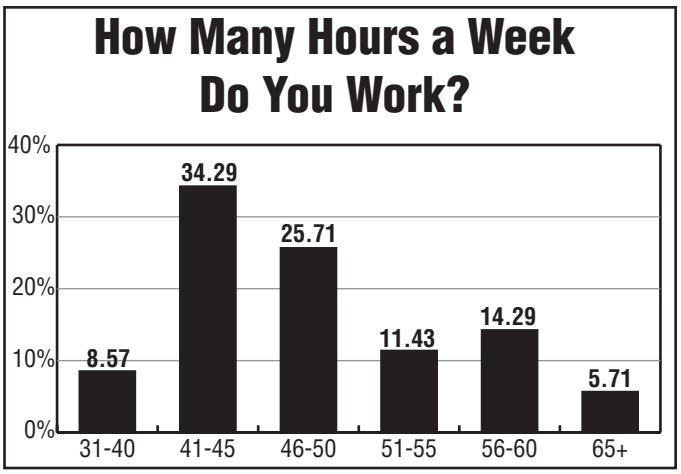
responsible for the quality programs now carry the title of vice president," he says.

To get ahead, quality professionals ideally should have two things: A clinical background and computer literacy, Catalano says. "Without those two ingredients, they may find themselves in the dark," she says.

Quality managers are responsible for a long list of expectations, including core measures, annual periodic performance reviews, mock surveys, and mock tracers, and must involve others in the process to avoid becoming overwhelmed, says **Paula Swain**, MSN, CPHQ, FNAHQ, director of clinical and regulatory review at Presbyterian Healthcare in Charlotte, NC.

"Engage staff, physicians, and leadership in all that is important," she advises. "For example, the National Patient Safety Goals might be the responsibility of the safety officer, but others are still accountable for compliance to standards," says Swain.

According to the survey, 42% of quality managers currently supervise more than 10 people. "Staffing for quality management responsibilities is slowly increasing. This is due to the overall increase in work needs which is also tied to the mounting requirements for concurrent data collection, audits, analysis, and implemented actions based on the analysis," says Meyerhoefer.



However justified, additional quality personnel may not be allocated due to budget problems at the organization, he adds. To support the need for more staff, point to the expected increase in efficiency, quality, and safety of patient care, Meyerhoefer advises.

If there is a bigger group of data collectors, the integrity of the quality might be a concern, says Swain.

Problems with inter-rater reliability might introduce variations or inconsistencies that render the data meaningless after analysis, she explains.

"The definition of each indicator is a primary focus of the quality manager, as well as the methodology for the data collection," she says. "Nothing is more frustrating than taking a report to a committee that is riddled with inconsistencies. This would be like leaning your ladder on the wrong wall. A lot of work with nothing accomplished."

To manage a multitude of requirements, quality managers need assistance, even for making appointments to meet with the multiple teams, committees and groups involved, argues Swain.

"If the quality manager doesn't have an assistant to work with other people's raw data and organize the findings from mock review and tracer activities, they will be sunk at the dock," she says.

These tasks can be done by individuals who don't have the knowledge base or global perspective of the quality manager, adds Swain.

In general, quality managers are reporting higher up than the earlier years, to CEO, COO, or other senior leaders, says Swain. "This is necessary, as the quality professional is going to be pulling resources from everything that is available. It would be very difficult to have to go to every director to request help," she says. ■