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Hospitals getting more RFIs in 2006: What problems are surveyors finding?

New process is better at uncovering areas in need of improvement

Since JCAHO's unannounced survey process began in January 2006, the average number of requirements for improvement (RFIs) given to hospitals has increased to 6.9 as of April 2006, compared with 5.8 in 2005.

"It's not a huge difference, but RFIs have gone up, about 1 RFI increase per organization," according to **Linda Murphy-Knoll**, vice president of service operations for JCAHO's division of accreditation and certification operations.

The trend could be due to the use of tracer methodology, which takes surveyors to the actual point of care with patients, and also the fact that surveys are now unannounced.

"It's obvious to everyone that we will find more, versus looking at policies and procedures in a room," says Murphy-Knoll. "I think that in the past two years the surveyors have just gotten better at doing tracers and pulling threads. They find something, become interested in what they have found, ask more questions, and find more RFIs."

JCAHO's new process is part of the reason for the additional RFIs, says **Judy B. Courtemanche**, president and CEO of Courtemanche & Associates, a consulting firm specializing in regulatory compliance and outcomes management, based in Charlotte, NC. "There is the element of surprise, and the tracer process reveals process gaps more quickly than previous survey methodologies," she says.

Increasing performance expectations

Scoring is also more severe: Three instances will earn an RFI in most cases, but in some cases only one infraction with a required element of performance can generate an RFI.

"There are also increasing performance expectations from JCAHO," says Courtemanche. "An unrelenting emphasis on medication management continues to generate RFIs. There is also a JCAHO requirement that surveyors note findings regardless of potential scoring."

In addition, technology alerts JCAHO to areas in need of improvement, even if findings are not discovered by surveyors, notes Courtemanche. At

the same time that JCAHO has better prepared surveyors with more intensive survey tools, organizations are struggling to keep up with the continual regulatory changes coming their way, she says.

"Preparing entire organizations to respond to the possible surveyor tracer has required unplanned resources of time and money just to stay afloat," she says. "Organizations that have always performed well are finding the new approach difficult to prepare for. The results are often an unexpected shock."

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Editorial Questions

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Leaders must change their approach to accreditation from a one-year ramp-up to adopting continual compliance strategies that render their organizations survey-ready at all times, says Courtemanche. "Organizational philosophies must embrace regulatory compliance as a basic operating tenet."

Quality professionals can advance this process by staying informed and keeping their leaders informed, says Courtemanche. "Leaders do not want to hear that the new survey process is producing unexpected results and that they could lose their accreditation. Leaders want to hear how the organization can standardize its approach to assure predictable outcomes," she says.

The RFIs are coming for medication reconciliation and other National Patient Safety Goals and Environment of Care (EOC) standards, according to **Susan Mellott**, PhD, RN, CLNC, CPHQ, FNAHQ, CEO of Houston, TX-based Mellott & Associates, a consulting firm specializing in health care performance improvement. "With the advent of unannounced surveys, the hospitals cannot prepare for survey like they did before," she says.

Quality professionals must assure that new standards are implemented prior to the date they become effective, says Mellott. "They must be proactive rather than reactive. They must also have members of the facility do tracers every month to assure that the processes are working," she says.

Here are some trends in RFIs received by organizations in 2006:

- **Use of unauthorized abbreviations.** Organizations are required to identify a list of abbreviations they will not allow to be used in daily medication-related documentation, and at a minimum must use the JCAHO's list of nine abbreviations, although they can choose to add additional ones.

"What we are finding is that it is really a cultural barrier," says **Darlene Christiansen**, RN, LNHA, MBA, JCAHO's executive director for accreditation and certification operations. "Licensed independent practitioners who have been in practice for a number of years were taught to use certain abbreviations. It's a matter of reeducation and reinforcement about the reason behind this, which is safety for the patient, because there have been medical errors made and sentinel events that have occurred when those abbreviations were used."

Organizations have been receiving RFIs for failing to educate contractual employees about unauthorized abbreviations.

"That can become challenging if there is a large group involved with a rotational schedule, but you have to work with the contractual service to develop an ongoing education plan," says Christiansen.

• **Medication reconciliation.** Although most organizations have a process for medication reconciliation, it's often not comprehensive enough, says Christiansen.

In 2005, organizations were only required to have developed a process to reconcile a patient's medications, but as of January 1, 2006, surveyors are looking to see that the process actually has been implemented.

"It begins at the patient's point of entry into the organization, and continues on through the continuum of care," says Christiansen. "Each time the patient changes the level of care, medication reconciliation is critical."

The point of entry is the most critical and most challenging part of the process, whether the patient comes through the ED or direct admissions, says Christiansen. "You may have a nonresponsive patient without family members immediately available, which poses a big challenge for the caregiver who needs to provide medication."

Surveyors want to see that staff obtain a complete medication history, not only for prescription drugs, but over-the-counter and herbal medications as well.

"The difficult piece is to be more comprehensive," Christiansen says. "If the patient is able to contribute, you can get much of the history from the patient. But even then, you may have to prompt the patient with questions. A patient may forget to mention that they take aspirin every day or other over-the-counter medications."

• **Communication during patient handoffs.** Surveyors want to see a process in place to ensure that caregivers communicate with each other with an opportunity to ask questions, when passing care on from one shift to another, or one care provider to another.

"We are not asking that the process be documented, but we want to ensure there is a process in place. When surveyors come through and do their tracer methodology they need to observe that process," says Christiansen.

• **Life safety code compliance.** A life safety code specialist is now present during surveys for hospitals with 200 or more licensed beds.

"So we are seeing an increased focus in EOC, and with that comes additional RFIs," says Christiansen.

"This has been a focus for JCAHO for the past four or five years, but the focus is now more intense. The EOC is a high-risk area for the patient population and for the staff internally," she says.

A common problem is that organizations having construction have not implemented the interim life safety code measures that are required, such as an increased number of fire drills. Another area is that when an organization brings in contract staff to do repairs or construction, they have not been educated on how to ensure patient and staff safety.

"When you are going through construction. you need to protect the patient from any infection control issues — you don't want debris or dust flying around. So education is important," says Christiansen.

• **Medication management.** This area is another common cause of RFIs, including ordering, filling prescriptions, administration at the bedside, patient identification, verification of the right medication and dosage, and labeling medications.

"As we evaluated safety trends in patient care, the failure to label has indeed increased adverse outcomes to the patient population," says Christiansen. "It was common practice for anesthesiologists to not label medications, so again it was a reeducation that was needed."

More RFIs allowed

JCAHO's recent decision to increase the number of instances of noncompliance hospitals must incur before being put on conditional or preliminary denial of accreditation has sparked some controversy.

Critics of JCAHO's decision say that this is a sign of weakening standards, but JCAHO insists the change was due to research showing that larger hospitals received a disproportionate share of RFIs.

"We had been noticing that the RFIs had been increasing and didn't know what that was based on. So we determined that we needed to do a statistical analysis of that increase," says **Linda Murphy-Knoll**, vice president of service operations for JCAHO's division of accreditation and

certification operations.

An analysis was done of the RFIs per organization looking at average daily census, the number of surveyor days, and the size of the facility. The researchers found a statistically significant difference for hospitals with 100 or more beds, linked to the numbers of beds and number of days the survey team is onsite.

"When we saw that there was a statistically significant different outcome based on size of the facility and number of surveyor days, we needed to move on that," says Murphy-Knoll. "It was not a change that was made based on anecdotal information. It was based on hard, statistical facts."

RFI threshold changes

The following RFI threshold changes were decided at a March 21 meeting of the JCAHO's accreditation committee and are retroactive to January 1: For large hospitals with an average daily census equal to or greater than 100, it takes 14 RFIs to receive conditional status (up from 10), and 20 RFIs to receive preliminary denial of accreditation (up from 15). For small hospitals with average daily census less than 100, it takes 11 RFIs to receive conditional status (up from 10) and 16 to receive preliminary denial (up from 15). In 2005, 2.2% of hospitals were put on conditional accreditation.

The thresholds are simply a means for identifying organizations that need further scrutiny, says Murphy-Knoll. The JCAHO's board committee considers each organization separately and decides whether to apply the rules for conditional status or denial of accreditation, she explains.

"This is not decreasing the strength or credibility of the survey process. It's just being fair to organizations, assuring that they not be treated differently based on their size," she says. "It is definitely not a weakening of the accreditation process." In fact, based on the changes made in the last few years, the process has been strengthened significantly, says Murphy-Knoll.

"I don't believe it's weakening standards," says **Faith D. Solkoff**, RN, BSN, MPA, director of performance improvement at Baptist Hospital of Miami. "Even though the tracer methodology has improved the survey process, RFIs are still at the discretion of surveyors who come with their own areas of expertise."

For hospitals to be placed in jeopardy of losing accreditation and harming their reputations based on an unscientific number of RFIs or surveyor preference is not in the best interests of patient safety, says Solkoff.

"Decisions to deny accreditation should be based on whether the RFIs directly affect patient safety and would result in harm if left uncorrected. It shouldn't be a 'numbers game,'" Solkoff says.

Survey scoring guidelines

According to Murphy-Knoll, survey scoring guidelines prevent subjectivity. However, anecdotal reports suggest that there is some variance. "I just returned from a meeting where three members shared their recent unannounced survey experience. All were in the same state but had different surveyors," says **Darlene Adams**, RN, MSN, director of quality management at United Regional Health Care System in Wichita Falls, TX.

"The surveys seemed to mirror each other, which is consistent, but there were still issues particular to specific surveyors. Some were very 'by the book' while others were more mentors or educators," says Adams.

Many quality professionals aren't surprised that JCAHO has increased the RFI threshold, pointing out that the new process is leading to more RFIs given.

"I'm not really surprised that the JCAHO has expanded the number of citations a hospital may receive during a triennial survey," says **Kathleen Catalano**, RN, JD, director of healthcare transformation support for Perotsystems, based in Plano, TX. "The new survey process has, in my opinion, changed the landscape for the survey."

Regardless of how prepared a hospital may be, the new process leaves a great deal open to the unknown, says Catalano. "I think that the way JCAHO checks on hospitals and assists the facility after an RFI is given is for the better," "she says. "I am pleased that large and smaller facilities have been separated out."

Surveyors are now uncovering real quality and patient care issues because they are not putting as much time into document review, Catalano says.

"The surveyors are spending more time with the caregivers," she says. "This is helping with the discovery of true system issues that should help keep patients safer."

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JCAHO under fire again: JCR is the issue

Congressional critics allege conflict of interest

Senators Charles Grassley (R-IA) and Max Baucus (D-MT) and Representative Pete Stark (D-CA) are calling for JCAHO to answer questions about its relationship with Joint Commission Resources (JCR), its consulting subsidiary, and to account for the results of its new accreditation process.

A 2004 Government Accountability Office (GAO) report found that "JCAHO's pre-2004 hospital accreditation process did not identify most of the hospitals found by state survey agencies in CMS's annual validation survey sample to have deficiencies in Medicare requirements," according to a GAO summary. As a result, legislation was introduced to provide more federal oversight of the accreditation process, but it did not pass.

The 2004 legislation would have removed JCAHO's unique hospital accreditation deeming status — requiring JCAHO to apply for deeming status for hospitals just as it must for nursing homes and other facilities. "That sort of change is still a possibility," says **Carol Guthrie**, communications director in Sen. Baucus's office.

The GAO is in the process of conducting a second study relating to possible conflicts of interest and other concerns, and Grassley, Baucus, and Stark say that they will introduce revised legislation based on any new findings.

Since November 2005, the Joint Commission has been working with the GAO on a study addressing the relationship between JCAHO and JCR. JCAHO has responded to the scrutiny by underscoring that JCR is a not-for-profit organization. "The missions of these organizations are complementary in improving health care quality and safety in the United States and around the world," according a May 19 statement from JCAHO.

The Congressmen question JCAHO's ability to independently accredit hospitals while JCR sells products and services that aid hospitals in meeting accreditation standards.

"JCAHO claims to be a not-for-profit organization that maintains state-of-the-art standards. Nothing could be further from the truth," Stark said in a May 18 statement. "For years, JCAHO's close ties to industry have jeopardized the health of millions of Americans."

In addition, said Stark, JCAHO's ownership of JCR has created new conflicts of interest that warrant additional investigation. "If JCAHO has nothing to hide, it will provide us with an accurate, complete, and timely response. Anything less than full cooperation will be noted when Congress takes future action," he said.

"We're all aware that JCAHO's accrediting process has been under scrutiny off and on for years," says **Kathleen Catalano**, RN, JD, director of health care transformation support for Plano, TX-based Perotsystems. However, JCAHO has done a "major overhaul" of its accreditation process, which calls for continuous compliance because surveyors could walk in at any time, she says.

She points to unannounced surveys and the addition of a life safety code specialist who is present during surveys of organizations with 200 or more licensed beds.

"We know that organizations are being cited for more noncompliances, and that is why JCAHO has offered to increase the number of RFIs before a facility reaches preliminary denial of accreditation," says Catalano. "So I think we can say the accreditation process is working better than it was."

However, JCAHO's critics want hard evidence that the new process really is more effective. "It's very important to determine whether or not the new accreditation process is delivering results and overcoming the shortcomings of the old system," said Grassley, chairman of the Senate Committee on Finance, in the May 18 statement.

"Hopefully, the Commission's new accreditation process is improving the effectiveness of their work, which showed serious deficiencies just a couple of years ago. But if the business practices of the Joint Commission continue to compromise the safety and performance of America's hospitals, it's vital to know that now and take corrective steps," said Baucus, ranking member of the Senate Committee on Finance.

According to the Joint Commission, the 2004 GAO study was seriously flawed. "That study utilized grossly misleading metrics and omitted highly relevant and positive information about the Joint Commission's performance," according to the statement. "However, despite the biased findings contained within the report, the Joint Commission engaged in a constructive dialogue with the Congress on ways to strengthen federal oversight of all hospital accreditation activities. We welcome the opportunity to further that discussion."

From the perspective of dozens of quality professionals interviewed by *Hospital Peer Review* since unannounced surveys began in January 1, 2006, the new process is clearly more effective at finding problems.

"It brings the survey to the heart of patient care, which is where an organization should be measured as to their level of compliance with the standards," says **Leisa Oglesby**, assistant hospital administrator of quality at Louisiana State University Health Sciences Center in Shreveport.

However, some organizations are rethinking their accreditation by JCAHO and are moving to annual Medicare or osteopathic accreditations, Oglesby notes.

"Ongoing compliance with ever-changing standards is complicated and requires huge resources," she says. "Today's environment of declining resources, staffing shortages, shrinking budgets and revenues will mandate a closer look by all organizations as to their continued accreditation process."

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Study: Why are wrong-site surgeries still occurring?

Is Universal Protocol ineffective or underused?

Do you assume that if the Joint Commission's Universal Protocol is followed, wrong-site surgery would always be prevented? A new study conducted by the Agency for Healthcare Research and Quality puts that assumption into question.

Researchers concluded that the Universal Protocol developed in 2003 by the Joint Commission may have prevented only 62% of wrong-site surgery cases.[1] The protocol requires preoperative verification of site and patient, marking the surgical site on the patient, and the institution of a "time out" in the operating room.

However, according to **Richard J. Croteau**, MD, JCAHO's executive director for strategic initiatives, there is a serious flaw in this conclusion. If followed to the letter, he says, the protocol would have prevented virtually all of the cases.

"I went through the cases and in fact, the universal protocol would have prevented all but one of the cases — if it had been followed as it was intended," he says. "The problem was that not all of the steps were followed. *All* the three steps are necessary. We're not claiming that it will prevent all cases, but if it's done and done consistently, it should prevent the vast majority."

The researchers examined records from 2,826,367 operations between 1985 and 2004 in Massachusetts, and identified 40 cases of wrong-site surgery, a rate of one in 112,995. In the JCAHO's database of wrong-site surgeries, which has 10 times the number of cases in the AHRQ study, almost all were lacking one or more of the steps, says Croteau.

Last year, health care facilities reported 84 incidents of surgeries involving the wrong body part or the wrong patient to the JCAHO. While some states require hospitals to report these incidents, many hospitals across the nation aren't required to account for them publicly.

"While the article did make reference to the fact that not all cases are reported, they then proceeded to treat the numbers as if they represented all the cases that had occurred, when in

(Continued on page 99)

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Proposed Medicare discharge rule faces criticism

It targets inpatient discharges but has roots in post-acute world

A new rule being proposed by the Centers for Medicare & Medicaid Services (CMS) — and drawing criticism from case managers who have reviewed it — would require hospitals to alert all Medicare patients 24 hours before discharge that their costs probably won't be covered if they stay longer, and that they have until noon the next day to request a review of the discharge decision.

That step would be in addition to the existing "Important Message From Medicare" — advising patients of their rights — that hospitals must give patients upon admission to the hospital.

"I believe this is adding more bureaucracy to an already complicated and confusing discharge process for a population, generally over age 65, who need our assistance and guidance," says **Barbara S. Leach**, RNC, MS, CNA, ACM, director of case management, Sacramento/Yolo, with the Sutter Health Sacramento Sierra Region.

"The average hospital stay is already targeted to be four days or less," she adds, "and to provide [extra] paperwork in advance of the discharge will only add tasks to an already overworked system."

Even in scenarios where there is a plan of care in place, she notes, there are many factors that could disrupt the plan, including changes in the patient's condition and the availability of services at the next level of care.

Proponents of the proposed rule, published April 5 in the *Federal Register*, contend that the "Important Message" is not a timely notice, says **Ellen Pryga**, director of public policy development for the American Hospital Association (AHA), which has several concerns about the proposal. "They're saying [the "Important Message"] isn't close enough to discharge, even though the average length of stay for Medicare patients is six days."

The two-step process being proposed also would replace two existing forms — the hospital inpatient notice of noncoverage (HINN) for regular Medicare patients and the Notice of Discharge and Medicare Appeal Rights (NODMAR) for those with Medicare Advantage plans — with a new form that must be completed if a patient indicates any disagreement with his or her discharge plan.

"The HINN requires all the details about why the patient would no longer be covered and why the patient no longer needs inpatient care," Pryga says. "It also includes more details on the appeal process."

The proposal is not a new idea, she notes, but got its impetus from a final rule (68 *FR* 16,652) published April 4, 2003, in the *Federal Register* that requires post-acute providers to conduct a two-step notice process in connection with the termination of Medicare coverage to an enrollee in a Medicare Advantage (then Medicare Choice) plan.

Among the problems AHA has with the inpatient proposal, she adds, are that in most instances the notice of discharge would add 24 hours to a patient's hospital stay.

"By requiring that it be rendered after the discharge decision is made and yet 24 hours before discharge," Pryga says, "you end up in many cases keeping people another day, and with diagnosis-

related groups [DRGs], hospitals don't get paid for that."

Hospital employees would be required to have Medicare beneficiaries sign a copy of the notice of discharge, a largely generic document that would leave space for the patient's name and date of discharge, and attest that they have received it and understand it, she says. "The entire thing is a recitation of how the person has the right to protest the discharge and stay in the hospital free while [the issue] is adjudicated."

"If the patient isn't able to comprehend the notice," she adds, "then that has to be done with whoever the person's representative is, and whether or not their representative is even available to get the form and acknowledge receipt is problematic."

Pryga says she also is concerned about the way the notice is written. "It will create the impression that it is likely that the patient will be sent home too soon and should automatically be asking the quality improvement organization [QIO] to review the decision."

"It doesn't speak to medical necessity," she adds, "but is all about noncoverage, and 'you will be charged if you stay.' I think patients will be asking for many more requests for review that really aren't founded."

Perhaps the most troubling thing about the proposed rule, Pryga says, is that its proponents "don't really understand who makes the discharge decisions. The hospital doesn't. It's the physician. Trying to pretend that isn't the case isn't helpful."

"The physician doesn't generally make the decision to discharge until all the clinical markers are met," Pryga continues, "which is usually the morning of discharge or late the evening before — but that still wouldn't meet the requirement."

There are situations where the proposed process simply cannot work, she says, such as a one-day admission or an admission in which the patient is scheduled to be discharged on a certain day but then develops a fever overnight.

"We're also trying to figure out how to make it work on off-hours and on weekends," Pryga notes, "because discharge planners are usually on duty Monday through Friday, on a 9-to-5 schedule."

The CMS description indicates that if the patient stay is expected to be only two or three days, the new notice may be given upon admission, Leach points out. "However, the rules clearly say [notice is given] 'where the physician concurs with the discharge decision.'"

"Concurrence with the discharge decision is not defined," she adds. "I don't know if it is a discharge order saying, 'Discharge Mrs. Smith tomorrow after her antibiotic,' or if it is a note in the progress section saying, 'Plan to discharge tomorrow,' or if it is a hallway conversation with the nurse, patient, or family."

"I don't know how the 'physician can concur with the discharge' on admission of the planned two- or three-day stay," Leach says. "There are rules around how the hospital can process this new notice without physician concurrence, but that is with the review of the QIO — not an easy process."

The burden the proposed rule represents for hospital case managers "already overloaded with high caseloads and workloads" is the biggest concern of **Sandra Lowery**, RN, CRRN, CCM, CNLCP, president of CCMI Associates in Francestown, NH.

Like Pryga, she also is concerned about how the extra step would affect lengths of stay, Lowery adds.

CMS cost estimates included in the *Federal Register* article were about $5,200 for issuing the standard discharge notice to all beneficiaries and about $1,875 for issuing a more complex notice of noncoverage, she points out. "I am not sure they took into account:

- physician education;
- review and approval of the notice by hospital administrators and others;
- copying the medical record (for appeals);
- mailing or courier expenses (for appeals);
- monitoring, evaluation, and improvement measures to ensure we are following whatever process is established to meet this requirement," Lowery says.

Lowery, Pryga, and Leach all point out the folly in the agency's estimate that the process of delivering the notice will take about five minutes.

Consider the need, says Leach, to explain to older patients — increasing numbers of whom do not speak English — that they are scheduled to go home the next day, but have the right to appeal that decision by contacting a QIO, and that their stay beyond that point may not be covered by their payer.

Then staff must have the person sign a form acknowledging that he or she understands what is being explained, she adds. "Five minutes will not begin to do this justice, and a quality case management department will spend many more than five minutes preparing and executing this process. The cost will be great."

After the form is signed, notes Pryga, hospital

staff must copy it, file it, and maintain those files — on some 12 million admissions a year.

At a time when the industry focus is on electronic records, she says, "there is no provision made other than dealing with paper copies."

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Can CM impact this case? That's question in busy ED

ID those with potential to be moved

"Why is the patient here? Why is the patient being admitted? What needs to be done, and is there a possibility it can be done in a less acute setting?"

In his role as case manager in the emergency department (ED) at Massachusetts General Hospital, which sees between 200 and 250 patients a day, says **Peter Moran**, RNC, BSN, MS, CCM, his focus is always on those questions.

"If you can move them," he adds, "what are the barriers to getting them out? Some clearly can go home, some clearly need to be admitted, but the struggle is to identify cases where case management can have an impact."

One of the things with the biggest payoff in terms of answering those questions in a timely and effective manner, Moran says, is to quickly identify patients who have the potential to be moved.

One target, he notes, might be those who are on Medicare and who have had a three-day stay in the hospital within the past 30 days.

Patients who meet those criteria and who are found not to have an acute medical condition can be moved directly from the ED to a skilled nursing facility (SNF), Moran says. "The key is having the correct information."

Another trigger might be certain diagnoses, he points out, noting that a lot of chest pain cases, for example, can be put on observation status, depending on whether the patient has a history of heart problems — and a lot of payers want them in that designation. If the correct designation occurs upfront in the ED, Moran says, claims can be processed and paid more quickly, with fewer denials.

One problem with finding the cases in which one can have a measurable impact, Moran continues, is that it's difficult to identify these patients without picking up every chart and scanning it - something that's difficult to do in a busy ED.

Mass General is implementing a faster way to identify these patients, he notes, through a report run off the information system it uses for utilization review, which also has a case management component.

He suggests that case managers develop a list of the types of patients they want to target and determine if reports can be generated based on certain diagnoses, repeat visits, or "whatever the [case management] program is aiming to impact."

"Try to use the systems you have," Moran says, "but sometimes the information you want is not found in a standard report. A lot of us have systems that are not state of the art, so you need to create special reports."

Although Mass General is still fine-tuning its report, it has been helpful, he adds. "When I come in, it's not unusual for me to have 15 or 20 people waiting for admission. If I see someone had a Medicare admission and discharge within the past 30 days, I look at those charts first."

On the other hand, if someone comes in and is definitely going to be admitted, that case is not a priority, Moran says. "With certain payers, you can't move a patient [to another level of care] without preapproval, and that will impact how I prioritize certain cases."

"For example, I know for a fact that with Massachusetts Medicaid, I need pre-approval to send someone to a SNF or rehab facility," he says, "so if a patient comes in over the weekend, and if he can't go home, that's a patient I cannot impact - he will be admitted. I can do an initial assessment, I can identify where the patient would like to go and I can have the patient screened, but I know I can't get approval until Monday."

Complicating the process, Moran notes, is the fact that most EDs are "getting overwhelmed with geriatric and mental health [cases]. The patients are getting older, and a lot of them are alone."

"We're also starting to see more people who are primary caretakers who need to be admitted to the hospital," he adds. "When they get hospitalized, what happens to the person they are caring for? If the 92-year-old [patient] has been taking care of a mentally impaired person, who is now 64, is there a way we can arrange for someone to

take care of the dependent? Can we mobilize family members or community agencies?"

If not, Moran notes, such patients will frequently present to the ED and may become "social admissions" — patients who have no acute medical needs but who are not safe to discharge.

During the hours of 9 a.m. to 7 p.m., when case management services are available, there is time to see only so many patients, he says. "I'm being used for the person who is in the ED because he or she had a fall, is frail, elderly, and lives alone, and for the homeless and uninsured populations."

In addition, Moran says, he is consulted by physicians and families looking for assistance in caring for chronically ill people at home.

In looking at whether the person is fit to go home, he points out, he must consider what the person's "baseline" is: "How are they managing, what services are in place? So many are chronic — they're at home on a banana peel anyway — the question is, "Is [the current condition] different, or is this their baseline?"

[For more information, contact Peter Moran at pmoran3@partners.org.] ■

Specialty hospitals not exempt from transfer rules

Provision clarified in new regulations

Specialty hospitals that do not have emergency departments (EDs) are still subject to the Emergency Medical Treatment and Labor Act (EMTALA) rules on acceptance of patients for transfer, cautions **Stephen A. Frew**, JD, a risk management specialist and web site publisher (www.medlaw.com).

That provision is not a recent change in policy, but is made "absolutely clear" in proposed new regulations from the Centers for Medicare & Medicaid Services (CMS), Frew recently noted.

"CMS has always taken this position, and has cited specialty hospitals for failure to take transfers," he says. The new regulations follow a recommendation based on reports that specialty hospitals have turned down patients on the theory that because they do not have an ED, they are exempt from EMTALA.

The new language in 42 CFR 489.24(f) will be: "Any participating hospital with specialized capabilities or facilities, even if it does not have a dedicated emergency department, may not refuse to accept an appropriate transfer if it has the capacity to treat the individual."

The language does not mandate that specialty hospitals add an ED, Frew says, but emphasizes that private specialty hospitals of any type may not evade the obligation to accept transfers required by EMTALA.

He predicts that more psychiatric, obstetrics, orthopedic and cardiac hospitals will be cited by CMS as frustrated general hospitals begin reporting turn-downs of ED and inpatient transfers of unstable patients in need of a higher level of care.

"I am aware of many locations where this battle has been building toward explosion, and 'fair notice' has now been given," Frew adds. "Transfer requests and reports of denials are going to push this issue into open warfare if specialty hospitals don't heed the warning."

One concern likely will be that specialty hospitals will have to have some mechanism for achieving coverage for these transfer patients, he suggests.

"If [specialty hospitals] don't have an ED, they often don't have an on-call system," Frew notes, "but as a practical matter, they may have to put physicians on-call or have hospitalists to address this acceptance obligation."

Otherwise, he says, such hospitals could face charges of inadequate care. ■

AHRQ study looks at admissions from ED

Fifty-five percent of admissions to the nation's community hospitals for conditions other than pregnancy, childbirth, and neonatal care begin in the hospital emergency department, the Agency for Healthcare Research and Quality reports.

More than one-quarter (26%) of the 29.3 million patients admitted through the ED in 2003 had heart or blood vessel diseases; 15% had respiratory diseases; 14% had digestive disorders; and 11% had injuries, according to the agency's Nationwide Inpatient Sample database.

Pneumonia led the top 20 specific conditions warranting hospitalization through the ED, with 935,000 admissions.

More information is available at www.ahrq.gov. ■

fact we don't know how many are occurring," says Croteau.

"We are seeing what we believe to be an increase in the rate of reporting, which is why the number of cases appears to be going up every year reported to us," adds Croteau. "That's a pattern that we see with all types of adverse events as we call attention to them, and we've called attention to wrong-site surgery a lot in the past couple years."

The researchers also found significant variation among hospital protocols for site verification, which were analyzed at 28 hospitals. They found an average of 12 redundant checks on the correct surgical site, involving two to four staff members. "Simplification of protocols would improve adherence and efficiency and allow surgical teams to focus their limited time and energy on prevention of more common or harmful errors," write the researchers.

No protocol will prevent all cases, say the researchers, adding that it will ultimately remain the surgeon's responsibility to ensure the correct site of operation in every case.

Noting that only two-thirds of the cases might be preventable under current conditions, the authors suggest implementation of a universal site-verification protocol with a preoperative verification process of patient identity, procedure, site, side, and vertebral level performed by two health care staff members, one of whom should be the surgeon. Any inconsistencies or uncertainties about the proper site should be resolved by the surgeon with confirmation and agreement by the patient and at least one of the inspecting caregivers, recommend the researchers.

However, these recommendations are virtually identical to those in the JCAHO's Universal Protocol, notes Croteau. "They are seemingly dismissing the efficacy of the Universal Protocol, yet they ended up offering the exact same three recommendations," he says.

The problem is that organizations are struggling to get these three steps implemented consistently, Croteau says. "They are finding resistance from physicians on site markings and time out," he says. "More organizations are doing fairly well with implementation in the operating room, but that's not the only place they do invasive procedures. This applies across the board."

Surveyors are reporting that 15% to 20% of organizations are not consistently doing the time out procedure, Croteau reports.

At Carroll Hospital Center in Westminster, MD, the time out policy is followed not only for OR procedures but for invasive procedures done at bedside or any department including radiology. "Initially we experienced some resistance to this practice change, but over the years staff have come to expect it," says **Kimberly Lau**, RN, risk management coordinator. "The culture has accepted it, and it's part of routine practice."

The time out and site marking are documented on both the pre-op checklist and intraoperative record, and this is audited. "There is also rounding done by team leaders and managers who monitor the process," adds Lau.

At Inova Loudoun Hospital in Leesburg, VA, a Universal Protocol checklist is used. The first section verifies two patient identifiers, that responses match the patient's ID band, that documentation including current H&P is present, and that the informed consent describes the procedure, site, and laterality. The second section verifies site marking as follows:

1. Patient/guardian states procedure to be performed and points to the site. (Yes or No)
2. Patient/guardian confirms the side for surgery, if applicable. (Yes or No)
3. Physician/LIP has marked the site. (Yes or No or exempt by criteria from marking)
4. Patient identification verified and site marked according to policy. (Yes or No)
5. Signature for pre-procedure verification check.

The third section is for the Time Out procedure:

1. Correct procedure (Yes or No)
2. Correct side confirmed (Yes or No)
3. Site marked and visible to team (Yes or No)
4. Special equipment available (Yes or No or N/A)
5. Correct implant (Yes or No or N/A)
6. Correct position (Yes or No or N/A)

All team members agree that the procedure about to be performed is the correct procedure, is correctly marked, and is on the correct patient. At the bottom of the form, there is space for discrepancy and resolution of the discrepancy.

"We believe we have covered the entire content suggested by JCAHO," says **Tootie Lunsford**, RN, quality outcomes coordinator. "We do both real-time and concurrent audits to assure compliance to the process."

JCAHO surveyors liked the patient identification form used at Christiana Care Health

Services in Wilmington, DE. "They paid a great deal of attention to that aspect of documentation," says **Judith A. Townsley**, MSN, RN, CPAN, director of clinical operations for perioperative services. "They asked many questions, and if there was not a documented time out, they investigated why and made sure that it was a true emergent procedure."

Universal Protocol compliance for patient procedures done in a non-operating room setting is done with a safe practice behavior monitoring tool which also is used for measuring several National Patient Safety Goals. The tool assists inpatient, outpatient, and perioperative nurse units to assess compliance with safe practice behaviors. "This single measurement tool provides for efficient and effective monitoring," says **Terri Lynn Palmer**, MPA, manager of clinical information at Christiana Care.

Since a single tool is used for all units and departments to collect monthly data, this results in a simplified review process for the data collector. "The collector reviews documentation in charts for all National Patient Safety Goals at one time," says Palmer.

Data collectors answer the question "Was safe practice behavior performed/not performed?" with no tolerance for partially correct behaviors, says Palmer. Timely results are available to units, so staff can identify actions to improve safe practice behaviors.

A sampling of five charts per unit per month provides a sample size of up to 340 per National Patient Safety Goal, she says. Compliance is also monitored with direct observations from management rounding on units and auditing of safe practice behaviors by performance improvement personnel.

All organizations in the Baptist Memorial Health Care system use a preprocedure verification policy as the guide for compliance to the Universal Protocol.

"All documentation is completed on the invasive procedure record," says **Beverly Jordan**, vice president and chief nursing officer for Baptist Memorial Health Care. "Audits of these records are conducted weekly and reported monthly through facility performance enhancement committees."

Reference

1. Incidence, Patterns and Prevention of Wrong Site Surgery. *Arch Surg*. 2006;141:353-358. ■

THE QUALITY - CO$T CONNECTION

Get actionable results from surveys

Part 2 of 2

By Patrice Spath, RHIT
Brown-Spath & Associates
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One of the very best methods to obtain feedback on performance is through the use of survey instruments that give respondents an opportunity to speak directly and frankly. However, formulating a series of questions to obtain answers about important topics is not a simple task. Constructing a questionnaire that will elicit accurate information from most respondents is more complicated than it seems. Many factors must be considered during the process of creating a questionnaire. For example, will most respondents interpret every question in the same way? If not, the survey results might not provide the information you hoped for. Maximum effort is needed during the developmental stage, because once a questionnaire has been distributed, problems are costly or impossible to correct. The time spent in developing the questionnaire will be repaid by collection of relevant, better quality data. In the second part of this 2-part series, pilot testing, survey administration, and results reporting are described.

Once a draft of the questionnaire has been prepared, try it out on a small number of respondents. A debriefing session with these pretest volunteers is helpful in identifying and correcting any problems.

Pretest instrument

No matter how well you've thought out the survey instrument there still are likely to be a few minor problems that must be identified and corrected. This is the function of the pilot test. Prepare a small number of surveys as mock-ups, and recruit volunteers to respond to the question-

naire as though they were members of the sample population. Immediately after completing the instrument, ask the volunteers to identify any flaws or errors in the survey. Find out if the instructions and items were as clear as they possibly could be. Did the respondents know whether they were to make choices, indicate ranking, circle answers, etc., and how this was to be done? Did the respondent know when to turn the page and how to respond each time a new type of item, scale, or topic was used? Even if the number of pretest volunteers is quite small, this step is crucial. It is almost certain that some problems will be identified.

After problems identified through pretesting are corrected, prepare a final copy of the survey for reproduction. Carefully check the final product before distribution. Errors that don't get caught at this step can be costly, especially if you have to discard some of the survey results because of problematic questions or typographical errors.

Administer survey

Ideally, the survey instrument is administered to everyone at the same time. For example, the instrument is administered at a department staff meeting or in a focus group session with former patients. However, usually this is impossible. It may be necessary to distribute questionnaires to individuals who complete and return them either by hand, intra-company mail, or U.S. mail. Although this administration technique does increase privacy and anonymity for respondents, it also leads to decreased return rates. When individuals must be relied on to voluntarily return the survey, you must do everything possible to boost the return rate. There are several in which this can be done.

First, the importance of the survey must be emphasised. This can be emphasized in three ways: (a) in the cover letter; (b) in informal conversation when the questionnaire is being handed to the potential respondent; and (c) by explaining that some authority (e.g., management) supports the survey and why. The second aspect to be emphasized is the confidentiality and privacy of individual responses. Again, this should be stated in the cover letter and verbally. Explain that the survey results will only be reported in the aggregate, not by individual respondent. If possible, questionnaires to be returned by mail should be sent to an address other than the organization's. If employees are expected to return questionnaires at work, provide a sealed box so that respondents can drop their completed questionnaires into it. It should be specified verbally and on the questionnaire form that no names or identifying marks are to be put on the questionnaires or response forms.

Invest as much time and effort as possible in

Figure 1

Tabulation Examples

Sample Tabulation of Aggregate Continuing Education Satisfaction Scores

Satisfied with CE % (N)

completely	very	mostly	slightly	not at all	total
61 (82)	18 (25)	10 (13)	7 (10)	4 (5)	100 (135)

Sample Cross-Tabulation of Continuing Education Satisfaction

Satisfied with CE % (N)

Unit	completely	very	mostly	slightly	not at all	total
Medical	75 (15)	20 (4)	5 (1)	0 (0)	0 (0)	100 (20)
Surgical	70 (24)	15 (5)	10 (4)	5 (2)	0 (0)	100 (35)
Intensive Care	60 (24)	15 (6)	10 (4)	10 (4)	5 (2)	100 (40)
Labor/Delivery	50 (15)	25 (8)	10 (3)	10 (3)	5 (1)	100 (30)
Emergency Department	40 (4)	20 (2)	10 (1)	10 (1)	20 (2)	100 (10)
overall	61 (82)	18 (25)	10 (13)	7 (10)	4 (5)	100 (135)

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

personal contact with the potential respondents, explaining the objectives of the survey verbally and asking for and answering questions. People participating in workplace surveys should be promised a summary of the results. Where possible, survey forms should be given directly to potential respondents, and they should be thanked for their participation. In short, everything possible should be done to maximize personal contact. Respondents should be asked when their responses could be expected, and an attempt should be made to obtain verbal commitments to a specific time frame. These investments of time and energy will pay off in terms of higher return rates.

If you are conducting a one-time survey, set a deadline for receipt of the responses. This date should be included on the questionnaire and mentioned verbally to the respondents. The date given should be at least one week earlier than the actual deadline. Shortly before the stated deadline, all respondents should be reminded of the date by means of a letter or memorandum. An offer can be made to provide another copy of the questionnaire if the first was misplaced.

Tabulate results

The aim here is to present the data so that people can understand and make interpretations from the information generated. Sample tabulations of responses for each item, using percentages (not just raw numbers), generally will suffice. This can be indicated on a "doctored" copy of the questionnaire, with percentages filled in where the check marks would go.

Many results may be ignored later, but it is important to begin by tabulating everything. An example of a tabulation of nurses' answer to a question related to their satisfaction with the continuing education offered by the hospital is found in Figure 1.

The next step is cross-tabulation for items that have some important relation to one another. For example, to determine whether nurses in one unit are less satisfied than those in another, one would cross-tabulate unit by satisfaction, as is shown in the second example in Figure 1. The items in parentheses are the numbers of respondents from given units who gave specific satisfaction-level responses. For example, of the 40 nurse respondents in the intensive care unit, 60% (or 24) were completely satisfied. Of the 10 nurse respondents in the emergency department, 40% (or four peo-

CE *questions*

1. Which is true regarding requirements for improvement (RFIs) and JCAHO?
   A. Smaller hospitals receive a disproportionate share of RFIs.
   B. The number of RFIs given has decreased since the new survey process took effect.
   C. The number of RFIs an organization may receive before being put on conditional accreditation has increased.
   D. The number of RFIs an organization may receive before being put on conditional accreditation has decreased.
2. Which is true regarding JCAHO's medication reconciliation requirements?
   A. The requirements do not apply if the patient comes through the ED.
   B. The process must begin at point of entry into the organization.
   C. Medication reconciliation is only required for inpatients.
   D. Only prescription drugs are included.
3. Which is true regarding life safety code compliance?
   A. An increased number of fire drills are required for organizations undergoing construction.
   B. A life safety code specialist will be present at all organizations during survey.
   C. Contract staff do not require patient safety education unless they are working in clinical areas.
   D. The number of RFIs given for life safety code compliance has decreased due to less stringent standards.
4. Which is true of wrong-site surgery cases and the JCAHO's Universal Protocol?
   A. The protocol failed to prevent over half of cases.
   B. Only two of the three recommended steps needs to be followed to prevent cases.
   C. If all steps are followed, the protocol should prevent almost all cases.
   D. Time out processes are not needed for bedside procedures.

Answer Key: 1. C; 2. B; 3. A; 4. C

CE instructions

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

ple) were completely satisfied. One may not know if a trend such as this is statistically significant but might decide later that it is worth testing. Effective tabulation of survey results leads directly to data interpretation, the final output of all survey work.

Prepare report

The exact form of the final report will depend on how it will be used and other circumstances. If the data will be used to work on problems, with small groups involved at different levels, the report should avoid inferences and conclusions. It should contain data grouped by unit, department, or division.

If senior leaders will be using the report to develop action plans, then more summary, charts, and recommendations usually are desirable. When preparing the final report, consider who will use it and the purpose for which it will be used. ■

ACCREDITATION
Field Report

Surveyors zero in on emergency preparedness

Disaster planning is critiqued

During a January 2006 survey at Baylor All Saints Medical Center at Fort Worth (TX), there was an additional focus on disaster planning during the environment of care (EOC) session, reports **Paula Chaloupka**, MSN, RN, director of care coordination. "This provided us a great critique of our disaster planning process," she says.

Because of the timing of the mid-January survey, the organization's EOC committee had just completed the 2005 annual management plan reviews of each of the EOC plans.

The committee had prepared one summary sheet on each management plan listing the indicator results for 2005, accomplishments, and the new 2006 indicators.

This handout was distributed to everyone participating in the EOC session as well as the surveyor. "Together as a group, we reviewed the information for each plan with him, and he asked clarifying questions about the material," says **Leslie Phillips**, accreditation coordinator. "The surveyor seemed pleased we had prepared the information. We felt it allowed for a more organized and controlled discussion of the material."

After the EOC management plan review and discussion, the physician surveyor was called in, and both surveyors provided a disaster response scenario. "He did look at our hazard vulnerability analysis but did not end up using a situation that we had identified in our 'Top 5,'" says Phillips.

The scenario given was a tornado that had hit nearby, with two schools and several restaurants affected. "He asked us to start by taking him to the location where our decontamination equip-

COMING IN FUTURE MONTHS

- ■ Measure compliance with new JCAHO leadership standards
- ■ Obtain buy-in from clinical staff for hand hygiene
- ■ Pros and cons of all the PPR options
- ■ Make sure your core measure data is flawless
- ■ Foolproof ways to get buy-in from administrators

ment was stored," says Phillips. "He talked through how it would be deployed, and we then walked down to the physical space where the decontamination tents would be set up."

The surveyors asked questions about how the flow of traffic around the decontamination area would be handled or re-routed, and how patients would be assessed, triaged, and registered and where they would receive care.

Next, they asked to see the incident command center and discussed more operational issues, such as how many days of water and food were on hand if the organization had to stand on its own.

"The surveyor emphasized the importance of assessing our abilities to operate independently for an extended period of time, referencing the Katrina and Rita disasters," says Phillip.

To prepare for the survey, mock patient tracers were conducted. "We conducted many, many tracers to help staff feel comfortable with the tracer methodology, answering questions from the surveyors and bragging on what they do well," says Chaloupka. "We also had staff from our system come to our facilities and conduct practice surveys."

A "My JCAHO Companion" pocket guide was given to all staff, with key points covered such as requirements for the National Patient Safety Goals. "The pocket guide was split into clinical staff information and all staff information," says Chaloupka.

The organization had a list of duties assigned to be done when the surveyors showed up. These included e-mailing staff, managers, directors, and system directors of the surveyor's arrival, and notifying the page operator to announce a welcome to our surveyors. "This welcome announcement was another way to notify staff, as well as notifying our patients and visitors the JCAHO was onsite," says Chaloupka.

The organization's accreditation coordinator began checking the JCAHO web site every morning about 6:30 a.m. EST to see if the surveyors were coming. "The day they came, she was able to get to the hospital before they arrived and had their room set up with all the notebooks on the tables for them," says Chaloupka. "The surveyors were so impressed by our preparedness and welcome that they thought we were tipped off concerning the survey date."

The surveyors liked the performance improvement (PI) posters, which were displayed on all units and in each department. "These posters demonstrated how we use data and the PI process to improve patient care," says Chaloupka.

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CE objectives

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

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