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JCAHO, unannounced: Just-surveyed organizations share compliance tips

The first three hours can make or break your next survey

When a group of surveyors from the Joint Commission on Accreditation of Healthcare Organizations walked into St. Jude Medical Center in Fullerton, CA, in January 2006, staff were ready and waiting for them — even though the survey was unannounced and completely unexpected.

"We didn't really expect them until March, since that was when our last survey occurred. It was just a wishful hunch, although we heard they were running early," says **Pat Wardell**, vice president of quality management and patient safety officer.

So how did staff know the surveyors were coming that January morning? They checked the Joint Commission's Extranet site religiously every morning beginning January 1, 2006 — as any organization can. At 7 a.m. Eastern Standard Time, the site will tell you if today is the day — information that's posted along with surveyor biographies. For organizations in other time zones, the window of advance warning is up to four hours, since surveyors arrive at 8:00 a.m.

"Our house supervisor checked the site at 5 a.m. every morning, and called me at 5:01 to tell me that JCAHO was coming that morning at 8:00 a.m.," says Wardell. "Staff were here by about 6:30 a.m. It did give us some leeway, and kept us from being panicky when they walked in the door."

Quality managers at La Cross, WI-based Franciscan Skemp — Mayo Healthcare System—also one of the first organizations surveyed in 2006 — found out that JCAHO was coming by checking the Extranet site as well. "That gave us about 20 minutes time to start the communication rolling, which was a definite plus," says **Kristine Von Ruden**, RN, the organization's quality improvement specialist and Joint Commission coordinator.

The time was used wisely — to gather documentation, notify staff, arrange for catering and refreshments, and make arrangements for the conference room to be available for surveyors' use. "It was like running a code. We delegated tasks and knew what had to be done," says Von Ruden.

The extra few minutes of lead time allowed the organization to project a calm, confident demeanor, as opposed to being caught completely by surprise, Von Ruden explains. "Their first impression is a lasting impression,"

she says. "The majority of us were able to be there when the surveyors arrived, and our CEO was able to greet them in our hospital lobby."

When it's your time to greet surveyors, will you be blindsided, scrambling to collect a current patient census, wondering why key leaders haven't responded to pages?

Or will you have spent the past hour waiting for the surveyors to arrive, ready to greet them with a firm handshake and all the required documentation in hand, with all hospital staff already on full alert?

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Editorial Questions

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The answer really depends on whether you've done some simple advance preparation, says **Paula Swain**, MSN, CPHQ, FNAHQ, director of clinical and regulatory review at Presbyterian Healthcare in Charlotte, NC.

"The first three hours will make or break your survey," says Swain. "That's the time when you can project an image of organization and show surveyors you've got it together. That is where you want to put your practice time."

If you are frantically getting paperwork together when surveyors arrive, it puts you in the defensive mode and you'll be playing "catch up" during the rest of the survey, she warns.

JCAHO's unannounced surveys began on January 1, 2006, so no more advance warning will be given to any accredited organization. *Hospital Peer Review* interviewed several of the first organizations to be surveyed under the new 2006 process. Approximately 1,500 hospitals will undergo an unannounced survey this year.

"We were not expecting our survey for another five months. This was truly unannounced and a complete — 7:45 am — surprise," says **Mike Zwirko**, CHE, vice president of Holyoke (MA) Medical Center. "We were the first hospital in Massachusetts to have the unannounced survey."

The very first thing staff did was ask the surveyors for identification, says Zwirko. "With reports of imposter JCAHO surveyors last year, we were trained to ask this of anyone who identifies themselves as an inspector or surveyor," he says.

Next, the surveyors were given a conference room as a "home base" to work from, and a beeper system was used to notify senior staff and managers — the same process used by the organization to alert staff during disasters.

"That was very effective, and the surveyors were impressed how quickly the hospital staff were notified," says Zwirko. "We also provided a runner to get them the needed policies and documentation."

Although harrowing at times, quality professionals say the Joint Commission's new survey process is a definite improvement. "Since we were one of the first organizations surveyed with the new unannounced process, we had to get rid of some preconceived ideas," says Wardell. "But if you are trying to look at really improving patient care, this method makes the most sense."

Here are proven strategies from just-surveyed organizations:

• **Use the JCAHO's Survey Guide as a resource.**

The guide is an essential tool in being prepared for the new unannounced process, and there are some important changes for 2006, says Swain. "The concepts are the same, but it is somewhat different as JCAHO is trying to address the unannounced process," says Swain. "If you don't follow this guide and practice it, you won't have the right people in the right places."

Pay close attention to the section that addresses the surveyor arrival and preliminary planning session, says Swain. "In that session, the surveyors and the hospital come to a consensus on the 'general survey logistics,'" says Swain. "All of the surveyors will be there together with the possible exception of a life safety code surveyor, who may not show up until the following day."

• **Have alternatives identified for staff notification.**

Everybody needs to know who his or her "backup person" is, says Swain. For instance, Presbyterian does its orientation presentation in a slide program because it prompts staff to address all the required topics. "But what if the speaker you've planned to present it isn't there that day? You've got to have somebody else who has practiced it and is familiar with it," says Swain.

On survey day you have to go with whoever is there, so cross-training is essential, says Swain. "Even in my office, if I am gone, then others can step in. If my administrative assistant who opens the command center is gone, the CEO's assistant steps in," she says.

At Mayo Healthcare, a three-tiered response plan was used with key persons identified for various roles. "We had a plan A, B, and C — so if one person wasn't able to be there, we would just go to the next one on the list," says Von Ruden. "We generally knew if someone wasn't in that day or had conflicts that could not be rearranged."

• **Be strategic about JCAHO's location.**

Chose a room for surveyors that is not right next to your staging area — where you do your planning, dispatching, chart review, personnel file review, and policy acquisitions. "Don't make them too close together," recommends Swain. "While you are previewing personnel files, medical records, and strategizing, you do not want the surveyors bumping into your commotion. What is presented to the surveyors, is cool, calm, and without surprises!"

Before the survey, Wardell met with the catering service and the CEO's administrative assistant to come up with a plan for the room the surveyors would work from. "That was very helpful because once we found out JCAHO was coming, we could immediately set about getting the rooms open that we had discussed so there was a place for them to set up right away," she says.

In addition, a room staffed with two people was arranged in advance, so whatever surveyors requested could be provided quickly. "Those were the things that kept us from having a confusing first morning," says Wardell.

However, the organization's staging area was located on the floor below the surveyor's area. "So it was close enough, but far enough away. Once they requested a particular policy or procedure during patient tracers, we could quickly get it to them," she says.

Mayo Health decided to have JCAHO surveyors set up in a conference room adjacent to the administrative offices, says Von Ruden. "Staff would sit outside and just wait to hear what they wanted to look at. We gave them a list of survey contacts so if they needed something and one of us wasn't around, they knew who to call."

• **Have a schedule available just in case.**

When one of the surveyors at Presbyterian realized she didn't have a schedule in hand, Swain quickly produced one that she'd used during mock surveys. "I had gotten it off the Extranet, and we used it to practice with. They were very thankful that they had a guide for where they were going," says Swain.

• **Find trouble spots in the schedule.**

If staff members are responsible for more than one area, individuals might end up required to be in two places at the same time — something you'll need to negotiate in advance. "In smaller hospitals, staff may wear two or three hats. By going over the schedule with the surveyors, you can identify those problem spots," says Swain.

On the last day of the survey, be sure to factor in enough time for all the "clean up" and reporting the surveyors have to do. "Be clear as to which hospital staff will attend the surveyor's exit briefing," says Swain. "They really like to have very few people attend and will not want to discuss any of the standards cited."

Despite the surveyors' request for few people, Presbyterian had the entire senior operations group present, which comprised about 15 people, she adds.

• **Give surveyors the right materials.**

If surveyors ask to see a personnel file during a patient tracer, you need someone in the staging area to look it over to make sure it's complete, says Swain. "You need good communication to keep material rolling. You don't want to give them material that you haven't had a chance to preview," she says. "Is it the right thing, based on their request? Is it complete and concise and what you want them to see?"

If your policies are not accessible electronically, there's a risk of someone going to a binder and pulling out an outdated policy, says Swain. "Most likely, a master book has a revised policy, and that is the one you should hand them," she says. "You want to control from the staging area who is handing them what."

To be sure that information is always updated, some organizations have developed Survey Readiness Boxes, similar to "disaster boxes" used during mass casualty incidents, says **Darlene Christiansen**, RN, LNHA, MBA, JCAHO's executive director for accreditation and certification operations. The boxes typically include the most current patient census, a phone tree for notification, policies and procedures that you know surveyors will ask for, and pertinent data, kept updated all the time.

At St. Jude, blue binders with the required information each have designated "owners" responsible for keeping them updated at all times. "If a "Code Jude" is called, that individual takes the books to the staging area," says Wardell. "Everyone has a 'buddy' who knows where the books are kept. That way, if the 'owner' is not there, we still know where to find it."

• **Drill your process of staff notification.**

At St. Jude, telephone operators were asked to put all managers and supervisors into a "Code Jude" group, so a single page could alert everyone at once. The group page was accomplished in about eight minutes during the survey, reports Wardell.

The notification of staff should be tested during your disaster drills, to identify people with outdated numbers or beepers without text paging capability, says Swain.

"Every single time we have practiced, we have been able to update our emergency notification list," she says. "When you do the exercise, either the individual is notified or not. And if not, then they have to fix that. People will say, 'I didn't get paged.' This testing policy puts the responsibility on staff to fix it now."

During a practice session, it was discovered that one hospital didn't have its text paging system rolled out yet, so Swain contacted the corporate IT department, which had it up and running just a few hours later.

If this hadn't been resolved before the organization's unannounced survey, every single person would have had to be contacted individually. "It would have taken an hour just to do the notification," says Swain.

If you don't have text paging, two-way phones or walkie-talkies also can be used — or in a pinch, even faxes. One hospital printed out a stack of pages that stated "I am at _____." "When surveyors left an area, the nurse could stick a page in the fax saying 'I'm at OB,' so that way we at least knew where they were," says Swain. "They also began to fax pages saying, 'We are going to…' to let us know where they were going next."

The key is to be creative and use any method that works, says Swain. "Think of any way you can to keep the communication open and then practice that. It's an extra edge."

• **Take immediate action when surveyors spot a problem.**

"It isn't until the mid-point of the survey that the surveyors compile the list of things they are really going for broke on," says Swain. "That is when you are doing damage control."

Your goal is to try to ensure that after surveyors find a problem, they won't find that problem anywhere else in the organization. If surveyors note a cigarette butt in the stairwell, put out an all-points-bulletin to alert staff to make sure they don't find another one anywhere. "Or let's say you get a recommendation for a patient plan of care. You need to get examples of patients inhouse who have good plans of care. You want to show surveyors that their one finding was just a fluke."

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Watch for these changes during 2006 surveys

Avoid problems with emergency management

When organizations gave feedback on the 86 unannounced pilot surveys done in 2005, many told the Joint Commission that they were happy with the new process overall but that they really needed a few minutes to collect themselves after surveyors arrived.

As a result, JCAHO changed its process so that the surveyors now have a planning session immediately upon their arrival. Now, after the surveyors announce themselves, organizations have that window of time to gather documents and alert staff as needed.

"We used to have an opening session right away, but we found the organizations needed a bit of time to pull everything together," says **Darlene Christiansen**, RN, LNHA, MBA, JCAHO's executive director for accreditation and certification operations. "This helps to alleviate some of that anxiety."

Here are other key changes for 2006:

• Tracers are being done for emergency management.

JCAHO has had a strong focus on disaster preparedness for the last several years, so this is not a big change in agenda, Christiansen says. But 2006 surveys will have an extra component — tracer activities conducted by the administrative surveyors or life safety code specialist.

The tracers may be based on scenarios identified in the organization's hazards vulnerability analysis, such as asking staff about the process when a hurricane or airplane crash occurs, and asking for evidence that staff are educated on this process.

"This is being done at all organizations. It may not be clearly defined on the agenda, but it is part of the Environment of Care (EC) review," says Christiansen.

• Problems have been identified with plans for improvement for life safety code compliance.

"Previously, when organizations knew we were coming, they had an opportunity to update these and address all areas related to life safety code," says Christiansen. "Now that surveys are unannounced, we are finding that Section 4 of the Statement of Conditions is a problematic area."

This is the area that identifies deficiencies and the time frame to correct them, and also allocates dollars and resources for the plan for improvement. "What we are finding at times is that the organization has not kept to the timeline that they originally documented," says Christiansen. For instance, the organization may have said the problem would be corrected by June 2006 but it is still not corrected during a January 2007 survey, she says.

"We do have an extension process that they could submit to us, but many organizations don't take advantage of that," says Christianson. The surveyors have to sign off on the plan for improvement, and if the timeline is exceeded, that can result in a scenario that leads directly to conditional accreditation, she explains.

"The EC area is critical to successful accreditation for an organization," she emphasizes.

In general, there is an increase in the number of requirements for improvement (RFIs) given for the EC standards, adds Christiansen. "Part of that is due to the culture change needed to move from survey preparation to continuous readiness," she says. "Sometimes a reeducation and a refocus of the staff is needed, to understand that they need to embed those standards and use them on a daily basis."

It's important to have ongoing implementation processes related to the standards, as opposed to addressing them once every three years as organizations have done in the past, says Christiansen. That's where the periodic performance review (PPR) can be a tremendous help, she says.

"That is one of the beauties of the PPR tool, because now it is an annual requirement," she says. "It really reinforces compliance, because organizations are reviewing all the standards each time they go through it. If you really use that tool as part of your performance improvement process, then you are going to accomplish culture change."

• There is an additional option for the PPR.

Previously, the PPR was only available to

organizations every 18 months for a three-month period, but as of January 2005, it has been continuously available and can be updated every month or quarter. "Effective January 2006, the PPR submission is an annual requirement," says Christiansen.

Organizations previously had three options to submit the PPR tool: Option 1, in which a mid-cycle self-assessment is performed but information is not submitted to JCAHO; Option 2, in which the organization undergoes a mid-cycle on-site survey; and Option 3, in which the mid-cycle survey is performed but no written documentation of the survey is left with the organization.

In 2006, there is now an addition to Options 2 and 3 — to have a full PPR survey, either announced or unannounced. "The organization of course would be charged for that, but the beauty of the process is that it has no direct impact on the accreditation decision," says Christiansen. "The outcome of the survey is for their knowledge and can be used to improve the processes internally. This gives you exceptional insight as to what is going on with the organization."

Only one organization has done this so far, she says. "They felt it was tremendously valuable in providing insight into the organization. It was also valuable because staff knew this survey outcome would not have a direct impact and were very open with the survey team. So a great deal of information was shared back and forth."

• A telephone consultation for RFIs is now optional.

Previously, there was a required telephone consultation with JCAHO's standards and interpretation staff if any RFIs were given, so that the plan for improvement could be reviewed. "The standards interpretation staff still reviews every submission for plans of action or measures of success. But in 2006, that call became optional, unless standards interpretation staff feel it is important to clarify a plan of action or measure of success," Christiansen says.

However, the organization still can request a call for guidance — something that Christiansen highly recommends.

"Take advantage of that and request the call," she says. "We will give approval for processes put in place. And if you have official approval, then during a regular accreditation survey, the surveyors cannot question whether the plan is valid or not — unless the organization has failed to implement it." ■

Comply with JCAHO's goal to label all medications

Many organizations are not in compliance

The JCAHO's National Patient Safety Goal requiring all medications to be labeled sounds simple enough, but it's proving to be difficult for many organizations. "I think the biggest challenges for an organization center around the back table labeling of syringes and containers," says **Susan Mellott**, PhD, RN, CLNC, CPHQ, FNAHQ, CEO of Houston, TX-based Mellott & Associates. "While the operative areas may be already doing this, this has not always been occurring outside of those areas."

Even within the operative areas, staff may not have been labeling syringes or basins that contain normal saline or other "non-medication" fluids, says Mellott. "I am sure that a clarification will be coming out stating that any procedure area will have to comply with this goal. If there is not such a clarification at this time, organizations would be well advised to implement this goal in the non-perioperative settings, as it is really best practice," she says.

Newly revised requirements for the safety goal have been changed to make them more consistent with the requirements in Medication Management standard MM 4.30. The new requirements are as follows:

• Labels include drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours.

• All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.

The revision deletes a previous requirement to include on the label the initials of the person preparing the medication or solution and the date of preparation. Neither of these items is required under MM.4.30 and, after review by the Sentinel Event Advisory Group, it was determined that they provide "no additional safety to the preparation and labeling process," according to a JCAHO announcement.

Inventory the types of fluids and medications

(Continued on page 55)

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Letting go of the 'that's not how we do it here' mindset

System takes flexible approach to enhance flow

When it comes to discharge planning and other health care challenges, "don't be afraid to rock the boat," advises **Jonathan Morris**, RN, bed management coordinator at Wake Forest University (WFU) Baptist Medical Center in Winston-Salem, NC.

"Part of the problem at many hospitals is they get locked into 'that's not how we do it here,'" adds Morris, whose background is in nursing and case management. Resist falling into that routine, he says, by asking, "Is there a better way? Is there something else we can do?"

When it comes to patient throughput and bed management solutions, Morris notes, that might mean letting go of the "discharge at 11" mindset, for example, or being flexible about using specialty beds for general medicine patients when appropriate.

"We try to look at evidence-based research practice," he says, "and we're constantly looking at other facilities to see what initiatives they've put into place."

Surveyors with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recognized WFU Baptist Medical Center for its own patient flow and bed management initiatives, Morris says, suggesting on a recent visit that the facility submit the program for a JCAHO award that honors best practices in different areas of health care.

Those patient throughput initiatives have included, among other things, a new pre-admit tracking and electronic bed board system, a change in bed management oversight, and the creation of an emergency department (ED) holding unit that has been successful in reducing the percentage of patients who leave without being seen (LWOS).

The 10-bed holding unit was initiated at the end of 2003, Morris explains, to improve ED throughput by accommodating patients who are still being screened for various conditions or who are waiting for inpatient beds.

The unit is designed for patients awaiting a clinical decision or "rule out," he says. "We don't put higher-level-of-care patients in there.

"It's hard to say what helped the most, between [the holding unit] and coming on the pre-admit tracking board, but [the ED] is now below the national average for percentage of patients who leave without being seen, Morris says. Formerly between 4% and 6%, he adds, the hospital's LWOS rate now is 2% or below.

Gradual implementation

The gradual implementation of the pre-admit tracking and electronic bed board system, completed last November, has enabled the medical center to consistently meet its goal of assigning a "clean, ready bed" to 96% of unscheduled patients in less than two hours, notes Morris, who was hired as a "bed czar" in May 2003, in part to bring that system into being.

"When we started collecting that data — how long it took from request to the point we were able to assign a clean bed — [that percentage]

was in the mid-to-upper 80s," he says. The improvement happened even before full implementation was achieved in November 2005, Morris says, because his staff began using the new computer program "a few steps at a time" in December 2004 while still handling bed requests over the telephone.

"We did a pilot using the post-anesthesia care unit [PACU] and two nursing units — one medical and one surgical," he explains. "We used that pilot to look at each step in the process — 'right-click here, left-click there' — so we would know how to take the request from the PACU and the best way to funnel it to the receiving unit."

While using the new computerized system "to the [highest] degree possible, we were still taking requests by phone," he adds. "As we turned around and called the units, we were also pretending we were doing [the same steps] in the system, so we could look at any glitches."

The idea, Morris says, was for his staff to fine-tune the process before beginning to train other nursing personnel. "We looked at, 'Who will do what? What will my staff do? Do we have the information we need without talking to someone? Is there a step we missed or is this an interface issue?' We did that for a couple of months before bringing up [other units]."

Before he assumed the bed coordinator role and the tracking system was implemented, Morris says, "bed control for this 821-bed inpatient facility was strictly pieces of paper." A month after he came on board, an admissions nurse who reported to him was hired, he adds, and a little more than a year later, in July 2004, bed control officially was moved out of admitting and into nursing.

Bed management

The location of the bed management area — next to admitting — stayed the same, "but the reporting structure and focus has changed," Morris notes. The idea behind the switch, he says, was that a nurse would be more adept at the process from the perspective of triage and level of care.

Changes in status to a higher or lower level of care — both at the beginning and during an inpatient stay — happen more quickly and easily because of the increased clinical focus, he says. "Before, we might have beds in some locations that would not be used because it was ingrained in the work flow of the [previous bed control employees] that this was a hands-off area."

In some instances, however, it is appropriate to use oncology or cardiac beds for patients coming from the ED, he says, and employees with a clinical focus are more comfortable making those exceptions.

"With oncology [bed occupancy], there typically are peaks and valleys," Morris notes. "A lot are scheduled, and you can almost predict [the number of beds] you will need."

Bed management staff with clinical training also are aware of any medical implications — the kinds of nononcology patients who are appropriate to place on an oncology unit, for example.

Increased clinical focus

"Prior to me and some other clinicians coming in, the thought process wasn't there. It was, 'I can't go into that unit. I have to make the patient wait.' They were pretty much black-and-white, and health care [decisions are] so gray. You have to think," Morris says.

While the majority of his staff still are nonclinical, he adds, "we've worked hard on educating them, explaining the thought process behind why we do what we do. There is a lot of open dialogue."

Bed management staff now are better able to communicate with the hospital's nursing units, he says, and, if necessary, obtain reports from outside facilities to better facilitate patient placement, although that function typically is handled by nursing.

Another benefit of the increased clinical focus, Morris says, is that nurses are able to "proactively communicate with physicians as to why we're doing what we're doing, to alleviate any backlash from the medical staff."

In the past, physicians often suspected that their patients couldn't get to a unit because nurses were "hiding" beds until the next shift, he adds. "It's practically impossible now to hide a bed with the systems we have in place, because they're all connected."

As for feedback from physicians on the improved process, he ascribes to the "no news is good news" theory, Morris adds. "To me, a positive [reaction] from a physician is not hearing a negative. When I first took this role, there were a number of complaints — not only to nursing administration but to hospital administration —

about patients being scattered on different units and about bed crunch issues. There has been a decrease in that."

General medicine practitioners, in particular, he says, had complained about their patients being spread out on multiple units, while cardiologists contended that there were "too many noncardiac patients using [cardiac beds] for telemetry."

In response to those concerns, the department developed algorithms to establish "cluster units" — grouping surgical units and medical units based on medical specialty, Morris says. "There were slight algorithms in place before, but they were not as intense."

Other improvements

To further address the situation, the hospital has added more telemetry beds on the medical units, he says. Not having to move a patient to another bed at the same level of care to free up a telemetry bed — for another patient who may be waiting in the ED — saves valuable time and improves patient flow, Morris notes.

With the pre-admit tracking system and electronic bed board, he says, staff are "able to visualize every single unit and every bed in real time — whether it's clean, dirty, occupied — and it's all done through interface activity with our mainframe."

That biggest improvement has resulted in many other improvements, Morris notes, including the ability to "time stamp" to determine where backups are occurring and to do process-time analysis with the ED and the neonatal intensive care unit (NICU) to determine "how we're doing from a patient flow and patient throughput standpoint."

The sequence of events, he explains, is as follows: "We electronically page the nursing unit and funnel a request, and they have a 10-minute time frame to assign a bed. When they assign the bed, the requesting unit or area will be notified by electronic page that the bed has been found, and will see in real time if the bed is clean or dirty, waiting to be cleaned."

The process has "truly eliminated all of the telephone tag and the 'he said, she said'" conversations about assigning blame, Morris says. "This puts everybody on a whole new honor system."

The bed management department has four other RNs in addition to Morris, he says, as well as 13 clerical employees, some full-time and some part time. "We operate 24-7 — we don't close down and let the ED take over [after hours]."

Transport tracking

There was also 24-7 coverage when the function was overseen by the admitting department, Morris notes, but while day-shift employees were designated for bed management, after-hours staff performed other admitting functions in addition to bed control.

When the switch was made, he adds, the number of full-time-equivalents (FTEs) that had been allocated to the admitting department for bed control were shifted to his department. Another 1.7 FTEs were added, Morris notes, to make up for the after-hours employees, who remained in admitting.

Transport tracking is another feature of the bed management software "suite," he notes. This tracking device for medical center transporters — who wheel patients down to the discharge area, for example, or to radiology for a scan — interfaces with the bed tracking and preadmit tracking/electronic bed board functions, Morris says.

"[Transporters] get a page from the response center giving them a number to call," he explains. "They dial in and get a computerized message saying, for example, 'Room so-and-so needs discharge with a cart.'" The system, Morris adds, automatically locates the closest idle transporter.

The transporter accepts the job by dialing into the system, Morris says, which logs in the transporter and tracks his or her time and productivity.

Following up

When the transporter is ready to leave the unit with the patient, he or she uses the house telephone or the phone in the patient's room to call in and report that he is in progress, Morris says.

"If it's a discharge, the system flags that bed as dirty, and we automatically see it. Before, we were solely dependent on nursing to send down the information to us."

In the past, it was not uncommon to get notice of a discharge "two or three hours after a patient had left the building," Morris notes. "When the shift ended, [unit nurses] would put in all of the

discharges, and the next shift would get hit [with handling them]."

To ensure that the system continues to run smoothly, he follows up regularly with unit managers and directors, Morris says, to make sure that unit secretaries and staff are actually putting the pending and confirmed discharges into the system. "It's a wonderful system, but it is a computer," he points out. "It's only as good as its users."

[Jonathan Morris, RN, can be reached at jomorris@wfubmc.edu.] ■

Set discharge time that works for you

'Don't obsess on that number'

Consider patient volumes and staff constraints and set a discharge time that makes sense for your facility, suggests **Jonathan Morris**, RN, bed management coordinator at Wake Forest University (WFU) Baptist Medical Center in Winston-Salem, NC.

"Look at those processes within patient flow and within the discharge process itself," he adds, "and ask, 'What are those that will make or break the goal?' If you're setting an unreasonable goal, why even set it?"

"Don't obsess on that number, just optimize what you have. Your [appropriate time] might be noon, 1 p.m. or 2 p.m. At a smaller facility, you might be able to do 11."

At academic medical centers like WFU Baptist, where residents do teaching rounds before handling discharges, "that in itself will prevent you from getting [patients] out" at 11 a.m.," Morris points out.

Waiting on ancillary departments to finish tests and lab work further complicates the effort, he adds.

"In my opinion, [consistent 11 a.m. discharge] is unobtainable because there are so many other factors in a complicated medical environment," Morris says. "In order for a patient to be discharged before 11, they should have been ready the day before. If they're ready the day before, then in order to do that, you've increased your length of stay."

If everything has been finalized and a patient is ready to be discharged the day before — at say, 5 p.m. or 6 p.m. — go ahead and let the patient go, he advises. "Don't get into the mindset of, 'You can't get out by 11, so just stay another day.' If they're ready to go, why hold them?"

"You have to look at it from the quality perspective, as well," Morris adds. "Research shows that the longer you're in a hospital, the higher the risk of catching other things. Immune systems get accustomed to being at home."

While improvements at Wake Forest have enabled staff to move some discharges to earlier in the day, more than half of the medical center's patients still leave after 2 p.m., he notes. "We've looked at how many are discharged after 2 p.m., as opposed to 11 a.m. Don't set yourself up for failure."

When there is an occasional backup in the flow to patient beds, hospital staff do other things to ease the situation, Morris says. "We work with patients to make sure they are comfortable, are getting the things they need."

If people are waiting in the lobby, he adds, "we check on them, and if it's lunchtime, send them for a meal in the cafeteria." The most important thing, Morris notes, is to explain why the wait is occurring. "Most patients are much happier if they know you recognize that they're waiting."

Discharge unit tried

For about six months, the hospital experimented with a special discharge holding unit aimed at enhancing patient flow, Morris says. The unit was designed for patients whose discharge orders are written but who are waiting for medication, for example, or a ride home, he adds.

That unit has been closed for the time being because not enough patients were using it to make it worthwhile, Morris says. "Obviously, we weren't using it for the nursing home population, and those waiting for rides were leaving early enough that it wouldn't justify coming down [to the unit] for an hour or two. There were all sorts of different factors and variables. It helped, but not enough to justify keeping it open with two nurses."

In place of that unit, he says, the hospital wants to establish an express admission unit, which is expected to have a bigger payoff in terms of increasing patient throughput. ■

used during procedures and then obtain preprinted labels for these solutions, recommends Mellott. "There could be a standard set for the facility and specialty labels for areas that require more labels than the common ones, such as the cardiac catheterization lab," she says. "The organization should then monitor for compliance after implementation."

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Report: A growing 'quality chasm' for hospitals

Mortality rates are 27% lower

A new study from HealthGrades, a Golden, CO-based health care ratings company, names the top 5% of hospitals in the country — and also shows that this group has mortality rates that are 27% lower than other hospitals, with a 14% lower risk of complications. The researchers analyzed 39 million hospitalization records at 5,122 hospitals over a three-year period, for 26 medical procedures and diagnoses.

The findings are strong evidence of the growing "quality chasm" between the nation's best hospitals and others, says **Jeff Goldstein**, MD, senior consultant with HealthGrades' hospital quality assessment and improvement group. "We are seeing a widening gap between hospitals doing well and those hospitals who are not doing well," he says.

To qualify for the list, hospitals were required to meet minimum thresholds in terms of patient volumes, quality ratings, and range of services provided. Before comparing the mortality and complication rates of the nation's hospitals, data were risk-adjusted so that hospitals that treated sicker patients would be on equal footing. Hospitals with risk-adjusted mortality and complication rates that scored in the top 5% or better nationally were then recognized as Distinguished Hospitals for Clinical Excellence.

"These are difficult goals to achieve because they require a big commitment from the hospital. There has to be a top-down solution, with a true leadership imperative. This can't be done with one department or service line; it has to be system wide," says Goldstein.

As an example of this, Goldstein points to the RACE (Reperfusion of Acute Myocardial Infarction in Carolina Emergency Departments) consortium of North Carolina hospitals working to improve outcomes for patients with coronary disease throughout the continuum of care. "Patient care literally starts even before they walk in the door," he says.

Quality requires a significant amount of resources and is "more than just paint and plaster in the hallways," says Goldstein. "But this is an investment that any industry would have to make," he says.

Researchers concluded that 152,966 lives could have been saved, and 21,896 complications could have been avoided, if the quality of care at all hospitals matched the level of those in the top 5%. Armed with this type of information, consumers are playing a much bigger role in the health care decision-making process — not just patients but also their family members and employers, says Goldstein.

"People want to be certain they are getting the best possible outcome and the most value for their dollar," he says. "No one wants to go to a hospital that is not performing well. Any hospital administrator who is not sensitive to this fact is being very short-sighted. The more information the consumer has, the better off everyone will be." (To access the report, go to www.healthgrades.com.) ■

Are improvements getting lost in committees?

Too many patients are getting injured from falls at your organization, and you've got the data to prove it. You've drilled down to identify specific units with the highest fall rates, and zeroed in on the exact shift and type of patient that are most at risk. An action plan is developed to make specific changes to reduce fall risk but requires funding and approval at the administrative level. The topic has been discussed in one committee after another. Six months later, your plan is still not implemented.

Does this sound familiar? If so, your organization's committee approval process might need

overhauling. "You need to take a look at your committees and make sure that their purpose and objectives stay current and fluid," says **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting, based in Metamora, MI. "You may need to look creatively at combining or collapsing some of the committees."

For example, some organizations are forming patient safety committees, which may overlap some of the activities performed by other committees, she says. "By adding another piece, you slow down the movement because it has to go to another group, which delays decision making," she says. "People don't want to spend hours rehashing the same thing."

• Combine functions of committees when possible.

Make a list of all your committees, teams and task forces and assess their purpose and why they are in place, says Homa-Lowry. "Take a look at the minutes and evaluate how effective they have been at what they are doing," she says. "Then consider potentially combining or collapsing some of these."

For example, there may be overlap between your quality improvement and patient safety committee, says Homa-Lowry. Smaller organizations might consider combining infection control and the pharmacy and therapeutics committee, she suggests.

Evaluate the purpose of committees, such as addressing regulatory requirements, and then assess whether these activities are being duplicated by other committees, teams, and task forces, Homa-Lowry recommends.

Always get input from committee members as well as the chief of staff, medical director for medical staff committees, and the CEO and COO for administrative committees, she adds. "Be prepared to justify why you think this change will be beneficial to the organization," says Homa-Lowry. "You may even want to present how this may be a cost savings by decreasing the resources needed to operate the committee and the potential delay in decision making."

• Have a mechanism to move important issues through faster.

This usually takes place when a sentinel event occurs, but if a patient safety issue is important enough to bring forward as a priority, and you know your timeline of decision making is three to six months, then you should find a way to move it along more quickly, says Homa-Lowry.

"It might have an impact on patient care, and people will also lose interest if it continually stays on the agenda," she says. "By the time it gets approved, people may have already done workarounds to get around the problem, since it's been hung up in committee for so long. Sometimes you may have to go back and start addressing the issue at the beginning and also address the workarounds."

• Have a mechanism for accountability.

Many times, issues are deferred or moved to the next committee because somebody hasn't followed up. "Leadership or the board may need a report as to why it's taking so long to get this through the infrastructure, and hold people accountable for doing their job," says Homa-Lowry.

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Part 1 of 2

THE QUALITY - CO$T CONNECTION

Too exhausted to act safely?

How to assess worker fatigue

By Patrice Spath, RHIT
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Concerns about the relationship between worker fatigue and patient safety are a relatively new issue for the health care industry. Residents are now limited to working 80 hours a week, and various groups have recommended that nurses should not provide direct patient care for more than 12 hours in any given 24-hour period or in excess of 60 hours in any seven-day period. Limiting worked hours can reduce caregiver fatigue; however, even people working 40 or less hours a week can make fatigue-related errors. When a significant adverse patient inci-

dent occurs, it is not sufficient to merely examine the worked hours of those involved to determine the potential for worker fatigue. It is true that long hours or overtime assignments may cause staff to be working at a less than fully alert state. However sleepiness on the job can be caused by a variety of factors, not just worked hours. Described below are techniques for examining whether worker fatigue-states contributed to an adverse patient incident.

Because physicians and staff members must work long and unusual hours to meet the needs of patients, fatigue should always be considered as a potential underlying factor in any significant adverse event. During investigation of the event a systematic evaluation of all factors affecting worker fatigue should be undertaken. There are many manifestations of human error, some due to fatigue or reduced alertness. If fatigue is found to be a root cause of the incident, the next step will be to correct the situation. To identify fatigue-related concerns, start by evaluating the following four factors:

1. Time of day of the occurrence. If the incident occurred between 3 and 5 p.m. or between 3 and 5 a.m., fatigue may have played a role.

2. Disruption of people's normal circadian rhythm. If those directly involved in the incident were working at a time when they normally would have been sleeping, fatigue may have played a role.

3. Number of hours since people last slept. If the involved individuals had been awake for more than 16 hours when the event occurred, fatigue may have played a role.

4. The 72-hour sleep history of people directly involved in the incident. If those directly involved had been averaging less than seven hours of sleep per night, fatigue may have played a role.

If this initial inquiry indicates a problem, then fatigue should be investigated in greater detail. Use a two-stage process for this investigation. First, establish that the person or persons involved in the incident were in a fatigued state, and second, determine if the unsafe act or decision was consistent with the type of behavior expected of a fatigued person.

To ascertain whether people involved in the incident were in a fatigued state, you need to know more about what created this situation. This requires an in-depth look into significant factors relating to fatigue. Probing questions should be asked about sleep quantity and quality prior to the incident, work history, and work schedules. To establish whether the people involved were sleep deprived at the time of the incident, ask questions such as:

• What was the length of your last consolidated sleep period? (Ideal: seven to nine hours.)

• When did your last consolidation sleep period start? (Ideal: normal circadian rhythm, late evening.)

• Was your sleep period interrupted? If so, for how long (Ideal: no interruptions.)

The quality of a person's sleep can also contribute to a fatigued-state. To examine sleep quality, consider:

• How did the individual's sleep period immediately prior to the incident relate to his/her normal sleep cycle (usual start/stop time)?

Figure 1

Fatigue-Related Impairments and Manifestations

Fatigue-Related Performance Impairment	Signs/Symptoms of this Impairment
Attention	• Overlooked sequential task • Failed to perform tasks in correct order • Preoccupied with single task • Lacked awareness of poor performance • Reverted to old habits • Focused on minor concern while overlooking major one • Lacked appreciation for gravity of the situation • Failed to anticipate impending problem • Displayed decreased vigilance • Did not observe warning signs
Memory	• Forgot a task or element of a task • Forgot the sequence of tasks • Inaccurately recalled past event
Reaction time	• Responded slowly to abnormal or emergency situation • Failed to respond altogether to abnormal or emergency situation
Problem-solving ability	• Displayed flawed logic • Displayed cognitive problems (e.g. arithmetic or other cognitive processing problems) • Selected inappropriate corrective action • Inaccurately interpreted situation
Mood	• Less conversant than normal • Unable or unwilling to perform low-demand tasks • Irritable • Distracted
Attitude	• Unwilling to take risks • Ignored normal procedures • Displayed a "don't care" attitude
Physiological effects	• Slurred speech or inappropriate speech content • Reduced manual dexterity

• How many times was the individual awakened during his/her last sleep period?

• Was the individual's environment conducive to restorative sleep (e.g. quiet, dark room, own bed)?

• Does the individual have any sleep pathologies (e.g. insomnia, sleep apnea)?

Factors attributed to the work history of involved individuals also can create fatigue states. Establish whether the hours worked and the type of duty or activities involved had an impact on the person's quantity or quality of sleep. For examine, consider:

• How many hours was the individual on duty and/or call prior to the incident?

• What was the individual's work history in the preceding week?

• Did the individual have adequate rest breaks (e.g. regularly scheduled 10- to 15-minute complete breaks from work)?

Work schedule irregularity can cause worker fatigue-states that result in an adverse patient incident. To determine whether scheduling was problematic with regard to its impact on an individual's sleep quantity or quality, ask questions such as:

• Was the individual working an evening or night shift? If yes, is this the individual's permanent shift or do they rotate between shifts?

• Was the individual working overtime or scheduled for a double shift?

• Was the individual expected to perform critical tasks at a time when he or she was least likely to be alert (within the context of the person's usual circadian rhythm)?

If worker fatigue is established as a possible root cause of the adverse event, next look at the link between fatigue and the unsafe act or decision. What you want to determine is whether or not a cause-and-effect relationship exists. Several performance impairments can be directly attributed to individual fatigue. Listed in Figure 1 (see page 57) are common fatigue-related performance impairments and how these impairments may be manifested.

If the adverse event investigation team substantiates worker fatigue as one of the root causes of the incident, actions should be taken to improve the alertness of caregivers. Researchers have found that a complex interaction of timing of sleep, work schedule, environment, and personal habits all affect worker fatigue. Mitigating the effects of these issues will require a spectrum of approaches. Techniques for reducing staff

CE *questions*

13. Which is recommended to prepare for JCAHO unannounced surveys?
    A. Have a single individual identified for key roles.
    B. Avoid checking JCAHO's Extranet site to avoid the appearance of having advanced notice.
    C. Identify individuals with inaccurate contact numbers during disaster drills.
    D. Always set up the surveyors in a room next to the organization's staging area.

14. Which of the following is true about 2006 surveys conducted by JCAHO?
    A. A full periodic performance review survey will be required.
    B. The periodic performance review is no longer required.
    C. A telephone consultation is mandatory for all requirements for improvement.
    D. Patient tracers for emergency management will be conducted.

15. Which is accurate regarding hospital performance, according to a recent HealthGrades study?
    A. The gap between the best and worst performers is getting smaller.
    B. There is a growing gap between the best performing hospitals and others.
    C. Even in top performing hospitals, mortality rates are similar to poorly performing hospitals.
    D. Complication rates were comparable in all the hospitals.

16. Which is true regarding an unannounced JCAHO survey at Presbyterian Healthcare in Charlotte, NC?
    A. They wanted to know what trends and patterns in medication errors were identified.
    B. They agreed that a single assessment for a patient's fall risk was sufficient.
    C. Surveyors were satisfied with summary data for performance improvement processes.
    D. They agreed that operative notes could be added to the chart within 72 hours.

Answer Key: 13. C; 14. D; 15. B; 16. 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 **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. ■

member fatigue and the patient safety risks that it carries are discussed in part 2 of this series. ■

ACCREDITATION
Field Report

Survey is rigorous, but staff get morale boost

JCAHO likes 'very visual' data

During a recent unannounced Joint Commission survey at Presbyterian Healthcare in Charlotte, NC, staff underwent a "rigorous, in-depth" process, says **Paula Swain**, MSN, CPHQ, FNAHQ, director of clinical and regulatory review. "By that I mean that each of the surveyors were experts in their field and knew their standards," she says. "But the staff were left feeling good. Basically they caught us doing our own thing, and they liked what they saw."

During previous JCAHO surveys, there was a feeling that surveyors were on the lookout for mistakes made by staff, as opposed to observing what they did right, says Swain. "There was a lot of chatter about failing. This time we walked through what we do everyday and got credit for it."

Surveyors wanted direct responses from staff as opposed to staring at story boards or charts, says Swain. "Story boards are passé — people can still do them for internal purposes, but surveyors don't like them because they are flat. Surveyors want to hear staff talking about the care they give," she says. At the end of the survey, one of the surveyors gave a compliment that "the managers were there, but the staff talked." "They said it really shows us you have confidence in your staff, which tells us a lot about the organization," says Swain.

Surveyors wanted to see graphics to illustrate performance improvement processes. "You can't just have the summary data; you've got to have the data that shows the drilldown and deliberation process," she says. "You've got to defend your quality processes for improvement."

Here is specific feedback given by surveyors:

• **Tracking of medication errors and occurrence reports.**

These data need to be "very visual" to show that improvements were made and that your gains were sustained over a period of time, says Swain.

"There is a system tracer on medication management where they expect to see improvement for monitoring medication errors, so that needs to be well laid out with graphics analysis," she says. "You need to show, 'Have you fixed this?' and 'Did it stay fixed?' You can't talk about it otherwise."

Surveyors will want to know what your analysis showed, and whether you have drilled down, says Swain. "If you haven't done the PI process well and have that documented, you're talking off the top of your head. With medication management, they are extremely well versed," she says. "They looked at all of our data, and we had about a day to pull everything together."

The organization uses an electronic medication administration checker (MAC) system, which has the ability to track error reports, adds Swain. "The surveyors wanted to know what trends and patterns were identified. We had identified that overriding of the system in several areas was an opportunity," she says.

• **Transport of crash carts.**

While tracing a patient who was resuscitated, surveyors went to pharmacy and then to materials management to check whether supplies and medications were locked while in transit — in effect, tracing the path of the code cart. "The surveyors noted that the people transporting the crash carts didn't have special training in medication security," she says. This led to a simple change in policy: Staff no longer take open drug trays to pharmacy. Instead, these are locked before they go into storage. "The staff were trained to a new process that secures a used cart with a different-colored lock," she adds.

• **After-hours entrance to the pharmacy.**

The after-hours access log was requested, as well as training of non-pharmacy personnel who entered the pharmacy and what drugs were being

COMING IN FUTURE MONTHS

- ■ Effective ways to involve physician leaders during surveys
- ■ Proven methods to improve core measure data collection
- ■ What administrators really want to see from quality leaders
- ■ Organizations share strategies for medication reconciliation

taken out. Surveyors discussed their expectation that there be minimal access and were happy with the provisions made to stock pharmacy inventory in other high-use sites, such as the emergency department and intensive care unit.

• Operative notes for procedures.

Surveyors noted that a pediatric patient had an operative procedure, but no operative note was dictated that day. "The standard says you need the note dictated within 24 hours," says Swain.

• Protection of stored equipment.

"We had many medication infusion pumps kept in a storage area that was near construction, and they wanted to see that we protected them from dust and dirt, because you will be taking that into the patient's room," she says.

• Flash sterilization in the operating room.

"They really like to see very little flash sterilizing," she says. "Our organization will review the practice, to validate what our frequency really is."

• Inconsistencies in documentation.

When an orthopedic patient was being traced, surveyors noted the patient was at high risk for falls — something that wasn't noted on the flow sheet. "She had a cast on postoperatively, which made her at high risk for falls. They were looking for that to be reassessed and updated," she says.

• Vendor documentation.

For vendors who come to departments such as operating rooms (ORs) and information technology, JCAHO wanted to see a vendor file with orientation to the area and confidentiality agreement signed.

• Range orders.

"The issue is whether a nurse is practicing medication without a license," she says. If a nurse gets a range order for 2-10 mg of morphine sulfate to be given intravenously to control a patient's pain, for example, surveyors want to know how the nurse determines what dose to give. "Our policy says that they give a drug based on assessment, and they start on the lowest level on the range." When surveyors interviewed a staff member who had a problem describing this process, the command center sent out an all-points bulletin so all staff could review the practice and articulate clearly. "We sent out an e-mail to everybody with the policy so could do a quick review. Thus, surveyors did not find this problem again."

• Policy for temperature and humidity ranges in the OR.

Surveyors asked staff what to do when these fall out of range and found that the individuals being interviewed were unclear about the process. "Although we had a policy for this and it was addressed in our training process, staff wasn't comfortable explaining it to the surveyor," says Swain. Quick action was taken so this problem wouldn't occur again during the survey, she says. "We put it on our command center update information list that went out to all staff. In addition, that evening, during a manager debriefing, we decided to "wallpaper" the OR, and we put a sign in every OR that listed temperature range and what to do if it was outside that range, so that every single staffer knew that policy." ■

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. ■