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## IN THIS ISSUE



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MAY 2007
VOL. 32, NO. 5 • (pages 53-64)

# Are conflicts and disruptive behavior putting patients at risk at your hospital?

*Intimidation, rudeness can be dangerous*

Rude remarks, intimidated staff, unresolved conflicts between leaders, and abusive behavior — your organization will need to have effective processes in place to address all of these scenarios.

After a field review by The Joint Commission of the entire leadership chapter in May 2006, two proposed standards were developed with new requirements for conflict management and disruptive behavior. The standards have completed field review, and, if approved, will be implemented in January 2008.

The proposed conflict management standard was developed in response to concerns about potential conflicts between leadership groups in hospitals, according to a spokesperson for The Joint Commission. The proposed standard is an expansion of an existing requirement in hospitals and would require organizations to develop an ongoing process to manage conflict among leadership groups, including meeting with involved parties to identify and resolve the conflict.

Disruptive behavior and its effect on patient safety have been the focus of several studies by groups including the VHA, the American College of Physician Executives, and the Institute for Safe Medicine Practices, which identified intimidation as a significant factor impacting the quality of care patients receive.[1] The Joint Commission's proposed standard would require leaders to develop a code of conduct defining desirable and disruptive behavior, and develop processes to manage disruptive behavior.

"The Joint Commission is becoming more involved in setting standards for human behavior," says **Geri Amori**, PhD, a Shelburne, VT-based health care consultant specializing in patient safety issues. "What they are requiring of health care organizations is a more sophisticated level of psychological awareness than ever before."

The proposed standards address important issues for health care organizations, says **Adele Sullivan**, PhD, president of Palm Beach Gardens, FL-based Interventus Inc., a health care consulting firm specializing in conflict management. "Constructive conflict resolution in health care organizations is essential to provide quality patient care," she says.

## More training is needed

"Unfortunately, these standards are necessary as people don't know how to be kind and professional to others these days," says **Diane Horvath**, Joint Commission coordinator and director of the medical staff office at Sacred Heart Hospital in Allentown, PA. "Enforcement of this type of standard may create more conflict in the beginning, but eventually most health care professionals will conform."

Disruptive behavior has been considered "normal" in many settings for years, notes Horvath. "Most hospitals today have a code of conduct but the disruptive behavior piece will have to be strengthened," she says. "More education and training on how to effectively control this type of behavior would be necessary."

Traditional methods of resolving conflict often do more harm than good, leading to adversarial working conditions and less interdepartmental teamwork, notes Sullivan. "As managers and executives, we expect leaders know how to manage conflict. However, they usually use the strategies that are most comfortable to them without knowing whether it is the best strategy," she says.

In fact, most conflicts reoccur because they aren't resolved at the root level, says Sullivan. "This allows it to resurface, perhaps with a different face or name, but nonetheless the same conflict," she says. **(See related story on p. 56 about a conflict that was poorly managed.)**

As a quality professional, you play an important role in seeing that the necessary structure for constructive conflict resolution is established, including the education and training to support it. "The silent costs of conflict are many, including the quality of patient care, employee and patient satisfaction, turnover, inferior decision making, and the bottom line," says Sullivan.

At Louisiana State University Health Sciences Center in Shreveport, a team was put together to address conflict resolution and disruptive behavior, composed of administration, human resources staff, and a privacy officer. "It is a difficult standard. However, if institutions review the intent, most will find they have policies already in place that address the standard," says **Leisa Oglesby**, assistant hospital administrator of quality.

The hospital's current policies address most of the proposed requirements, says Oglesby. The biggest change that will have to be made is the education and documented approval of the governing body for the staff conflict management process and code of ethical behavior, she says.

For example, most organizations have a code of conduct that is reviewed with all new employees, with policies in place to address disruptive behavior should it occur. In addition, there is usually an organization-wide policy that addresses conflict resolution. "Both are usually reviewed with new employees during their hospital orientation," says Oglesby. "The policies have probably been in place for a long time; however, they usually have not been presented and approved by the governing body."

**Hospital Peer Review**® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Peer Review**®, P.O. Box 740059, Atlanta, GA 30374.

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for **Hospital Peer Review**® is hospital-based quality professionals.

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The hospital's medical staff have approved a due process to manage disruptive behavior exhibited by individuals granted with clinical privileges, which was also approved by the governing body.

If organizations are truly seeking to improve the quality and safety of care, they are already measuring staff perceptions, which may enhance the quality and safety of care delivered, says Oglesby, with variance or incident reporting processes in place to track and trend safety issues on an ongoing basis.

"We are in favor of these changes," says **Herman Williams**, MD, MBA, chief medical officer at Baptist Health System in San Antonio. "Currently, we not only have a process for conflict management, we have a disruptive policy and sexual harassment policy that clearly states the expectations of behavior."

At Durham (NC) Regional Hospital, the medical staff bylaws, code of conduct, and conflict resolution policy already in place cover the new elements that The Joint Commission is proposing, says **Edward N. LaMay**, MD, chief medical officer. "These proposed changes don't come as a surprise," he adds.

At Baptist Hospital of Miami, issues related to conflict management are addressed at a sub-committee of the board, where administration, board members, and medical staff leaders meet monthly. "We also have staff at our system level that are trained in conflict management. Issues, if they arise, would be identified through these activities," says **Faith D. Solkoff**, RN, BSN, MPA, assistant vice president. Risk management and medical staff leaders track the outcomes related to disruptive behaviors.

"I believe we have many pieces to this puzzle already, but the process related to conflict management will need to be more formalized so that the process meets the intent of the standards," Solkoff says. "I think the conflict management standards will create a lot of busy work, but at the end of the day, will not prove meaningful to most organizations."

As for disruptive behavior, a human resource process is used for staff and a disruptive physician policy is used for medical staff members. "Both have measurable outcomes," says Solkoff. "Again, the process owners track compliance — human resources for staff and risk management for physicians."

The measurable outcomes are related to whether the individual counseled changes his or her behaviors, as well as the responses by both staff and physicians on annual satisfaction surveys related to culture and patient safety. "Our outcomes have trended well, compared to national comparative rates," says Solkoff.

If disruptive physician behavior occurs, bring in the hospital attorney early on in the process, advises **Kathleen Catalano**, RN, JD, a consultant with Plano, TX-based Perotsystems. "The medical staff policy and procedure on disruptive behavior should be followed to the letter for each and every such occurrence," she says.

To address the upcoming standards from The Joint Commission, consider the following items:

**• Be specific with definitions.**

"The Joint Commission is walking into an area where definition of what is meant by the words used are extremely important," says Amori. For example, the rationale in the disruptive behavior standard refers to use of "rude language" and "threatening manners"— both broad terms that can be interpreted in many different ways.

What one person considers rude or threatening, another may not. "So one of the things that organizations are going to have to do is to take this out of the realm of the subjective, and make it very specific," says Amori. "Otherwise I see potential for abuse for these standards. You can get into, 'That was rude. No, it wasn't.' It could get out of hand unless this is clearly defined."

**• Address underlying issues.**

Just as your process for incident reporting should address system failures instead of placing blame on specific individuals, the same should be done with disruptive incidents, says Amori. "We need to look at what in the system precipitates stress, which leads to disruptive behavior," she says. "It would be too easy to jump to a blame position, without looking at the involvement of system failure."

**• Encourage staff to report problems.**

Even if your hospital has an "open door" policy, staff might not feel comfortable walking through that door. Consider the various ways that staff handle conflict currently other than filing a grievance, such as spreading rumors, complaining, and talking with union representatives. "These are usually unproductive and not in the organization's best interest," says Sullivan.

Develop an alternative dispute resolution process and present this to the governing body, leadership, management, and key individuals. "You need a system that is stakeholder-derived, accepts conflict as a normal part of interaction,

and that is realistic and collaborative," Sullivan says. She advises the following:

• Create multiple points of entry so an individual can bring up a dispute through many people or positions.

• Build prevention mechanisms into the foundation of the conflict management system.

• Design procedures to get disputants back to negotiation and communicating with each other.

• Set up a database to compare similar conflicts, to determine what worked and what is recurring.

**• Measure success.**

To assess the impact of your conflict resolution system, Sullivan recommends measuring the expense of legal disputes, employee turnover, the number of grievances, hours and expenses related to managing disputes, employee and patient satisfaction, and the number of days used for sick leave.

You also should be seeing fewer incidents over time. "Measure the willingness of staff to use the tools available to them, and how they are utilizing the skills they learned in training," says Amori. "Do this not right after a training, but by spot checking."

**• Have a specified group of individuals skilled in conflict management.**

At Baptist Health, annual education is given in conflict and negotiation management skills for medical staff leaders. "We also have chiefs at each of our facilities, as well as selected clinical specialty chairs who have delineated roles for addressing complaints, behavior, and peer review," says Williams.

**• Have effective follow-up in place.**

The rationale for the proposed conflict management standard states that some of the organization's leaders should be skilled in managing conflict through experience, education, and training. Although most organizations have taken steps to prepare leaders for conflict management, many don't have adequate follow-up after these programs are completed, says Catalano. "Quality professionals will need to be kept current on instances where conflict management skills have been called into play, and the effectiveness of these efforts," she adds.

In addition, when conflict management skills have been initiated, the outcomes will need to be tracked. "Has the behavior or conflict arisen subsequent to intervention? All of this will be important to further shape the conflict management program," says Catalano.

### Reference

1. Institute for Safe Medication Practices. (2004, March 11). Intimidation: Practitioners speak up about this unresolved problem (Part I). *ISMP Medication Safety Alert!*

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# A physician's disruptive behavior goes unresolved

*Poorly managed conflict resurfaces*

A hospital CEO received three occurrence reports from a charge nurse on labor and delivery about several problems involving the same physician. Nurses reported feeling intimidated, hurried, and made to feel incompetent due to being berated, sometimes in front of the patient.

The chief of staff and CEO previously had met with the physician to discuss similar concerns. During that meeting, he was defensive, insisting on details and names of his accusers, and was able to surmise who they were by the event descriptions. "For a while, he seemed to get better with his behavior on the unit, but then the problem resurfaced," reports **Adele Sullivan**, PhD, president of Palm Beach Gardens, FL-based Interventus Inc., a health care consulting firm specializing in conflict management.

In this type of scenario, have the risk manager

or other appropriate individual interview the nurses on the unit, ask a series of questions about the physician, and then let him read their anonymous comments, suggests Sullivan. "Tell him that you want to keep this out of the disciplinary process and this is the last attempt to do just that, but that you need for him to hear what others say about him," she says. In addition, the following questions should be considered:

- Has the behavior been rewarded in any way by others, such as the medical staff or otherwise, or the system in which he works?
- Is the behavior a coping mechanism — a way of adapting or coping within the system?
- Can the organization become more responsive in how it responds to his actions?

After having collected the information from the nurses, the next step is to meet with the doctor to assess why he behaves this way. Does he feel that this is the only way he will be able to get respect? Does he recognize that a problem exists with his relationship with the nurses? Are there any cultural issues?

Also examine if the staff are in some way creating or perpetuating the problem. "As the previous attempt has shown, you won't be able to solve the problem at the root level by only focusing on one side of the equation," says Sullivan. "If the doctor knows that the nurses will be part of the solution, he may be willing to consider any changes."

In health care, professional roles are interdependent and relationships are ongoing, and working together without good communication has a negative effect on patient care, says Sullivan. "Even though it may be uncomfortable for the nurses involved, ultimately it will be difficult to solve this issue if they cannot come face to face and discuss it, especially since they will have to continue to work together," she says.

Eventually, a mediated meeting between the parties involved could open up communication and make each side understand the possible consequences to patient care. "It may take some time and effort to get to this point, but it is critical," Sullivan says.

This type of conflict should be addressed as early as possible before it has an impact on any more people, says Sullivan. "Even if the other nurses are not directly involved, it is only natural that they form opinions and take sides, drawing them into the web," she says. Staff must know their options when it comes to resolving conflict, confidentiality must be ensured, any form of reprisal should be prohibited, and a neutral person should be available who can guide the process to successful resolution, says Sullivan.

Procedures should also address "what ifs," such as what to do if the supervisor does not see the situation the same way — where does the employee go for assistance?

Sullivan says the question to ask is, "How do we resolve this at the lowest level without bumping it up into counsel's office?" She recommends the use of an employee ombudsman, a hot line, or using a resolution facilitator.

"Making people accountable is essential. But they must have the right tools, know how to use them, and the culture must support them," she says. ■

# Database compares safety culture survey results

*Share lessons learned and effective interventions*

Currently, 382 hospitals have submitted data to the Agency for Healthcare Research and Quality (AHRQ)'s Hospital Survey on Patient Safety Culture's comparative database. This new database serves as a central repository for data so hospitals can compare their safety culture survey results, and includes data from all participating hospitals, with 108,621 individual respondents.

Previously, hospitals were able to compare their results only against preliminary benchmarks based on data from 20 hospitals that participated in a pilot test of the survey in 2003. (These preliminary benchmarks are available at www.ahrq.gov/qual/hospculture/prebenchmk.htm.)

Organizations may find it helpful to look at trends impacting other institutions, says **James B. Battles**, PhD, senior service fellow for patient safety at AHRQ. "It gives them a look at other hospitals, broken down by region," he says. "Or organizations that have carefully analyzed their results can serve as their own benchmark, and start developing programs to target areas where they have weaknesses." AHRQ has developed several tools designed to help institutions address problems identified by the culture survey, such as poor teamwork and communication. AHRQ and the Department of Defense have just released a comprehensive team work improvement initiative called TeamSTEPPS.

Battles says "it is based in part on the airline industry, with methodologies to improve patient care and safety in high-stress situations like ORs and emergency departments," says Battles.

Quality professionals will find it useful to compare themselves against other hospitals, says **Joann Sorra**, PhD, of the Rockville, MD-based Westat, a research organization that developed and pilot tested the AHRQ's survey tool. "While it is useful for hospitals to examine their own data to identify areas for improvement, it is also helpful to know what areas other hospitals are struggling with," she says.

The database report provides averages, standard deviations, and percentiles on the survey items and composites. It also provides averages broken down by bed size, teaching status, geographical region, hospital work area, staff position, and several other variables.

The overall goal is for hospitals to identify areas for improvement in their patient safety culture, says Sorra. Hospitals can examine their own data as well as compare against other hospitals when trying to identify these areas of focus.

"As hospitals begin to address these areas, they can share lessons learned, interventions, and strategies with one another to share what has worked," she says.

## Surge of momentum

A number of recent initiatives have mirrored the goals of the AHRQ's patient safety culture survey, including the Patient Safety Improvement Act of 2005. "There are provisions in that act designed to deal with the issues that are showing up in the culture survey," says Battles. "It reinforces why that legislation is necessary. We badly needed it and it is finally here."

In light of this new legislation, hospitals should carefully review their human resources policies and procedures regarding incident reporting, advises Battles. "There may be HR rules and policies in place that tend to be very punitive, and if hospitals are not careful they could find themselves in trouble," he says.

In the National Quality Forum's report "Safe Practices for Better Healthcare — 2006 Update," the use of a patient safety culture instrument is recommended. "Everybody is talking about creating a culture of safety in health care, and the patient safety culture survey is a way to measure our progress in getting there," says Battles. "We have an instrument in the public domain that is valid and reliable and we want people to use it. Now this new database allows institutions to see where they may stand in relationship to that."

The benchmark data will allow Denver-based Catholic Health Initiatives to compare similar size facilities with their peers, says **Jeff Norton**, director of clinical services.

"The data is going to be extremely useful and we are anxiously awaiting it," he says. "The availability of this data is part of what's making the AHRQ culture of safety survey the industry gold standard."

The analysis tools and benchmarking data are transparent and available to everyone, which makes conducting the survey and analyzing the results easier. "Subsequently, we can spend more time making changes to improve safety for our patients and that's what this is all really about," says Norton. "At the end of the day, a good hospital stay is to go home healthy. That's what we want for every one of our patients and the AHRQ safety survey and the benchmarking data are helping to make that happen." To share results with senior leaders, the organization will publish a system-level report with the benchmark data.

However, some quality professionals question whether they will be able to get truly valid comparisons. "I have not placed a lot of value on comparative external data," says **Barbara Horne**, RN, vice president and chief nursing officer at Indian River Memorial Hospital in Vero Beach, FL. "It is difficult to determine the validity of the comparisons. To me, the more valuable comparison for us is comparing our scores year to year."

When comparing your hospital's results against results from the database, it is important to keep in mind that the database only provides *relative* comparisons, says Sorra. "Even though your hospital's survey results may be better than the database statistics, you may still believe there is room for improvement in a particular area within your hospital in an *absolute* sense," says Sorra.

The database results show that there are some patient safety composites that even the highest-scoring hospitals could improve upon. "Therefore, the comparative data should be used to supplement your hospital's own efforts toward identifying areas of strength, and areas on which to focus patient safety culture improvement efforts," advises Sorra.

Indian River has completed the AHRQ's survey twice, and is going to complete a third survey

in fall 2007. By comparing the results to previous surveys, the organization can see if they are making progress in any area or department more than others, says Horne.

"We are now using the safety culture survey results as one of the areas managers must address in their incentive pay program goals, if appropriate based on identified needs," reports Horne. "It will be interesting to see if the focus will result in improvement in problem areas."

As a result of the first safety culture survey, changes have been made to formalize communication during patient handoffs when patients are sent for diagnostic testing, and also between units when patients are transferred to another level of care. "Those changes resulted in some incremental improvements," says Horne.

In the last 18 months, every one of the 70 hospitals in the Catholic Health Initiatives system has completed the AHRQ's survey tool. "It has been an instrumental tool in accelerating our system-wide patient safety activities," says Norton. One of the hospitals in the system, Martin, KY-based Our Lady of the Way Hospital, implemented a revised handoff process as a result of the survey's results. "They were recently surveyed, and The Joint Commission specifically noted that they were doing an excellent job with this," Norton reports.

Several Catholic Health facilities are now in the second round of surveying, having implemented improvements since the first survey. "We know there have been significant changes made to improve safety, and we are looking forward to seeing how this is reflected in the survey results," says Norton.

## Staff concerns revealed

The survey results give you an opportunity to show senior leaders the reality of how professional staff truly feel about patient safety. "For those of us who have been working in this area the results are not surprising, but in some cases the results can be quite surprising to management," says Battles. "There is a tendency for senior leaders to overestimate this, and they may need to take a good hard look at this area."

Indian River's second survey revealed that staff were fearful of punitive action being taken when reporting incidents. "There is still a great deal of concern on the part of our staff, which is reflected in the survey results. We are now looking at our incident-reporting system, trying to determine the best approach to taking the fear of punitive actions out of the process," says Horne.

To assuage concerns, staff were offered access to their personnel files in their home departments at the time of their annual performance evaluations, or any other time during the year they might want it. "Some took the opportunity, but most did not," says Horne. "It didn't have any impact on the feeling that there is a threat to job security within the existing incident-reporting system. That strongly implies that staff do not use the system as it was intended."

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**THE QUALITY - CO$T CONNECTION**

# Tips to make your hospital patient-friendly environment

*Potential areas of concern addressed*

By Patrice Spath, RHIT
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What can possibly be more frustrating than walking into a hospital and being treated poorly?

Poor treatment might come in the form of a receptionist who takes too long to acknowledge a patient's arrival because he or she is too busy laughing and joking with another employee. Or what about those overly complicated registration procedures that often confuse patients rather than help them feel at ease?

One of the many key responsibilities of a health care facility is to provide top-notch, high-quality service to its patients. Whether the patient interacts with the provider by phone or in person, the interactions should be patient friendly. Being patient friendly requires more than a smile and a pleasant manner. It requires that physicians and staff demonstrate a caring attitude to patients throughout the entire health care experience.

First impressions are often formed in the outpatient departments. That's where the majority of the hospital's customers receive services. For this reason, all outpatient areas should be routinely evaluated to determine where customer service improvements are needed. Potential areas of concern are discussed below:

## The reception desk

Reception desks are the first point of contact for most patients. Their first impression, formed in the reception area, influences their attitude toward the entire organization. However, reception areas often are busy places; reception staff deal with queries that come in by phone and in person and also must welcome incoming patients.

To make sure someone is available to greet patients properly, it may help to separate the reception area and the task of welcoming patients from the registration area. If separating the areas is not possible and registration staff are too busy to provide a personal touch, volunteers could help with greeting and providing basic information to patients. It can be very useful for these volunteers to learn about the various hospital services so they have a better understanding of patients' needs.

## Outpatient diagnostic departments

In outpatient diagnostic departments the waiting areas should be warm and comfortable, preferably with plenty of space. Upon arrival in the outpatient area, the patient should be told approximately how long they may have to wait. If there will be an unexpected long delay, patients need to know as soon as possible so they can rearrange their schedule or take care of other matters such as childcare or work arrangements. Waiting times should be monitored in all areas.

Patients coming to the hospital for outpatient procedures or diagnostic studies may be very nervous about what will happen. It is important that they are given information about the procedure, how long it may last and the effects it may have. The hospital should make available well-written patient information leaflets that include the following important information:

- How long the patient will need to spend in the department.
- What advance preparations the patient should make.
- Whether patients may suffer any side effects.
- Whether patients may need someone to accompany them — they will need to know this in advance.

# Patient Satisfaction Questionnaire — Radiology Department

**Reception**

1. Were the staff at reception polite?
Not polite 0 1 2 3 4 5 Very polite

2. Were the reception staff wearing name badges?
No: __ Yes: __

3. Did members of the staff who spoke to you introduce themselves?
No: __ Yes: __

**Waiting Areas**

4. Was the waiting area a pleasant place to wait?
Unpleasant 0 1 2 3 4 5 Very pleasant

5. Were there enough seats?
No: __ Yes: __

6. Were there enough magazines and other reading material?
No: __ Yes: __

**Changing Room**

7. Were you satisfied with the privacy of the room when you were getting changed for your exam?
Not satisfied 0 1 2 3 4 5 Very satisfied

8. Were you embarrassed while getting changed?
Very embarrassed 0 1 2 3 4 5 Not embarrassed

9. Was there a clean gown in the changing room?
No: __ Yes: __

10. Was there a safe place for your personal belongings?
No: __ Yes: __

**Examination Room**

11. Were you satisfied with the explanation of what was about to happen to you?
Not satisfied 0 1 2 3 4 5 Very satisfied

12. Were all the staff wearing name badges?
No: __ Yes: __

13. Did all the staff introduce themselves to you?
No: __ Yes: __

14. Were you reasonably comfortable during your examination?
Very uncomfortable 0 1 2 3 4 5 Comfortable
If not, what did you find uncomfortable?

_____

15. Were you anxious during your examination?
Very anxious 0 1 2 3 4 5 Not anxious
If you were anxious, what was the main reason for this?

_____

**After the Examination**

16. Were you told how you would obtain the results of your examination?
No: __ Yes: __

17. On the whole, what was your overall impression of the Radiology Department?
Not favorable 0 1 2 3 4 5 Very favorable

18. Are you likely to recommend this Radiology Department to your family and friends?
No: __ Yes: __

19. Have you any comments you would like to make?

_____

Thank you for your help.

• Whether patients will be able to return to work immediately after the test or procedure.

Many patients feel self-conscious, insecure, and vulnerable during an invasive diagnostic test or procedure although they may not wish to admit to these feelings. It is important that staff are sensitive to this and that steps are taken to preserve the dignity and privacy of every patient.

Patients should not need to wear flimsy or ill-fitting gowns in public areas. A secure area should be provided for patients to store their clothes and other personal belongings. Changing rooms should be big enough for elderly or infirm patients to manage satisfactorily and should have doors wide enough for wheelchair access. If the changing area is too small or if it is necessary for the patient to change in the procedure room, use screens to provide a more private area.

All staff should avoid talking about other cases, individuals or clinical matters when patients are within earshot, or during a procedure. Discussions between staff should be kept to a minimum. It can be unsettling for patients undergoing a procedure to think that the professional's mind is elsewhere.

During outpatient procedures and diagnostic tests there may be several health care professionals (physicians, technicians, and nurses) providing services to the patient. Consistent communication between team members and the delivery of clear information to the patient is essential.

It is important to avoid giving patients or their relatives conflicting information and advice. Consider setting up standard protocols to ensure that everyone communicates the same information to the patient. For example, a protocol in the radiology department would state how long after any examination the report will reach the referring physician and how that physician will then contact the patient. Everyone should agree on the post-procedure instructions they will give patients to avoid conflict and confusion.

A real test of your environment is through the views of your patients. They have information that no one else can give you. On page 61 is a patient satisfaction survey that could be used in the radiology department or adapted for use in other outpatient departments. You do not need to carry out large surveys of all diagnostic and procedural areas; it may be just as useful to focus on a certain area for a period of time and then conduct a survey in another area. Most patients will be pleased to be consulted about their experiences and happy to contribute to improving services for others. ■

## CE *questions*

17. Which is recommended to address conflict management and disruptive behavior?
A. When educating staff, clearly define what is meant by the term "rude."
B. Don't consider the possibility of system failures when disruptive behavior occurs.
C. Always keep definitions of undesirable behavior subjective.
D. Encourage staff to handle conflicts by meeting with union representatives.

18. If disruptive physician behavior occurs, which is recommended?
A. Avoid consulting with risk management.
B. Involve the hospital attorney early in the process.
C. Consult with the hospital attorney only if a formal complaint is filed.
D. Follow your medical staff policy for disruptive behavior only if the problem has occurred previously.

19. Which is recommended for hospitals completing the AHRQ's Hospital Survey on Patient Safety Culture?
A. Use the comparative database to benchmark against other hospitals.
B. Examine your own data to determine if staff feel comfortable reporting concerns.
C. Compare survey results from one year to the next.
D. All of the above.

20. What did surveyors say about handoff process at Anaheim Memorial Medical Center?
A. They wanted to see different processes used at each unit of the hospital.
B. They liked that the handoff process was applied consistently across all services.
C. They asked that staff avoid using prompt cards during handoffs.
D. They did not want to see the "Situation-Background-Assessment-Recommendation" (SBAR) technique used.

**Answer Key: 17. A; 18. B; 19. D; 20. B.**

## CNE 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 credit letter. ■

# Surveyors: Handoff process is "best they've ever seen"

*'Great ideas' shared during sit-down sessions*

At Anaheim Memorial Medical Center, a 224-bed acute care hospital in Orange County, CA, surveyors from The Joint Commission were so impressed with the handoff communication process for perioperative services, they asked for a sample of the hospital's tool.

"They noted that our process was the best they had ever seen," says **Tamra Kaplan**, PharmD, vice president of ancillary and support services. During the leadership conference, surveyors asked for the pocket card that perioperative services staff use as a prompt for effective handoff communication. The tool lists key pieces of patient information that need to be shared between pre-operative, intra-operative, and post-operative team members. The survey team gave high marks to the Situation Background Assessment Recommendation (SBAR) technique used to communicate critical information during handoffs throughout the organization. "They saw it consistently applied across all services and disciplines during the survey process," says Kaplan.

The surveyors also complimented the performance indicators related to quality of care and patient safety integrated in each contract service that are then reported up through the organization to the governing board. Indicators were defined in the contract specific to each clinical service, with ongoing data collection and documentation of action plans for identified issues.

In general, the surveyors seemed to sincerely understand the challenges of providing high-quality, safe patient care every day. "The surveyors provided many opportunities each day for education and consultation, and our management team felt comfortable taking advantage of this," Kaplan says.

On several occasions, surveyors offered to give special sessions related to topics such as documenting timely reporting of critical values and enhancing the scope of environmental tours to improve safety in outpatient areas. "The extent of education and consultation provided, both during tracers and in sit-down sessions, was truly impressive," Kaplan says. "They



## CNE objectives

To earn continuing education (CNE) credit for subscribing to *Hospital Peer Review*, CNE 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 or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

## *COMING IN FUTURE MONTHS*

- ■ The best way to disclose serious medical mistakes to the public
- ■ Calculate your return on investment from pay for performance
- ■ What questions Joint Commission surveyors are asking about security
- ■ Strategies to improve patient safety by addressing language and culture
- ■ The best way to implement a team training approach to safety

offered these on several occasions and we never said no."

For example, staff asked for a sit-down session with representatives from imaging, pharmacy, and administration, and subsequently spent 45 minutes discussing the hospital's current process and interpretation of the standards for contrast administration. "The end result was that we did not get a supplemental, and we had great ideas shared with us that surveyors had seen at other hospitals, which we then used to modify our process."

The hospital's management team has been conducting ongoing monthly tracers in patient care areas for the last three years, which was evident to surveyors. "Surveyors could appreciate throughout the four-day survey that we operate from the philosophy of 'survey ready, every day,' and that Joint Commission expectations are ingrained in our culture," Kaplan says.

Surveyors were especially pleased to see that the significant amount of performance improvement data collected by staff is actually used to affect change. "Our PI report forms include specific actions taken and when, with ongoing follow-up data that either demonstrates improvement or a continuing opportunity," says Kaplan.

Data are also reported using dashboards, with internal and external benchmarks noted. "We set goals for ourselves relative to the benchmarks, and a timeframe for achieving that goal," says Kaplan. For example, the patient access and throughput performance improvement team reports data on ED diversions, bed availability and turnover, and the percentage of increase in inpatient admissions resulting from process improvements.

"They were also very positive about the teamwork and open communication channels between departments and disciplines, such as nursing and pharmacy," she says.

In terms of best practices they had seen at other facilities, the surveyors shared information regarding achieving the elimination of unacceptable abbreviations in a paper-based environment. "This is certainly no easy task," says Kaplan. "They emphasized that it takes hard work, but the most effective interventions are immediate."

The surveyors suggested having a pharmacist contact the prescribing physician prior to dispensing the drug to let them know that an unacceptable abbreviation had been used. "The hospital they mentioned had strong leadership support from administration and medical staff to ensure that physicians responded positively to staff phone calls," says Kaplan. "In a three-month period, unacceptable abbreviations were essentially eliminated."

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