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Does your organization have a 'culture of safety?' Here's how to find out

JCAHO will want to know your findings

Would you like some compelling evidence to present to administrators about a chronic safety problem? Do you want a foolproof way to achieve staff buy-in when a new patient safety initiative is implemented? How about finding out what staff *really* think about reporting safety concerns?

Doing a patient safety culture assessment can do all of these things for your organization, says **Joann Sorra**, PhD, of the Rockville, MD-based Westat Group, which helped to develop and test the Agency for Healthcare Research and Quality (AHRQ)'s Hospital Survey on Patient Safety Culture tool.

Although conducting a self-assessment of safety culture currently is optional, the Joint Commission is expected soon to require organizations to do this. "This is part of the draft standards, subject to approval, for the new leadership standards, targeted for implementation in 2007," says **Richard J. Croteau**, MD, JCAHO's executive director for strategic initiatives.

"It's clear, across the full spectrum of health care in this country, that organizational culture is not consistently supportive of patient safety," adds Croteau. "If we can accept that statement, then we need to somehow change the culture to be more supportive of safety. If you are going to change something, you have to measure it and know if you are improving."

The results of a patient safety culture survey will help you identify and prioritize areas to focus improvement efforts based on the input of hospital staff, Sorra says.

"A staff perspective is important, because it reveals what both clinical and non-clinical staff are concerned about in terms of patient safety," she explains.

Although other types of activities can be used to identify where to focus patient safety improvement resources — such as root cause analysis, patient safety rounds, patient safety indicators, and event reports — the self-assessment method is unique because it is based directly on input from staff, Sorra notes.

Until recently, there was no evidence-based way to assess culture, but now several validated tools are available. In addition to the AHRQ tool, organizations are using the Safety Attitudes Questionnaire and Safety

Climate Survey developed by researchers at the University of Texas Center of Excellence for Patient Safety Research and Practice, the Patient Safety Assessment Tool developed by the VHA's National Center for Patient Safety, and the Patient Safety Climate in Healthcare Organizations (PSCHO) survey tool, developed by Stanford University's Consortium for Patient Safety.

At the Johns Hopkins Hospital & Health System in Baltimore, safety culture is measured throughout the entire organization using the Safety Attitudes Questionnaire.[1] "Each department and nursing unit receives their results benchmarked to other hospitals," says **Peter J. Pronovost**, MD, PhD, medical director at the Center for Innovations in Quality Patient Care at Johns Hopkins University School of Medicine. "We use these measures as part of our safety scorecard."

The goal is to have 80% of staff in all units report positive safety and teamwork climate, says Pronovost. "For nursing units less than 80%, we implement a comprehensive unit-based safety program," he adds.

To be effective, the survey should be given organizationwide, stresses Croteau. "One of the things we learned is that there isn't a single culture in any organization," he says. "There is considerable variation from one unit to another. So you need to implement the assessment process at the unit level, since a problem may exist in a single unit."

While some organizations already are doing self-assessments to identify problems, others are far behind in this process, Croteau says. "Some are right out in front of the curve, but others just feel it's one more onerous burden being put on them by external forces. That's the range of organizations we are dealing with."

There is growing evidence that self-assessments can affect patient safety, with one study finding that safety climate improved in specific survey areas for 26 hospitals in a California hospital consortium. However, researchers also discovered wide variation in culture among hospitals.[2]

"The main implication is that while most employees view safety culture in hospitals as pretty good, there remains significant room for improvement," says **Sara J. Singer**, the study's lead author and a senior research scholar at Stanford University. When the researchers compared the California hospitals to naval aviation, they found that on average, safety culture among naval aviators was three times stronger, Singer notes.

"The key to the effectiveness of our survey method is that we provided benchmark data for our hospitals," says Singer. "They could compare themselves not only to an acknowledged high reliability organization — navy aviation — but also to the other hospitals in our study. This enabled them to identify areas of relative strength and also specific areas to target for improvement."

"We've got to attack the culture of the entire institution, rather than a piece here and a piece

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Editorial Questions

For questions or comments, call **Staci Kusterbeck** at (631) 425-9760.

there," says **Kevin Tabb**, MD, chief quality and medical information officer for Stanford Hospital & Clinics. "We're doing that in a number of ways, allowing us to look at every nook and cranny of the hospital to find out how we are doing in relation to where we should be. It's been a very good process for us."

Asking everyone for input

Completing the self-assessment required by the Joint Commission's Periodic Performance Review (PPR) is one way of doing this. "But you are then only speaking to a certain segment of your employee population," says Tabb. "You never know where you are going to get a good idea from. We've gotten important tips from transporters about patient safety."

The organization considers the results of its PPR findings, along with a broader random sample of employee responses, gathered annually using the PSCHO tool. "We have had a very good response rate. What I've found is that internally people are very honest and open to coming to the table with where we need improvement," says Tabb. "I am constantly surprised by the good suggestions that we get from all over the organization."

The culture survey is "another tool in our arsenal," in addition to the PPR, use of electronic patient safety software, and participation in national benchmarking programs, says Tabb. "In some ways, this is similar to other industries, such as automobile companies going down the line and asking people what they think, instead of just management," he says. "When you talk about culture, it has to permeate every aspect of the organization."

At Northwestern Memorial Hospital in Chicago, a survey was developed and administered in 2002 to assess patient safety culture. In December 2004, the hospital was going to repeat the administration of that survey, but right around that time got word that the AHRQ-validated survey was available. "So we changed our plans and decided to use the AHRQ survey instead," says **Marilyn K. Szekendi,** RN, MSN, APRN, BC, research nurse coordinator for the patient safety team, part of the organization's division of quality and operations.

The tool was pilot-tested to see if staff thought it was too long or if any of the questions were confusing, but no such problems were identified, so the organization decided to use it.

Upon administering the survey, it was found that survey items referring to one's "supervisor" didn't apply well to physicians, notes Szekendi.

"That is not a meaningful term to most physicians in the context of their professional responsibilities," she explains. "We realized that the survey is really meant mostly for care providers, but we decided to send it to all employees and did get responses from non-direct care providers. It was good to see what the general culture is, if non-clinical staff feel they can speak up about improvements in their own departments," she says.

In December 2004, the hospital's information systems (IS) department prepared a web-based version of the survey so it could be sent out electronically to more than 6,000 employees, plus nearly 2,000 medical staff and residents.

"We got back a tremendous response of 28%, with over 1,600 usable surveys returned," says Szekendi. "We had it online for about six weeks, and it was e-mailed to everyone. We sent out two reminders, and with each reminder we got a nice surge in responses."

Hand-off communication

At Indian River Memorial Hospital in Vero Beach, FL, staff completed the AHRQ survey in October 2004, with a total of 617 responses and a 57% response rate.

"One of our IS folks built us a program so we could give the test online, and we scheduled time for departments to use the computer training room to complete the survey," says **Barbara Horne**, RN, vice president and chief nursing officer. After the survey was completed, a coupon for a free meal in the cafeteria was printed out as an incentive.

The system gave real-time results, so that Horne could see how many staff had responded at any given time. "I was able to call a particular manager to say, 'Only two of your staff members out of 50 have responded to the survey. Please encourage people to take part in this,'" she says.

The biggest concern identified involved hand-off communication — staff were worried that information was falling through the cracks as patients were moved from one area to another.

"We have addressed that in a number of different ways," says Horne. For example, surgical floor nurses receiving patients from the post-anesthesia recovery area were uncomfortable with the handoff process. "We had those two

groups sit down together to outline the conditions that a transporter can be used as opposed to a nurse, and what exactly needs to be included in the report, which they both agreed on," says Horne.

Other changes involved the process for patients being moved from the ED to inpatient units, and an abbreviated form was developed for patients being transported to a floor for treatment.

The goal is to ensure that the receiving caregivers have all the information they need to care for the patient, such as the patient's "do not resuscitate" status, and facts that can impact the safety of both staff and patients, such as informing nurses that a pneumonia patient also happens to be a psychiatric patient.

"I'm eager to see if staff responses change when we compare the next survey results with our baseline data, as a result of these interventions," says Horne, adding that the organization plans to repeat the survey later this year.

Pinpoint problem areas

At Northwestern, the results were broken down by units and disciplines so they could be compared easily. The survey results were used to target three key areas for improvement: handoffs, communication between units, and feedback after reporting an incident. "One thing that surprised us was that people indicated more discomfort filling out incident reports than we expected," says Szekendi.

The data are useful to help with staff buy-in for improvement projects. "Now we can go to the department and instead of just taking data from the literature, we can tell them, 'This is what you told us was a problem,'" says Szekendi.

The following was done to address each area:

- A new web-based incident reporting system was implemented.
- Patient safety and nursing morbidity and mortality meetings are held monthly, taking a case study from a reported incident and asking staff for ideas on how to prevent future incidents.
- Training programs on handoffs and communication have been initiated.

Now the organization has a baseline and is planning to repeat the survey to assess the impact of the changes made over time, says Szekendi.

At Chesterfield, MO-based Sisters of Mercy Health System, the AHRQ tool was used as a pilot study in one hospital in fall 2005, and will be done across the complete health system during March 2006. "We will be working with each hospital to improve in areas that we find opportunities," says **Charles Gasper**, senior analyst for the organization.

Each question was evaluated for the mean responses, based upon whether the survey respondent was a clinician, worked directly with patients, and what shift he or she worked. These scores were further aggregated into 10 composite groups, such as "teamwork within units."

"We found the culture scores to be positive across the hospital," says Gasper. "However, in some cases, these sub-groups had statistically significantly lower scores for various safety areas."

A report was generated for hospital leaders with recommendations as to which composite areas should be addressed. The report gives information about the overall survey results and also is broken down by shifts, clinicians and non-clinicians, and whether staff work with patients, physicians, and nurses.

The summary report was presented to the hospital's CEO and senior leaders, with portions presented to targeted groups and individuals. In addition, posters reporting the ratings for each of the composite scores are being put up throughout the hospital to communicate the results to front-line coworkers.

"We view this first analysis as baseline data from which we will compare results going forward," says Gasper. "However, a few areas of opportunity presented themselves during the analysis. These will be addressed during this year, with improvement evaluated over the course of future surveys."

Results will be tracked for each hospital over time, with the health system also utilizing comparison data provided by AHRQ, says Gasper.

"This will give us a better idea of where we stand, and who within our health system might be able to give us better insight as to how to improve our culture of safety," says Gasper.

Some organizations struggle with determining what result constitutes an "area for improvement." "We have suggested that if 50% of staff are "neutral" or "negative" on an item, that would be an area for improvement," Sorra says. "An area of strength could be defined as 75% or more of respondents answering positively on an item."

However, some hospitals find these cutoffs don't work for them — either they end up with too many areas for improvement or not enough

— so they'll have to select a different cutoff, says Sorra. "These criteria can be raised or lowered with the overall goal of identifying a subset of areas for improvement where attention can be focused," she explains.

Once areas for improvement are identified, the next challenge is how to prioritize them. "The other problem is not knowing what actions to take or what initiatives to implement to improve a particular area," says Sorra. "This is something any hospital doing a patient safety culture survey is struggling with."

Free materials available from AHRQ include a survey user's guide that provides guidance for selecting a sample, collecting data, analyzing the data and reporting results, and a PowerPoint feedback report template that hospitals can use to populate their survey results data to make presentations.

(See www.ahrq.gov/qual/hospculture.)

"The PowerPoint template displays the percentages of responses on the survey items, grouped according to the safety culture dimensions the items are intended to measure," she says.

Another free, downloadable resource is available on Premier's web site (http://www.premier-inc.com/all/safety/culture/index.jsp) — an Excel data entry, analysis, and reporting tool that allows hospitals with 2,500 surveys or less to import survey data and automatically generate charts of the results.

Comparison survey results are available on the AHRQ web site, so that you can see how your organization compares with other organizations, says Sorra. Overall composite scores are posted from 20 participating hospitals, with guidance on how to evaluate results compared to the benchmarks.

Westat currently is under contract with AHRQ to develop a national benchmarking database. "We expect to have a call for data submission some time in late spring 2006 requesting hospitals that have administered the AHRQ survey, and that meet several eligibility criteria, to submit their data to the database," she says.

"Announcements from AHRQ and other sources will be forthcoming once the database is underway and criteria for submission have been developed."

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Collaborative cuts ICU infection rate in half

Rapid cycle changes, checklists were used

A 50% decrease in central-line infections and an increase in compliance with evidence-based practices from 30% to 95%. These are the dramatic results achieved by 10 hospitals participating in the two-year Greater Cincinnati Patient Safety ICU [Intensive Care Unit] Collaborative. The group earned the Joint Commission's Ernest Amory Codman Award, given for excellence in performance measurement.

Strategies included standardizing the insertion

of central lines by using sterile barriers such as gloves, gowns, and full-size bed drapes, using a chlorhexidine antiseptic, and training staff in high-risk units on organizational change methodology.

The 10 hospitals participating in the initiative are Bethesda North Hospital, The Christ Hospital, Cincinnati Children's Hospital Medical Center, Cincinnati Department of Veterans Affairs Medical Center, The Fort Hamilton Hospital, Good Samaritan Hospital, The Jewish Hospital, Mercy Hospital Mt. Airy, St. Elizabeth Medical Center, and The University Hospital.

"We used a modified Institute for Healthcare Improvement [IHI] model," says **Marta Render**, MD, the coordinating physician, who developed the Agency for Healthcare Research and Quality project, forming a regional collaborative through the Greater Cincinnati Health Council.

The IHI's model was modified to include "campaign strategies." The "political" campaign created alliances with leadership across the organization, while the "marketing strategy" focused on selling the change to clinical staff, and a military campaign mapped out timelines, "beachheads," and resources needed to win the campaign.

"The project differs from a usual research project, since if successful, the clinical staff would incorporate these evidence based-practices into their daily approaches forever," says Render.

The IHI model has a role for leadership in initiating the change, but then relies heavily on repeated measurement followed by small tests of change by the front-end staff, Render explains.

Four of the health care systems implemented chlorhexidine and maximal sterile barriers in the first year, while the other five hospitals implemented correct timing of antibiotics acting as a control for the ICU intervention, says Render. In the second year, all hospitals added a second project — either timing of antibiotics in the operating room or implementation of consistent use of sterile gown, gloves, large drape, cap, and mask during insertion of central lines.

The preferred site of insertion of the central line was in the chest or neck, femoral lines when inserted were to be removed in 48 hours, and all central lines were prepped with chlorhexidine rather than betadine.

"Personnel in the ICU were encouraged to use a daily checklist to identify the earliest possible moment when the central line could be removed," says Render.

Here are obstacles and how they were addressed:

• **Presently configured kits included supply items that are not recommended for best practices.** Items such as small drape and betadine were removed, and quality leaders worked with manufacturers to develop customized kits, says Render.

"The drapes and new kits added some cost to the procedure, which had to be justified to leadership," she says.

The lack of a clinical performance objective for supplies is an obstacle to justifying the use of safer products, Render says. "In the constrained economic hospital environment, a paramount performance objective for supply managers is controlling cost," she says. "The addition of a clinical performance objective for such operations might create a sense of partnership."

• **The IHI model was new to staff.** "The usual epidemiologic model for change in health care is inefficient and the newer model — rapid action cycles — was unfamiliar. Teaching that method was critical to success," says Render.

Moving from the idea that this was a "study" and short-term intervention for analysis to a "practice" was another challenge, says Render.

Unexpectedly, sharing of data and strategies across health care system boundaries did not prove to be a problem, perhaps because the groups reporting monthly were kept small, usually less than eight people. "Also, the infection control practitioners who were the project leaders had previous experience working together," says Render.

• **Time to enter the data, analyze the data and plan the next action was always in short supply.** "The teams were magnificent in their ability to put in an extra hour of work when it was needed," says Render. "Inventive and smart nurse managers identified nursing staff that were interested in moving up the nursing ladder, or master's nursing students who needed an intervention for a focus in order to draw nurses into creating a robust process."

At the Christ Hospital in Cincinnati, there were two goals: reducing central line infections and reducing surgical site infections. For Phase 1 of the project, a "Central Line Insertion Checksheet" was completed by each nurse every time a line was inserted. The nurse checks off whether hands were washed and disinfected, a mask worn, a

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Tiered structure helps ED improve flow, satisfaction

Department cuts LOS by 40 minutes

Between 2001 and 2005, average length of stay in the ED at Northwestern Memorial Hospital in Chicago has dropped from 85 minutes to 45 minutes. Throughput has fallen from 308 minutes to 230 minutes during the same period. In addition, patient satisfaction scores (Press Ganey Associates, South Bend, IN) have increased from 74.6% to 84%.

This improvement was due to a number of factors, notes **James Adams**, MD, chairman of the department of emergency medicine. For one, the department instituted a comprehensive Six Sigma initiative during that time period. But perhaps one of the most unique strategies, and one that has clearly had an impact on the aforementioned improvement, was the redesign of the ED management structure.

"We have four nurse managers, and each has a subsegment of staff and shifts," Adams explains. The new structure, he adds, was adopted in fall 2003. The nurse managers are assigned as follows:

- There is a night manager who works 11 p.m.-9 a.m. four days a week.
- There is another evening manager who works from 2 p.m.-midnight four days a week.
- There are two "day" managers, one of whom manages the observation unit (OU) and also has ED staff, while the other works entirely in the ED. Both of these managers work 8 a.m.-5 p.m., five days a week.

Managers split responsibilities

Their managerial responsibilities are further divided, explains **Deborah Livingston**, RN, MS, director of emergency services. "We've taken major pieces of what managers do, like staffing, salary and budget, quality management, and equipment, and assigned those responsibilities to each of them," she says.

Salary, budget, and staffing are assigned to the night manager. Quality management has been assigned to the evening manager. Equipment is assigned to the day manager who doesn't have the observation unit. The person who is upstairs with the observation unit and downstairs with the ED also manages staff educators, Livingston says.

They want to take advantage of efficiency in educational and orientation opportunities upstairs and downstairs, she adds. "Why run two programs when you only need one?"

These responsibilities were assigned based on expertise, Livingston says. "We put a person who was incredibly meticulous with salary, budget, and staffing," she says. She also has a scheduler who works with her, Livingston notes. "We have quality nurses in the department who work with the quality manager," she says. They do all the callbacks for left without being seen (LWBS), radiology callbacks, and nurse quality data collection.

'Double-duty' valuable

The assignment of a single manager for the observation unit and part of the ED staff was an extremely important part of the improvement process, says Livingston. "It really helped us make initiatives between the two areas flow better, as she has staff and influence in both areas," she says. "It's a big part of why we have been so successful."

Once example is the "orange," or middle triage, patients. (Northwestern has a five-level, color-coded triage protocol.) "These are mostly young, otherwise healthy patients with abdominal pain who would normally wait the longest," says Livingston. They often need a lot of tests and scans, she says.

The patients who go from the ED waiting room to the observation unit go there for their ED care, Livingston explains. "We call it 'ED2,'" she says. "We have an emergency room attending up there at all times these patients are up there. They are registered as ED patients with a special code that denotes their different location." This change starts to drive the culture that patients should not wait, Adams says.

After they have received their ED evaluation and care, if they need observation care, they then are admitted to the observation unit for outpatient observation. They stay in the same room and bed. The patients are happy, as they avoid long waits in the ED and they have a bed and a TV, says Livingston.

Inpatient holding patients (select admitted patients waiting for an inpatient bed) are also placed up in the observation unit. "This unloads the ED and improves throughput, so patients don't wait as long to be seen," she explains, "With inpatient beds very tight, the [observation unit] is our most consistent outflow opportunity for the ED. We are creatively maximizing its use."

All programs affected

Livingston notes that the tiered structure not only directly impacts performance in the ED, but also contributes to the success of specific Six Sigma initiatives.

"It's great to have more than one manager to work on these initiatives we are making," she says. "We always team a nurse manager with a physician, and this gives us more people to go around."

Personally, Livingston is extremely thankful for the new structure. "This would be a lot of work for one manager to be doing," she concedes. "It also helps the staff because they have a go-to person for whatever they need. It creates much less confusion about who is doing what."

Of all the improvements engendered by the new structure, the most important are those that impact wait times and throughput, Adam asserts. "Quality in the ED is time-based," he says. ■

Stroke program wins first Codman award for DM

Minimizing variance through staff training

The Joint Commission on Accreditation of Healthcare Organizations has named Swedish Medical Center in Seattle the winner of the inaugural Ernest Amory Codman Award in the disease-specific care category, for establishing a comprehensive program that deploys a coordinated team to assure comprehensive, timely, and efficient acute stroke care.

The program, initiated in 2001, has:

- reduced the mortality rate by 12%-16% from "already low" levels;
- reduced the cost of care significantly;
- cut average length of stay by 1.4 days;
- improved patient satisfaction;
- performed in the top 10% nationally in compliance with American Heart Association (AHA) guidelines for stroke care.

"The program was started to bring into Swedish Medical Center advances in diagnostic testing and therapy that had been going on in some leading institutions in the country, but which for the most part had not percolated down to most medical centers," explains **William Likosky**, MD, medical director for the stroke program at Swedish Medical Center. "The idea was to offer guideline-driven care to all patients — not just to some patients whose doctors might be familiar with the guidelines."

The reality, he says, is that most patients with stroke are admitted by someone who admits perhaps one or two stroke patients per year. "Therefore, there is a lot of variability in the doctor component; the same could be said for the nursing component, and the nursing unit component," Likosky asserts.

Tools readily available

The good news, says Likosky, is that the tools necessary to achieve his goal were readily available. "The American Heart Association and the American Stroke Association have been producing recommendations for care over the past five or six years," he notes. "These are very good guidelines, available for the taking, with regard to treating ischemic stroke, intracerebral hemorrhage, who might benefit from thombolytic therapy, and so forth."

Along with these guidelines, he continues, you must have certain structures in place to ensure the desired outcomes. "You have to train people; you also have to have a CT scan available '24-7' with trained personnel and units organized to take care of stroke patients," he asserts.

So, each nurse received eight hours of training in key areas such as the swallow screening (developed by Swedish Medical), deep-vein thrombosis prevention, and urinary tract infection prevention.

"They were trained to the point where you could not be admitted by a nurse here who was not trained in this," says Likosky.

The actual providing of care was restricted to three or four units, he continues. "We instituted the guidelines and assured they were followed."

As for the physicians, a stroke team was developed from among those physicians who specifically wanted to take care of stroke patients. "We provided literally hundreds of hours of available training," reports Likosky. "For example, everyone is trained and certified in the NIH stroke scale."

He notes three key areas that have contributed to the program's success. "We have measured our outcomes using the AHA's 'Get with the Guidelines' database," Likosky says.

"This is marvelous — it defines the processes of care and allows you to compare your performance with others. This way, you are actually benchmarking against some of the top institutions in the country."

The second component is the use of the Dartmouth Compass of Outcomes. "This is a way of looking at the relationship between quality of care, cost of care, and staff enablement in patient satisfaction," Likosky says. "Quality is very much related to training of staff; the better trained they are, the better your quality becomes. At the same time, if you watch expenditures — i.e., if people are not in the hospital as long, if they are treated more quickly — you will also improve quality."

Third, the facility employs the "bundles of care" concept developed by the Boston-based Institute for Healthcare Improvement. "This is based on the concept that if you want to minimize error, you must know how many processes need to be done, because your most likely errors are errors of omission," Likosky asserts. "So, if you have 100 processes of care, you need to know who's responsible for each of them."

Of course, he points out, these processes can be interdependent; for example, you cannot plan a discharge properly if the respiratory therapist has not let you know when the patient can leave. "We developed contracts, so that each of the processes is assigned to a group, and that group does the process each time," says Likosky. "However, they have the right to ask other groups for what they need in order to do their jobs correctly."

Finally, he adds, compliance is tracked regularly. For example, the program ensures that stroke patients receive expedited evaluations in fewer than 45 minutes when warranted.

"We have a nurse practitioner at the bedside virtually instantaneously, who works with the physician to immediately then create a plan of evaluation and therapy — all of which is fully in place within two hours," Likosky notes. "If we get all the guidelines right, we are less likely to have errors." ■

Nurse liaison must communicate well

Translate 'medicalese' into plain talk

Nurse liaisons can quickly become highly appreciated members of your staff, say experts.

"The staff in the pre-op area see the nurse liaison's interaction with patients and families as having a calming effect on the patient and family members, especially when there are delays, and [post-anesthesia care unit] nurses are relieved that the family is being taken care of so they can concentrate solely on the patient's needs," explains **Maureen Spangler**, RN, CNOR, director of perioperative services at Lexington Medical Center in West Columbia, SC.

A nurse liaison is only beneficial if the right person is in the position, and not all RNs are right for a nurse liaison position, she warns. Excellent communication skills are essential, she points out. After excellent communication skills and solid perioperative knowledge, the next most important quality the clinical nurse liaison must have is the ability to work with people, including patients, families, nursing staff, volunteers, and physicians, Spangler says. "The nurse liaison must also be able to work under pressure and multitask."

The nurse liaison must be able to explain everything to the family members in everyday terms, says **Lorraine Osborne**, RN, CPN[C], perioperative clinical educator of Kingston General Hospital in Kingston, Ontario. "The liaison also should be comfortable talking to all types of people and able to deal with people who are very emotional," she adds. Liaisons should be able to communicate with people from a wide range of backgrounds, races, and socioeconomic levels, she adds.

Make sure your liaisons have the resources they need to do their job, suggests Spangler. "Give the liaisons the authority to use service recovery items such as gift baskets, meal tickets, or gift certificates when appropriate," she says.

"It is a stressful role, and we have allowed them to identify ideas for service recovery based upon their own experiences."

For example, nurse liaisons were given beepers they can distribute to families if family members want to leave the facility, Osborne says. Another suggestion from the nurse liaisons was a cell phone for each nurse so they would be available at any time in any location, she explains. "They also make their cell phones available for patients or families to use if they need to make phone calls."

Don't forget to offer education to liaisons that is pertinent to their position. "We had the nurses work with guest services for two weeks prior to beginning their role," explains Spangler. In addition to reviewing communications skills, nurses also spent time learning how to identify and handle the different ways in which people react to stress, she says.

"Some people withdraw and others become aggressive, so it's important for the liaison to recognize these behaviors as stress-induced and talk with them in a manner that relieves the stress without taking their behavior personally," she explains. ■

Medicaid strategies eyed in Pew report

A recent report by the Pew Center on the States (www.pewcenteronthestates.org) examines state Medicaid reforms being tested to reduce program spending.

Reforms include changes related to long-term care, prescription drugs, new technology, program management, and privatization. The authors conclude that many reforms do not actually reduce spending but shift it elsewhere in the health care system. "We hope this report will help states see the costs and benefits of the approaches other states are taking and aid them in crafting their own strategies to tackle this growing challenge," says **Sue Urahn**, director of the Pew program. ■

RWJF report outlines health coverage plans

The annual "State of the States" report, summarizing strategies states are implementing or considering to expand health coverage, has been released by State Coverage Initiatives, a program of the Robert Wood Johnson Foundation. Illinois lawmakers have extended health coverage to children, according to the report, while Maryland legislators required large employers to increase their health coverage. Massachusetts officials are considering proposals to achieve universal health coverage. ■

AHRQ: Spending on trauma surpasses heart disease

U.S. spending to treat trauma-related disorders nearly doubled between 1996 and 2003 to surpass heart disease as the leading medical expenditure by condition, the Agency for Healthcare Research and Quality (AHRQ) reported. Over the same period, spending for heart conditions increased nearly 17%. The number of Americans with medical expenditures for heart conditions and cancer increased over the period, while the number of Americans with medical expenditures for trauma was roughly unchanged, according to AHRQ. The data are from AHRQ's Medical Expenditure Panel Survey. ■

chloraprep swab used, a sterile glown, gloves worn, full body drape used, and — if the patient had an ultrasound — whether a probe cover was used.

"The project was started in our Medical Intensive Care Unit (MICU) and rolled out housewide after we had worked with the line tray manufacturers and drape manufacturers so we could standardize the protocol throughout the hospital," says **Mary Nicholson**, RN, BSN, CIC, the project leader and infection control practitioner who led the data collection and analysis efforts.

The checklists are sent to the infection control (IC) department to monitor compliance with the eight indicators and also to identify patients who developed a central line infection.

Each patient record was reviewed by the infection control nurses, and Nicholson then reported compliance and infection rates to the ICU clinical collaborative committee. "The data was also posted in the unit monthly, and celebrations were held to applaud the work being done," she says. "After 12 months, our MICU unit saw a 60% reduction in central line bloodstream infections."

To ensure these gains are sustained, checklists continue to be completed, charts are reviewed by IC nurses, and data are posted quarterly.

In December 2004, Phase 2 of the project began, focused on the timing of antibiotics, beginning with a core group of patient rooms in the OR, using the Plan-Do-Study-Act (PDSA) cycle. A form was created for the same-day surgery nurses to complete, with results tabulated by the IC nurses.

"Through the PDSA cycle, we were able to work through all the kinks in the system before we moved onto other services in the OR," says Nicholson. "The goal was to have the project in all 33 OR rooms by the end of the year. However, we were able to do this much earlier, by September 2005."

Again, data were reported back monthly to the departments and posted for everyone to see. "We are now in the process of automating the reports, so the forms will no longer be used at that point," says Nicholson.

At the participating hospitals, quality professionals were included in the chain of command for reporting the project results. "The role of leader and teacher perfectly suits quality professionals, who could become change agents within their hospitals," says Render. "The systematic implementation of practices to reduce harm to patients and to improve their chances for good outcomes is a very hot area. The need for expertise is expanding exponentially."

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Do your disaster drills use a CQI approach?

JCAHO says there are 'missed opportunities'

After your disaster drills, do you identify areas that need improvement, and do you take steps to address these? That's what JCAHO surveyors will want to know, with a revised standard effective July 1, 2006, requiring health care organizations to improve the planning and evaluation of emergency management drills.

"This change is being made to help ensure that the field is conducting emergency management drills rigorously and thoroughly," states a JCAHO announcement. "It is believed that there have been missed opportunities during drills to identify and improve weaknesses."

The new standard calls for a continuous quality improvement approach to planning, conducting, and evaluating emergency management drills. Although disaster drills and hazards vulnerability analysis have been required for years, quality improvement often was lacking, 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.

"Our biggest weakness is failing to learn and implement from disaster drills. The JCAHO standard emphasizes the quality improvement approach — not only that you did the drill and conducted an analysis, but what did you learn from it and what did you do to close the loop," he says. "It will also be crucial to prove to the JCAHO that the drill to be done simulates a real situation."

In general, once areas for improvement are identified, the JCAHO wants to see evidence of compliance and measures of success, Weisul notes. "The same kind of thinking should be used for disaster drills — what improvements have been made and how will you continue to sustain these gains?"

In health care, the sense of urgency around disaster preparedness has increased after the 2005 hurricanes, says Weisul. "The planning is now in regard to not if but when," he says.

During an after-action debriefing following Hurricane Rita, areas needing improvement were identified and specific individuals assigned to take actions, reconvening at a later date to make sure that the improvements were put into place, says Weisul. For example, the organization found that it had relied on cell phones to communicate and that this broke down in some cases. As a result, two-way radios were obtained.

That specific aspect of communication will be tested during the organization's next disaster drill, Weisul says. "We do a monthly check of our disaster preparedness to make sure equipment is available and in working order," he adds.

In the past, most organizations geared disaster drills toward multicasualty events such as bus crashes or bomb explosions, but future drills need to incorporate scenarios such as power outages and evacuations, Weisul stresses. These are things that typical hospitals hadn't thought of in the past, he explains.

"In the past, we weren't as cognizant of that — until we experienced results and failures in those key areas," says Weisul. After 2005's Hurricane Rita, the hospital lost water pressure in a short time frame, and also lost air-conditioning. "We had to consider the effect on lab equipment and dialysis, and to try to do that in real time of less than an hour is a challenge. If we had drilled on that aspect, it would have been a very eye-opening experience."

The health care system has developed a plan to activate resources when facilities are damaged by storms, Weisul says. "What we found during Katrina is that resources are scarce. You may find you are not in line to obtain transportation and outside help."

Newly revised JCAHO standards address the verification of volunteers who are not licensed independent practitioners, including credentials and assignment of responsibilities during disasters.

The new standard, effective July 1, 2006, allows for a more streamlined process for volunteers if two conditions are met: The emergency management plan is activated and there are patient needs that the organization is unable to meet. "The new standard will not have the same level of scrutiny and state-specific licensure when volunteers cross state lines post-disaster," says Weisul.

At Christus, during an after-action review of Hurricane Katrina, quality leaders found that the process for doing emergency credentialing was too time-consuming, says Weisul. "The key is being able to develop a process that is streamlined and achieves the JCAHO standards but is not burdensome, because during times of crisis there is a lot going on for everybody. We need to make sure the processes we put in place during our times of leisure will work when we are overwhelmed during a disaster," says Weisul.

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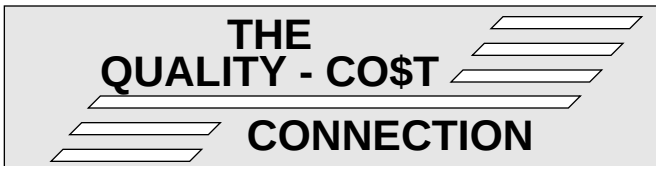

Worst practices in patient satisfaction measurement

Measuring satisfaction is harder than it appears

By Patrice L. Spath, RHIT
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There appears to be an endless search for the ideal measurement instruments and techniques for evaluating patient satisfaction. Researchers and practitioners now have more than a decade of know-how in determining whether a patient is satisfied with his or her health care experience. However, it is clear that measuring satisfaction correctly is far harder than it appears. Health care providers may not always know the right way to measure patient satisfaction, but it has become apparent that there are

several wrong ways. For a more effective evaluation of patient satisfaction avoid the following "worst practices."

• Worst Practice #1: Survey only your most recent patients

Your current patients are most likely happy with your health care organization. That's why they have recently received services at your facilities. If you only ask current patient about their satisfaction, you are likely to get an overly rosy picture of your organization. Unfortunately, in most health care facilities, surveying recent patients is the path of least resistance in measurement terms. But how about those potential patients who use other health care facilities; why aren't they receiving services in your organization? Seek out samples of competitors' patients and people who no longer use your facility. You often learn more from people who are angry than people who are happy.

• Worst Practice #2: Ask only about overall satisfaction

Health care organizations that focus on global patient satisfaction measures don't learn how to improve those measures. Asking whether a patient is satisfied or dissatisfied overall is a useful first step because it gives a summary picture of satisfaction. However if the questioning stops there, you don't know what is affecting overall satisfaction. In any patient satisfaction survey, include items regarding the specific benefits and attributes patients experience to gain deeper understanding of what drives overall satisfaction.

• Worst Practice #3: Ask only about your organization

Often patients choose among competing facilities. What drives their behavior is not their absolute satisfaction with your facility, but their satisfaction relative to the competitive options available. Always ask about satisfaction with other health care providers and report satisfaction with your offerings in terms of relative satisfaction. This also can be a useful exercise in segmentation, as you will find some people who are completely loyal, and some who have sampled services from many different providers.

• Worst Practice #4: Ask only about your health care services

Most health care services are acceptable to patients. This means that the basis of competition must shift from specific services to the "delight" factors. Evidence increasingly suggests that customer defection can be traced to intangible factors urelated to the technical quality of services. Survey customers about their entire experience with your organization; from initial contact to post-service billing. In *Figure 1* is an example of a survey tool that can be used to question patients about the "delight" factors related to their health care encounter.

• Worst Practice #5: Let your caregivers administer the survey

An early lesson in the satisfaction movement was that while having caregivers administer the survey may be an easy way to do it — after all, they see the patient anyway — it is not the best

Figure 1

Customer Service Satisfaction Survey

This survey asks about how well we measure up to your expectations. Being an outstanding health care organization is important to us, and we appreciate the advice of our patients as we seek continuous improvement.

Please mark the questions below according to the following satisfaction scale:
1 for poor, 3 for average, 5 for outstanding

	Satisfaction Level				
1. Employees are sincerely interested in caring for me	1	2	3	4	5
2. The organization has convenient service hours	1	2	3	4	5
3. Employees understand my special needs	1	2	3	4	5
4. The services and equipment are modern and up-to-date	1	2	3	4	5
5. The physical facility is visually appealing	1	2	3	4	5
6. I am kept informed about what services will be performed	1	2	3	4	5
7. Employees are never too busy to answer my questions	1	2	3	4	5
8. The behavior of professional staff instills confidence in me	1	2	3	4	5
9. I feel safe while I am receiving health care services	1	2	3	4	5
10. Employees have the knowledge to answer my questions	1	2	3	4	5
11. If I have a problem it is resolved quickly and satisfactorily	1	2	3	4	5
12. My health care experience is error-free	1	2	3	4	5
13. Employees give me prompt service	1	2	3	4	5
14. Services are done right the first time	1	2	3	4	5

If you wish to add information or provide examples that describe your opinions, please do so in the space provided below. Your comments are valuable to our understanding of your needs and we appreciate hearing from you.

Source: Patrice L. Spath, Brown-Spath & Associates, Forest Grove, OR

way to do it. First, caregivers are more likely to give the survey to happy patients. Second, they are particularly unlikely to give the survey to patients who are unhappy with them. Even if they are forced to distribute to all patients, there is a tremendous incentive for caregivers to attempt to manipulate the process. Patient satisfaction research should be performed by administrative staff or an external agency to avoid these biases.

• Worst Practice #6: Don't ask about price

Price increasingly is becoming an important factor influencing health care choices. Even many insured patients have out-of-pocket expenses when using health care services. Patients may like your services better than competitors', but not if they have to pay 20% more. Patient satisfaction research shouldn't focus only on areas of improvement without regard to the cost of the improvement to either the organization or the customer.

Follow up standard patient satisfaction research with a more detailed small sample study looking at how much more patients would be willing to pay for your services as compared to one that competes in relative quality. Similarly, examine how much patients would be willing to pay for improvements identified in the initial survey.

• Worst Practice #7: Don't segment the market

A single gross satisfaction measure across all patients is as useful as a weather forecast for "North America." Segmenting your patients into small market share units usually provides far greater insights into your strengths and weaknesses.

Segmenting your patients by customer loyalty variables such as frequency of use, recency of visit, type of services used, and duration of relationship with your organization can lead to powerful knowledge about the strength of your organization's actual and potential patient base.

• Worst Practice #8: Focus on the mean satisfaction score

Relying on a single mean satisfaction score masks a host of valuable variations. On the common five-point satisfaction scale anchored with "very dissatisfied" and "very satisfied," how many patients fall into each group? How do those patients look on the segmentation variables?

Be particularly wary of the popular practice of aggregating the "satisfied" and "very satisfied" numbers into a single "top two box" percentage.

CE *questions*

9. Which of the following is a benefit of organizations performing self-assessments of patient safety culture?
   A. Low response rates made results difficult to interpret.
   B. Organizational culture does not vary by unit.
   C. Areas for improvement could be prioritized.
   D. Staff were reluctant to complete the surveys, fearing retribution.
10. Which is accurate regarding hospitals participating in the Greater Cincinnati ICU collaborative?
   A. Customized kits were developed to ensure best practices.
   B. Sharing of data was a problem.
   C. Nursing staff were reluctant to do data analysis.
   D. Rapid cycle changes were not effective.
11. Which is correct regarding JCAHO requirements for disaster preparedness?
   A. More stringent requirements for credentialing of volunteers will apply.
   B. Only licensed independent practitioners can be used as volunteers.
   C. No out-of-state volunteers can be used.
   D. A streamlined process for credentialing of volunteers can be used if the emergency management plan is activated and there are patient needs that the organization is unable to meet.
12. Which is true regarding patient safety indicators including surgical infection prevention, according to a recent study's findings?
   A. Fewer hospitals are reporting these measures.
   B. Physician involvement has a detrimental impact on results.
   C. Despite practice changes, infection rates have not decreased.
   D. Physician involvement is a significant factor for success.

Answer Key: 9. C; 10. A; 11. D; 12. D

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■

While this often produces a gratifyingly large number — percentages routinely exceed 80% — there is increasing evidence that "very satisfied" patients often differ substantially in both attitudes and behavior from the merely "satisfied." In particular, the former group appears to be much more inclined to continue to use your facility for health care services than the latter group.

Converting these worst practices into corresponding best practices make it more likely you will accurately measure patient satisfaction. Understanding satisfaction levels does not however lead to success. Satisfying patients involves committing to a satisfaction management system, taking accurate measures, learning about the strengths and weaknesses of your strategy, and responding appropriately. Only in this way does patient satisfaction lead to true sustainable competitive advantage. ■

SIP measures now available to public

Momentum growing with health care consumers

Surgical infection prevention (SIP) performance measure sets are now available on the Joint Commission's Quality Check web site (www.qualitycheck.org). The evidence-based measures assess the overall use of antibiotics for surgical infection prevention.

SIP measure data are displayed only for hospitals that collect and submit SIP measure data to the Joint Commission through their selected performance measurement vendor.

The measure results that are posted cover the reporting period from October 2004 to June 2005. The comparative check, plus or minus symbol will be added when 12 months of data have been reported.

SIP measures data can be reported on seven surgical procedures: Blood vessel surgery; colon/large intestine surgery; coronary artery bypass graft surgery; hip joint replacement surgery; hysterectomy; knee joint replacement surgery; and open heart surgery other than coronary artery bypass graft.

SIP-2 measures, which cover patients having surgery who received the appropriate antibiotic which is shown to be effective for the type of surgery performed, will be added at a later date.

Beginning in mid-2004, the Joint Commission adopted the three antibiotic prophylaxis performance measures from the National Surgical Infection Prevention Project. "CMS and JCAHO are completely aligned on this important effort to reduce the incidence of surgical site infections in the United States," says **Dale W. Bratzler**, DO, MPH, medical director for the Oklahoma Foundation for Medical Quality, based in Oklahoma City.

Participation in the SIP project remains voluntary at this point, but more than 1,000 hospitals now are collecting and reporting these measures, Bratzler says. "There has been an increasing number of hospitals collecting this data and submitting it," he adds. "In addition, there is growing

COMING IN FUTURE MONTHS

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- How to make physicians your allies
- Proven tips for core measure data collection
- Update on JCAHO's revised leadership standards
- Strategies to comply with medication labeling

public pressure for hospitals to report infection rates. Improving performance on these measures represents a way to prevent infections."

Now that SIP measures are included on Quality Check, it raises the profile of the Surgical Care Improvement Project (SCIP), says Bratzler. (For more information on SCIP, go to www.medqic.org/scip/).

"Public reporting of quality measures often provides incentive for quality improvement activities," he says. "There is good data that show that when performance measures are reported in the public domain, they garner the attention of hospital leadership. That is essential for assuring appropriate resources for quality improvement activities."

Presenting publicly available data is a powerful was to get attention of hospital leaders, adds **Jill Garrett**, RN, CPHQ, perioperative care manager at Memorial Hospital in Colorado Springs, CO. "There are many valuable health initiatives, but when data is offered on a consistent basis for patients, clinicians, and family members to view, the driving force begins and the measure becomes meaningful," she says.

Patients are better educated about their medical conditions than ever before, adds Garrett. "The public domain reflects performance comparison and brings these valuable measures to the forefront," she says. "Publicized measures which are shown to impact patient outcomes and are evidence-based are a great place to start."

The organization's medical quality chair challenged section chiefs to undertake a process improvement project for the year, she reports. "Our surgery section chief has taken on the prophylactic antibiotic SIP measures. What better way to make improvements but by a physician leader?"

Garrett points to a just-published study demonstrating that physician involvement is a significant factor for successful quality improvement.[1] "At our institution, the directive of our medical quality chair and the commitment of our surgical chief are creating a successful quality improvement project with the SIP measures," she reports.

Reference

1. Weiner BJ, Alexander JA, Baker LC, et al. Quality improvement implementation and hospital performance on patient safety indicators. *Med Care Res Rev* 2006; 63:29-57.

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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