YOUR ORIGINAL AND BEST SOURCE FOR JCAHO COMPLIANCE

HPR HOSPITAL PEER REVIEW®

Accreditation • Credentialing • Discharge Planning • Medicare Compliance • Patient Safety • QI/UR • Reimbursement

AHC Media LLC

IN THIS ISSUE

Financial Disclosure:
Editor Staci Kusterbeck, Managing Editor Jill Robbins, Associate Publisher Coles McKagen, and nurse planner Paula Swain report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

JUNE 2007
VOL. 32, NO. 6 • (pages 73-88)

Your hospital's medical errors may soon become public knowledge

Trend toward transparency takes a new turn

The general public already can find out what percentile your organization scored in when it comes to quality measures for conditions such as acute myocardial infarction or pneumonia. But what about the number of times surgery was performed on the wrong body part of a patient? Serious medical errors such as these are now public knowledge in Indiana and Minnesota, and other states may soon follow suit.

Public reporting of medical errors is part of a growing trend toward transparency in health care. In 2003, Minnesota became the first state to publicly report data on medical errors, and Indiana followed in 2005, as a result of a gubernatorial order. Indiana's Medical Errors Reporting System now requires all 287 hospitals and surgery centers in the state to track the 27 preventable adverse health events identified by the Washington, DC-based National Quality Forum as "never events." According to Indiana's interim report, 77 serious preventable mistakes were made in 2006, including nine cases of surgery on the wrong body part and four patient deaths associated with falls.

Minnesota's adverse health event reporting requirement has put the issues of error reporting and public transparency "front and center," says **Alison Page**, MS, MHA, chief safety officer for Fairview Health Services in Minneapolis.

"I think this is a good law. The public has a right to know what happens in hospitals, and hospitals have an obligation to make it public," she says. "As hospitals, we are now able to learn from each other."

Prepare now for reporting

Quality professionals at St. Vincent Health in Indianapolis spent "considerable organizational and community effort" preparing for the release of Indiana's preliminary report, says **Jon D. Rahman**, MD, system vice president and chief medical officer.

Rahman says that the interim report displayed the results broken down by the number of discharges, which muted the impact somewhat. "We also expect that, in future years, the number of events will increase, as the Minnesota experience tells us," he says. Minnesota has seen its numbers rise steadily each year, from 99 in 2003 to 154 in 2006.

Be proactive to prepare for the possibility of public reporting of medical errors in your state. "Be open with the board, associates, and physicians about what the institution anticipates as far as the number and type of events that may be reported," Rahman advises.

Explain that the number of reported events will most likely rise over time, and also be clear about what has been implemented to prevent further occurrences. "If your organization is already moving toward greater transparency, this should be an easy task," says Rahman.

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.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcmedia.com. E-mail: customerservice@ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $469. Add $9.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

Editor: **Staci Kusterbeck**, (631) 425-9760.
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).

Editorial Questions

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

Since Minnesota's mandated reporting requirement took effect in 2003, most hospitals in that state have had an increase in the numbers of events reported, likely due to better identification of events. For example, as a result of hospitals learning more about the "never event" of foreign objects left in patients after surgery or other invasive procedures, it was determined that reported incidents should include retained sponges during childbirth.

"Working together through this reporting system, hospitals realized this was happening, consulted with the Minnesota Department of Health, and broadened the definition of what was reportable to include sponges and gauze used during delivery," says **Lori Johnson**, RN, director of improvement services/patient safety officer at Hennepin County Medical Center in Minneapolis.

To prepare for the reporting requirements, quality professionals at Hennepin made sure that there was a clear understanding of the organization's own data and the specific actions taken to improve care. "In preparing for the report, it is also important to keep your board, executives, employees, and physicians informed of its release and anticipate any questions they might have," says Johnson.

To develop a robust reporting process, your organization must promote an environment conducive to improving patient safety though "reporting, learning, fixing, and sharing," says Johnson. "As a quality leader, you must be knowledgeable and participate in any efforts to develop mandated state reporting, so that the process promotes the sharing of event learning and improvement strategies," she says.

Shared strategies

In Minnesota, the report's data are already proving to be a powerful tool for quality professionals. "We can learn more together than we can individually," says Page. "Now we can learn from what happens at 139 hospitals in Minnesota, vs. only learning from what happens in each of our organizations."

Page recommends identifying the top issues at your state's hospitals and forming collaborative work groups to resolve safety issues. For example, pressure ulcers are the No. 1 reported event in Minnesota. The Minnesota Hospital Association has convened a group of experts in skin care, identified best practices to prevent pressure ulcers, developed tools to assist organizations, and put out a "call to action" to all Minnesota hospitals to implement the best practices. "We are setting standards for ourselves and, in doing so,

raising the bar state-wide for what hospitals are expected to do to prevent these types of things from happening," says Page.

Quality leaders at Washington, IN-based Daviess Community Hospital intend on using the report as a tool for both risk management and quality improvement opportunities, rather than using it as a "fingerprinting exercise," says **Dawn Fritschle**, RN, director of quality/risk/case management.

It would be a mistake for the public to jump to conclusions based on one report without looking at the whole picture, she says, adding that patients at Daviess are frequently referred to hospital networks that have reported errors.

"We have no intention of changing our referrals based on the report," says Fritschle. "These hospitals often receive our most critically ill or injured patients. We work closely with them and can easily see their commitment to providing quality care for these complicated patients."

Data useful for QI

Though there are no comparative data available on a state-to-state basis, the report's data have helped quality improvement efforts at Munster, IN-based Community Healthcare System, says **Janice Ryba**, division director of regulatory and rehabilitative services. For the first-year report, the health care system's three hospital sites had zero reportable events.

"We are proud and grateful. But we are also acutely aware that the best way to acquire consistent excellent performance is by reporting events as they occur, so that we all benefit from the lessons learned and continue to improve," says Ryba. "One single year's report is not a reflection of the total quality care provided by any one hospital or health care system."

To prepare for the mandatory report, the health care system reviewed its policies and procedures already in place to protect patients. The organization is working to eliminate variability in practice, to reduce the likelihood of a serious error.

For example, the process to avoid the wrong surgical procedure performed on a patient was reviewed by a multidisciplinary team consisting of surgery directors, physician leaders, and quality managers. "After the policy was determined, staff and physicians were educated. But it certainly does not stop there," says Ryba. "The final and most important phase of process change involves monitoring to be sure the policy is effective."

Through direct observation and review of documentation in the medical record, the surgery department and quality management team determine compliance by staff and physicians. "The true outcome or goal is certainly zero wrong-site surgical events. Thus far, we have been successful in achieving this goal," says Ryba.

At Daviess, a Failure Mode and Effects Analysis (FMEA) is being done based on the two most common reported errors — correct site verification and hospital-acquired wound prevention. "The data clearly point out that these areas are high-risk areas for all hospitals, not just the hospitals that had reportable errors," says Fritschle. "We are grateful that we can take this information from the report and use it proactively to help us reduce the chances for errors in the same areas."

The FMEA process will identify any weaknesses in the hospital's current procedures for correct site verification, says Fritschle. "We'll do another FMEA on our screening process for identifying patients at high risk for developing a decubitus ulcer while they are in our hospital," she says.

If the patient is admitted with bedsores or is assessed as high risk for development of bedsores, specific protocols are initiated by the physician and nursing staff to prevent the escalation of the degree of bedsores. "Frequent rounding by bedside caregivers, with attention to the unique care required for particular patients is paramount," Fritschle says.

Quality managers at Daviess now are looking at whether the hospital had any incidents or near-misses that weren't reportable incidents, and are examining incidents reported by other hospitals to see exactly where breakdowns in the process occurred.

"The hospitals we've talked to have been very open with us, and have willingly shared information," says Fritschle. "By combining all the information gathered both internally and externally, we will be able to drill down quickly to areas in our own processes that could potentially cause us to have errors."

At Hennepin County, the state's report has augmented internal efforts to promote transparency, improve care systems, and reduce adverse events. "This reporting process provides a new avenue of learning, improvement and networking opportunities for the quality professional that otherwise may not exist," says Johnson.

This year, the Minnesota Hospital Association is hosting four "call to action" campaigns to reduce adverse events in the top four statewide

events: pressure ulcers, falls, retained foreign objects, and wrong body-part surgery. "This is an opportunity for all hospitals to hear from national and local experts, share what we have learned, and implement action plans to reduce these specific types of adverse events," says Johnson.

If each hospital were examining just their own events, valuable information would be lost, adds Johnson. "This type of reporting system provides a unique opportunity to gather the collective experiences from all hospitals and share what is learned, to the ultimate benefit of patients across the state," she says.

Long-term impact

Indiana's mandatory requirement in January 2005 set the stage for other patient safety initiatives in the state, such as the July 2006 launch of the Indiana Patient Safety Center. "The formation of the center provides an opportunity to go beyond mandatory reporting, and explore the role of voluntary reporting outside of that list," says **Betsy Lee**, RN, MSPH, director. The center is currently working with hospital-based quality leaders on many different initiatives, including pressure ulcers and preventing harm from high-alert medications. Topics for future initiatives include wrong-site surgery and retained foreign objects.

"The important thing is that clinical staff and quality professionals at hospitals are coming together to talk across typically competitive lines about ways to improve safety," says Lee.

The new requirements are part of a national movement toward public disclosure when things go wrong, and the jury is still out on whether this will increase the number of malpractice lawsuits filed. For the state reports, only the category of event is known, with no dates or patient or practitioner names released. "So, in that sense there is protection. However, due to the nature of many of these events, the fact that one occurred may already be known within a community," says Lee.

Regardless of the transparency trend, front-line staff may still be fearful of liability or other repercussions. "We have worked for many years with different rules of behavior around adverse medical events, so there will be a time of trust building during this period of change," says Lee. "I don't think we have that level of trust from the front line yet. We have a ways to go to improve the culture of safety, but hospitals are moving in the right direction."

Increased public awareness of medical mistakes could result in more of a tendency to sue health care providers, or it could wind up having the opposite effect. "I don't think we can predict with any degree of certainty which way it will go," says Lee. "Will the patients and families involved have a different threshold for seeking legal action? That might be true, but then again, it might go in the other direction."

After the Indiana report's release, two family members of patients that had been harmed contacted Lee and both asked, "How can I help?"

"I believe that the public's reaction may not always be what we predict," she says. "There are people who have been personally impacted who are now committed to improving the system. I believe we have some untapped partners in this process."

[For more information, contact:

***Lori Johnson**, RN, Director of Improvement Services/Patient Safety Officer, Hennepin County Medical Center, Minneapolis, MN 55415. Phone: (612) 873-4552. E-mail: lori.johnson@co.hennepin.mn.us.*

***Betsy Lee**, RN, MSPH, Director, Indiana Patient Safety Center. Phone: (317) 423-7795. E-mail: blee@inhha.org.*

*A**lison Page**, MHA, Fairview Health Services, 2450 Riverside Avenue, Minneapolis, MN 55454. Phone: (612) 672-6396. Fax: (612) 672-6060. E-mail: apage1@fairview.org.*

***Jon D. Rahman**, MD, System VP & Chief Medical Officer, St. Vincent Health, 8425 Harcourt Rd., Indianapolis, IN 46260. Phone: (317) 338-7057. Fax: (317) 338-4715. E-mail: jdrahman@stvincent.org.*

***Janice Ryba**, Division Director, Regulatory and Rehabilitative Services, Community Healthcare System, 901 MacArthur Boulevard, Munster, IN 46321. Phone: (219) 836-3465. E-mail: jryba@comhs.org.]* ■

Team training is "huge opportunity" for safety

New approach results in dramatic changes

Better teamwork. It sounds like a simple strategy, but this goal has proved surprisingly elusive for many health care organizations.

In its 1999 report, *To Err is Human: Building a Safer Health System*, the Institute of Medicine (IOM) reported that medical errors cause as many as 98,000 deaths each year, and suggested that

better teamwork and coordination could prevent harm to patients.

The IOM recommended that health care organizations establish team training programs for personnel in critical care areas such as emergency departments, intensive care units, and operating rooms.

In response, the TeamSTEPPS training program was developed by the Department of Defense (DoD), in collaboration with the Agency for Healthcare Research and Quality (AHRQ). TeamSTEPPS is an evidence-based teamwork system, which aims to improve patient outcomes with better communication and other teamwork skills among health care professionals, and is currently being used by more than 50 hospitals.

There is a growing body of evidence that improved teamwork directly relates to quality, according to **James B. Battles**, PhD, senior service fellow for patient safety at AHRQ. "We know that when we don't have good teamwork, quality of care suffers. There are lots of examples where poor coordination of care and handoffs lead to serious problems," he says. "We do believe that this is one of the major things that people can do to improve quality and safety in their institutions, but it does take a major commitment. It is hard work and requires strong leadership support."

After a series of errors resulted in the loss of a patient's baby in 2000 at Boston-based Beth Israel Deaconess Medical Center, a major reorganization of the obstetrics and gynecology unit led to a successful change of culture. "We believe that we were only able to embark on this journey as a result of being willing to confront a patient's loss and accept responsibility," says **Benjamin Sachs**, MD, chair of the hospital's department of obstetrics and gynecology. "Our philosophy is that health care has much to learn from the science of safety and quality developed by other industries, and that the search for quality is a never-ending journey."

Following the 2000 case, the obstetrics unit began working with the DoD and the Harvard Risk Management Foundation, the malpractice insurer for Harvard teaching hospitals, to apply the principles of Crew Resource Management (CRM), which are used to prevent errors in the military and in commercial aviation, to the field of obstetrics.

The obstetrics staff learned how to use CRM techniques to overcome poor communication and make it easier for all staff to participate in decisions about patient care. For example, doctors and nurses previously gave updates only on the patients under their care to the next shift. Now, the entire obstetrics staff are knowledgeable about all patients. Today, Beth Israel Deaconess has the lowest adverse event score of any comparable tertiary hospital reporting to the National Perinatal Information Center, a nonprofit organization that collects national data. As a direct result of the obstetrics unit's work, there are now statewide initiatives in Massachusetts, Maryland, and the District of Columbia to introduce obstetrical team training.

Outcomes data are key

SSM Health Care, a 20-hospital network based in St. Louis, is in the very early stages of implementing the TeamSTEPPS program. "We have come to the belief that teamwork training is a really important part of safety that was not easily addressed before TeamSTEPPS was developed," says **Andy Kosseff**, MD, the organization's medical director of system clinical improvement. "We think this is a huge opportunity for us to take."

As for many health care organizations, communication and coordination of care were significant obstacles to improving patient safety, outcomes, and satisfaction at SSM. "For that reason, one of the things we need to do is implement a more standardized and rigorous process for this, as one of the fundamental parts of our safety program," Kosseff says.

In today's hospital environment, more doctors and nurses are involved in the care of each patient, so communication and coordination of patient care is even more important than it may have been in years gone by. However, to implement TeamSTEPPS effectively is "no easy task," says Kosseff.

"We will need to prove to the people in our system that this is as important as we think it is," he says. "The literature has shown lots of benefits of teamwork training, but because it's so early on, we don't have a lot of outcome data. We will need to generate that data ourselves." Since the program is very resource-intensive, having solid data will make it much easier to obtain buy-in for a general implementation at the 20 hospitals in the health care system.

Currently, five individuals from SSM have been trained by AHRQ, including clinicians, patient safety officers, and quality professionals. "One of the things we think is key is that it should be people who have clinical backgrounds doing the training," Kosseff says. "Having a doctor and nurse

team starts the modeling of the interdisciplinary teamwork, right as you are doing the teaching."

The organization is currently selecting a few units to serve as pilot sites in the typical units that teamwork training has been shown to be most valuable — obstetric units, operating rooms, and emergency departments. "By selecting pilot sites, our hope is that we can learn more about the most effective way to make this stick and work," Kosseff says. Training is expected to be completed by fall 2007, with units up and running by the end of the year.

Outcomes on the units, as well as nurse retention and safety culture assessment, will be carefully measured to demonstrate improvements. "We will try to develop some measurements that give us an indication of how successful we are," says Kosseff. "We will of course be looking at the frequency of adverse events and hoping to see these decrease."

[*For more information, contact:*

***Andy Kosseff**, MD, Medical Director of System Clinical Improvement, SSM Health Care, 477 North Lindbergh Ave., St. Louis, MO 63141. Phone: (608) 238-1337. Fax: (608) 238-0054. E-mail: Andy_Kosseff_MD@ssmhc.com.*

Visit the TeamSTEPPS page on-line at http://dodpatientsafety.usuhs.mil/index.php?name=News&file=article&sid=31.] ■

THE QUALITY - CO$T CONNECTION

RCAs need leaders' care and feeding

Leaders bring greater likelihood of success

By Patrice Spath, RHIT
Brown-Spath & Associates
Forest Grove, OR

The greater amount of top leadership involvement in a root cause analysis (RCA), the greater the likelihood of significant patient safety improvements. Senior leaders don't need to be appointed to RCA teams but some level of leadership oversight and intervention is important throughout the life of the investigation. Root cause analysis teams should not be formed and then abandoned by leaders until the investigation is complete. What must leaders do to ensure a successful RCA? Participation starts even before the investigation is initiated and continues long after the review is done. The steps of an event investigation and the role of leaders at each step is summarized in Figure 1 (see p. 83).

Determining whether an RCA is necessary

Following a significant adverse event or undesirable clinical outcome, senior leaders should be involved in determining whether an RCA is to be done. Many factors will be considered in making this determination, including, but not limited to, the following:

- Does this event represent a substantial risk to patient safety?
- Is this event due to faulty processes or system failures that are likely to cause a similar, perhaps more harmful event, if not corrected?
- Will the organization receive substantial negative publicity if the cause of the event is not corrected?
- Will failure to conduct an RCA result in deterioration of staff or physician morale and/or loss of trust in the leaders' commitment to patient safety?

A multidisciplinary group, such as the patient safety committee, could be charged with triaging events or the task can be delegated to a smaller group of senior leaders such as the CEO, chief nursing officer, and the medical director or medical staff president. Even if an RCA is required by accreditation standards or state regulations, senior leader endorsement of the investigation is very important. Through this endorsement, leaders are communicating a vital message to everyone — finding and fixing root causes is a high priority for this organization and not something we are doing just to satisfy an external requirement.

Initial screening process

During this initial event screening process, leaders also can decide whether the case needs a thorough risk management investigation, peer review evaluation, and/or staff performance review. An RCA focuses primarily on systems and processes, not management of potential liability risks or eval-

(Continued on p. 83)

PATIENT SATISFACTION PLANNER™

Study shines light on poor transfer communications

Focus on discharge summaries can reduce problems

Quality improvement professionals have long known of the difficulties involved in discharge communications between hospital-based physicians and primary care physicians, but in the words of one observer, "This is the first time the problem has been quantified."

"This" is a new article in the *Journal of the American Medical Association* (*JAMA*), entitled "Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians."[1]

Extracting data from observational studies, the researchers found that:

• Direct communication between hospital physicians and primary care physicians occurred infrequently (3%-20%);

• The availability of a discharge summary and the first post-discharge visit was low (12%-34%) and remained poor at four weeks, affecting the quality of care in approximately 25% of follow-up visits and contributing to primary care physician dissatisfaction;

• Discharge summaries often lacked important information such as diagnosis test results (missing from 33%-63%), treatment or hospital course (7%-22%), discharge medications (2%-40%), tests results pending at discharge (65%), patient or family counseling (90%-92%), and follow-up plans (2%-43%).

"As a hospitalist, I and my colleagues have had a lot of anecdotal experience about the communications around hospital discharge being poor," notes **Sunil Kripalani**, MD, MSc, assistant professor in the department of medicine, Emory University School of Medicine and assistant director of the hospitalist program at Grady Memorial Hospital, both in Atlanta, and lead author of the paper. "I am also trained in primary care, and, as such, I know these doctors feel they often don't have enough information about the patient. But [this problem] has never been emphasized formally, so we decided to flesh out the specifics of the problem and see what can be done about it."

Kripalani and his colleagues did just that; they not only put the problem squarely into focus, but they also laid out a template for a new discharge form they think will help eliminate many of the quality issues they detailed in the paper.

"We know that this is a huge issue, and it occurs with specialists as well as with hospitalists," adds **Bev Cunningham**, MS, RN, associate administrator, clinical performance improvement, Medical City Dallas Hospital.

"For example, if your pulmonologist gets a referral, especially if you are a referral center, your docs should take a very good look at making sure their communications with the primary physician are handled well."

Discharge communications, she continues, raise a number of important issues. "One is safety; the patient can definitely get 'lost,'" she asserts. "Second is The Joint Commission standard of handoff, which does include the physician. The third is results: If you want people to refer patients back to you, you want to have the right processes in place, because it can affect volume."

A matter of time?

While The Joint Commission does have standards pertaining to this issue, Kripalani says quality professionals should look beyond those standards to achieve optimal performance.

"I think one of our main findings was the 'disconnect' between the information that needs to be communicated promptly at hospital discharge and what the current Joint Commission requirements say," he asserts. "The majority of times the primary care physician does not have detailed information from the hospital when he begins follow-up care.

"One of the reasons is that the current performance standards hold discharge summaries under the umbrella of all other hospital records, so there is a 30-day time period for completing discharge summary, and the physician is not considered delinquent until a certain percentage of their records has been incomplete for 30 days. In other words, the physician may have several chart summaries not completed within one

month before he is really considered an outlier."

That is just not sufficient for patient follow-up, Kripalani continues. "Patients often receive follow-up care within a week of discharge; I saw one study where the median was six days," he observes.

"This is so true," echoes Cunningham. "If someone comes here for a severe infection, or to see a big-time oncologist, what happens two days later when they are 100 miles away and their primary care doctor does not have a clue [about what happened]? It goes back to patient safety, which is why it is part of The Joint Commission standards and National Patient Safety Goals."

It's also why, she continues, a conscientious facility would not be satisfied with a 30-day wait, regardless of The Joint Commission's standards. "If you have a patient, regardless of the standard, why would we wait 30 days for that?" she poses.

But the first communication need not be written, she adds. "It could be a 'howdy' call, in which you give them a summary, and then document it," she offers. "It's like the immediate post-op note that you have to write in the record and then have to dictate."

At her facility, she says, "My hospitalist group is not employed [by the hospital], but the president of the group is entrepreneurial; he knows if his communication is good, his referrals will match. And I *want* him to have referrals, because I want full beds."

Cunningham provides her hospitalists with a nurse practitioner, who makes the "howdy calls," and then documents the calls. "In a smaller facility, it could be some sort of advanced practice nurse, or even a physician's assistant," she suggests.

Other ways to speed the process, Cunningham notes, include faxing the discharge form. "The other consideration here is with the EMR [electronic medical record]; as more and more hospitals move to this technology, it becomes easier to transition information from the patient's record to the physician electronically," she notes.

In any event, says Kripalani, time is of the essence. "There's a patient safety argument that can easily be made that information flow has to be prompt and complete — occurring within a week of discharge," he asserts. "Another line of thought is that perhaps the performance standard should be revisited."

Thus, to Kripalani's thinking, speed is not the only important element in discharge communication; the information that is received quickly should also be complete — ergo, the recommendations for a more detailed discharge form.

Elements of discharge summary

The researchers recommend, for example, that discharge summaries should include the following elements:

- primary and secondary diagnoses;
- pertinent medical history and physical findings;
- dates of hospitalization, treatment provided, and brief hospital course;
- results of procedures and abnormal laboratory test results;
- recommendations of any subspecialty consultants;
- information given to patient and family;
- the patient's condition or functional status at discharge;
- reconciled discharge medication regimen, with reasons for any changes and indications for newly prescribed medications;
- details of follow-up arrangements made;
- specific follow-up needs, including appointments or procedures to be scheduled, and tests pending at discharge;
- name and contact information of the responsible hospital physician.

"One important consideration from the process standpoint would be to systematize prompt completion of discharge summaries the day the patient is discharged," says Kripalani.

"Like most performance improvement initiatives, it should involve a multidiscipline approach; for example, in a hospital that relies on care managers to oversee the discharge process, you may make it their responsibility to ensure the form is completed. Other facilities may be configured around billing software, which could prompt the physician to enter the form when the charge is billed. There are a variety of ways completion could be anchored to something already in place in the individual hospital."

He adds that quality managers could play an important role by completing part of the form themselves, as well as by monitoring how consistently the new form is being used.

Tracking results

In tracking results, Kripalani thinks the successful use of the forms is worth measuring, but it's not

everything. "Simply completing forms in a timely manner would be an improvement, but it wouldn't be optimal," he argues. "An optimal process would also include ensuring the primary care provider has received the form in a timely manner. The reason I mention that is, today, patients are sometimes admitted without having a designated primary care provider. In that context, it's expected that 15%-20% of the PCPs following these patients still may not receive the hospital information, perhaps because they were not the PCP at the time the patient left the hospital or they were but their contact information was not available." In the study, he notes, 15% of primary care physicians reported *never* receiving a discharge form.

A simple way to track performance, Kripalani continues, would be on a subset of the discharge documents. "Include a postcard for the PCP to return upon receipt of the information," he suggests. "That's a simple way of auditing; you could even have a date on it." A more hi-tech counterpart, he notes, would be e-mail.

Another way to measure performance/results, says Cunningham, would be a survey, which could be part of your documentation. As for anticipated results, she says. "I would hope it would impact readmissions, satisfaction of PCPs, and I would hope it would also impact patient satisfaction.

"We do our [patient satisfaction] work with Gallup; we're currently fixing it so that we can drill down to the physician level."

As more and more national organizations look at pay for performance and at physician and nurse satisfaction, she says, "There might be a question such as, 'If you are the patient of a hospitalist, did you feel your primary care provider had the necessary communications to take care of you?' Or, 'Did you have the information you needed to take care of yourself when you went home?'

"Another might be, 'Did you feel your hospitalist and primary care provider worked as a team after your discharge?'"

References

1. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, and Baker DW. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care. *JAMA* Feb. 28, 2007; 297, 8: 831-841.

[For more information contact:
***Bev Cunningham,** MS, RN, Associate Administrator, Clinical Performance Improvement, Medical City Dallas Hospital. Phone: (972) 566-6824. Fax: (972) 566-7533.*

***Sunil Kripalani**, MD, MSc, Assistant Professor, Department of Medicine, Emory University School of Medicine, Atlanta, GA. Phone: (404) 449-1242.]* ■

How accurate are patient satisfaction surveys?

'Continual monitoring' brings best results

When it comes to quality assurance in the customer service arena, those patient satisfaction surveys that have become ubiquitous in health care may not be providing accurate feedback, suggests **Michael Friedberg**, FACHE, CHAM, a manager with Besler Consulting in Princeton, NJ.

"My feeling is that patient satisfaction surveys are potentially flawed," he says. "Many hospitals taint the process by preparing patients in advance of their receipt of the survey."

When he asked a recent gathering of health care professionals if they had a similarly negative opinion of such surveys, three-quarters of the hands went up, Friedberg adds. "I'm not convinced [patient satisfaction surveys] are an accurate representation of the service provided in patient access."

Among the more effective means of accessing managers and directors to measure customer service, he says, are to look at complaints to hospital administration and to create standard telephone scripts and then check to see if they are being used properly.

Since access is a 24/7 operation, that means calling late at night and early in the morning, Friedberg adds. "Many [access departments] have one or two access people on duty from 6 at night to 6 in the morning. If nobody is in charge, they can pretty much do what they want. You need to figure out a way to continually monitor them."

During his early years as a corporate director of access, Friedberg was also a new father. "When I gave the baby a bottle at 3 a.m., I also called all three hospitals. [Staff] used to hate that.

"Mystery shoppers also work very well for this," Friedberg adds. He recounts an example from his own experience in which a mystery shopper, pretending to be an existing patient, presented to his emergency department registration area.

"We expect our staff to re-interview [existing patients], especially in the emergency department,"

Friedberg says. "The mystery shopper reported that the registration representative did not speak to him during the process, except to ask his name, Social Security number, and date of birth."

The registrar then proceeded to hit the "enter" key all the way through the registration, asked the patient to sign in three places without any explanation, and then sent him on his way, he continues. "If a supervisor, manager, or director was in the area, [employees] would never show this behavior.

"Due to the 24/7 nature of patient access," Friedberg adds, "I would have to say that you must assume some of this is happening — especially on the third and first shifts, that is, 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. — but it is hard to prove." ■

Assess patient satisfaction with communications

The Agency for Healthcare Research and Quality (AHRQ) is developing a survey instrument to measure how effectively hospitals address patients' health literacy needs. The tool will consist of a new module for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and will solicit patients' perspectives on how well health information is communicated to them by health care professionals. Questions will consider the clarity of written and verbal communications about treatment choices, screening results, medications, educational techniques, and language assistance.

The CAHPS program began in 1995 with a survey and report on consumers' perspectives on the quality of their health plans. Since then, CAHPS has partnered with CMS and others to expand its scope, developing consumer surveys and reports on individual clinicians, group practices, in-center hemodialysis services, nursing homes and hospitals.

"AHRQ determined that the CAHPS teams should develop a survey to obtain the consumers' perspective on how well health plans, hospital, clinicians, and group practices address health literacy issues," says **Charles Darby**, CAHPS project officer.

The CAHPS health literacy module measures physicians' ability to communicate effectively with their patients, verbally and in writing, and their use of state-of-the-art communication practices. Patients are asked how often their doctor reviewed all the medications the patient was taking, gave verbal and written instructions about how to take medicine, provided explanations of possible side effects that were easy to understand, and checked to make sure the patient understood instructions.

AHRQ is cognitively testing the module in English and Spanish, to be followed by field testing, with an expected 2008 release. Although the tool is designed to be used with the CAHPS clinician and group survey, it could be adapted for use in the hospital setting, says Darby.

The health literacy set of items could be used to identify areas related to communication between provider and patient, both oral and written, where patients report that they are not receiving the help they need to understand issues about their health and their treatment. "The quality professional may choose to gather more in-depth information from patients to help in designing a quality improvement strategy," says Darby. ■

Leapfrog hospital survey gets tougher

This year, the Leapfrog Hospital Quality and Safety Survey will include the types of questions asked by other national initiatives such as The Joint Commission, the Centers for Medicare & Medicaid, and the Institute for Healthcare Improvement's 100,000 Lives campaign, says to the Washington, DC-based organization.

New survey questions will include the following:

- What will your hospital do if they make a big mistake?
- How well does my hospital treat my condition?
- How open with the public is your hospital?

A new "Transparency Indicator" will show which hospitals are doing a good job at publicly reporting their quality and safety track records by giving credit for the other public reporting initiatives in which they participate. In addition, the survey will provide a more complete picture of how well a hospital performs one of seven high-risk procedures and how adequately they can treat low-birth-weight babies.

The first round of survey results will be posted at www.leapfroggroup.org/cp in early June. Leapfrog will use these results to determine the list of Leapfrog Top Hospitals 2007. ■

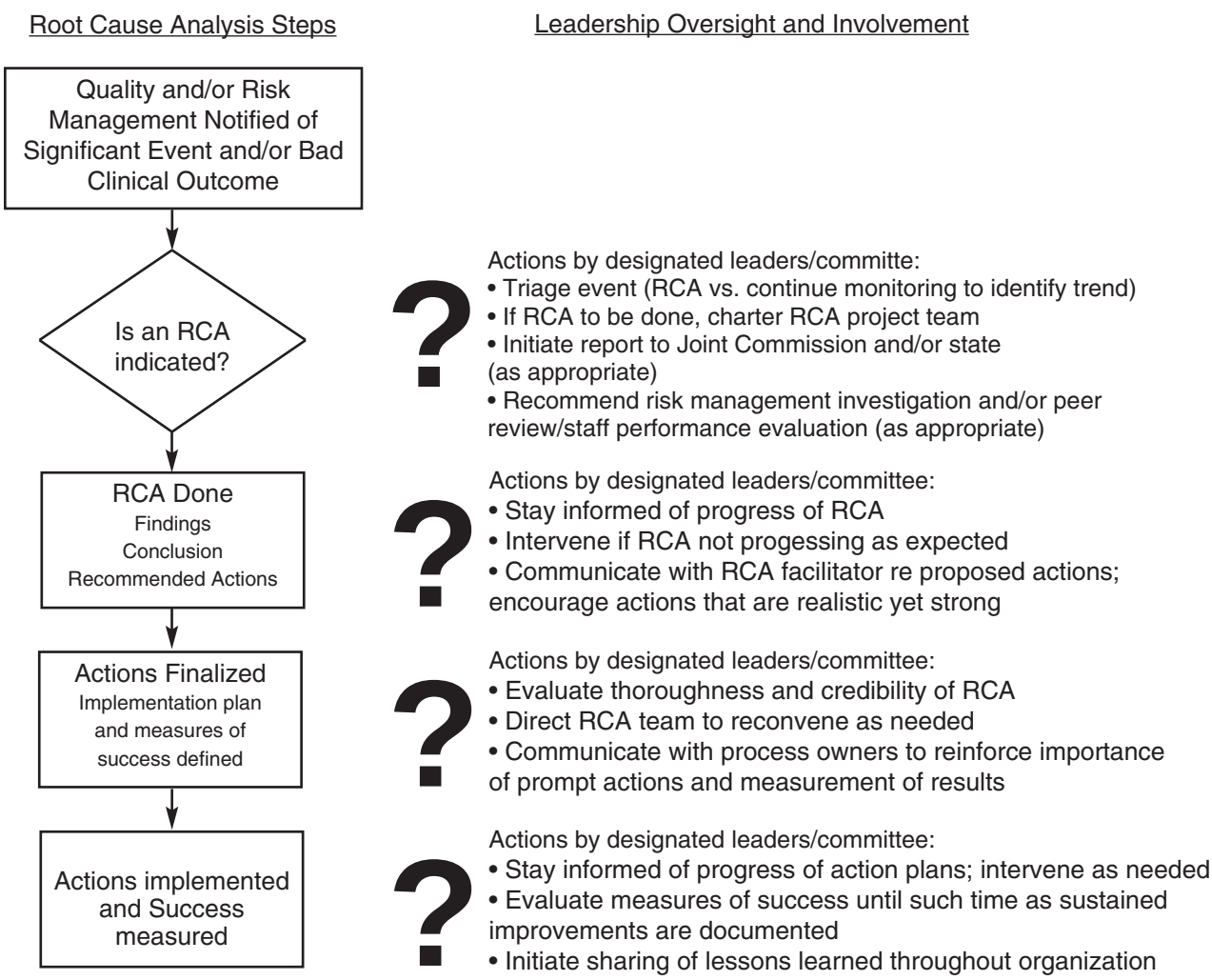
(Continued from p. 78)

uation of individual performance. These additional reviews can be conducted simultaneously with the RCA, but never in the same forum. Events not chosen for an RCA should be considered by the organization's leaders when establishing future patient safety improvement priorities.

Throughout the investigation, the RCA team facilitator should keep leaders informed. If some people are not showing up for the meetings or other issues are slowing the progress of the RCA, the leadership group often needs to intervene to resolve problems. When the RCA has reached the action planning stage, it is useful for the team facilitator to get input from relevant administrative and medical staff leaders. The following are issues that often need clarification before the RCA team finalizes the action recommendations:

- Are there pre-set assumptions that leaders hold about the recommended actions? Are leaders open to accepting the team's recommendations or do they have alternatives?
- What resources (dollars, time, etc.) can be spent on the action plans? What are the resource limitations?
- What will make leaders anxious during the action design and implementation phase? How soon do they expect to see positive changes?
- If a process owner does not complete their assignments will leaders initiate appropriate pressure to correct the problem?
- Will leaders help dismantle the "old way" of doing things by holding fast to and reinforcing the redesigned way until it has had time to prove its effectiveness?
- Are the desired time frames for short,

Figure 1
Leadership Oversight and Involvement of Root Cause Analysis Investigations



medium, and long-term action plan completion realistic? Can leaders support these time frames?

Once the RCA team finalizes corrective actions and identifies measures of success, the completed investigation report is forwarded to the leadership group or committee. This group should evaluate the thoroughness and credibility of the investigation and the merit of the action plans. Thoroughness and credibility is evaluated by considering the following questions:

- Did the root cause analysis have multidisciplinary participation and input from those closest to the processes and systems under review?
- Does the report clearly document the facts surrounding the event or hazardous condition?
- Did the team follow a logical and systematic process to identify the root causes of the event or hazardous condition?
- Did the team identify root causes (underlying system failures or process faults) that if addressed are likely to prevent recurrence of the event or reduce the hazardous condition?

The merit of the action plans is evaluated by considering the following questions:

- If the recommended actions are taken, is it likely that future events of this type will be eliminated or reduced?
- Can the actions be implemented within a reasonable time considering available financial and human resources?
- Are the people/departments responsible for implementing actions clearly identified and are the timelines for completion reasonable but aggressive?
- Will the measures of effectiveness adequately evaluate the success of the actions?

If the group leader does not approve the RCA, the team should be reconvened to address questions or concerns and make necessary changes. Upon completion of their charge, the team presents a new report to the leaders for review and approval.

When the RCA is complete and approved, a leadership group should receive regular reports of the progress of action plans and the results of success measures. The leaders need to evaluate whether action plans are being implemented as envisioned and if milestones are being achieved. Once the "fire" stops blazing after a significant adverse event, attention can sometimes move on to other issues and the root causes don't get resolved. If this happens, leadership intervention is needed to hold people accountable for their role in implementing action plans — otherwise things will drift back to how they were prior to the RCA.

If the actions do not achieve desired results, the RCA team should be reconvened to discuss and recommend revisions to the initial action recommendations. The leadership group should monitor the effectiveness of actions until such time as the group is reasonably assured that the actions achieved desired results (usually at least six months following implementation of the recommendations). Another important role for the leadership group is to make sure that improvement ideas derived from the event investigation are periodically shared with managers, staff, and medical staff members. Such sharing helps broaden organizational learning from each RCA.

Senior administrative and medical staff leaders must allocate appropriate time and attention to RCA activities to encourage ongoing patient safety improvement. An important aspect of this oversight is participation in each step of the investigation. By selecting events that will undergo an RCA, leaders are reinforcing the importance of such investigations. By reviewing the ongoing progress of the RCA, leaders can clear away barriers and help support implementation of worthwhile, cost-effective improvement plans. By enforcing accountability for completing actions and achieving improvement goals, leaders help assure and sustain patient safety gains. ■

ACCREDITATION
Field Report

Surveyors look at newborn security, staff competencies

Hospitals get big star for FMEA

Has your organization ever conducted a "Code Adam" drill, which simulates how staff would respond if there were an attempt to abduct a baby from the obstetrics ward during a fire drill?

This question was asked of staff at Valley Regional Hospital in Claremont, NH, during a recent survey by The Joint Commission. "I thought it was a great question," says **Sandy Gee**, quality improvement director. "I found it very intriguing. We hadn't really thought about it but I understand the reasoning for it. A perpetra-

tor could pull an alarm to distract the staff."

Surveyors looked closely at security systems on the hospital's maternal child health unit. They asked whether staff had ever caught the perpetrator during a Code Adam drill, and what improvements had been made as a result of previous drills.

Nurses explained to surveyors that after a recent drill, the alarm systems were changed. An audio and visual flashing light was added in the admitting area as a visual signal; since other alarms go off in that area, this would be a clear warning that could not be overlooked.

The nurse surveyor looked at staff competencies during every patient tracer. After asking a patient's diagnosis in the behavioral health unit, she asked how the nurse did the medication reconciliation process, the history and physical, pain assessment, and assessment of vital signs. She also asked, "What are you doing as an individual and as a team to treat the patient? How often is the treatment plan updated? How is patient education done?

"Then she asked the case manager about her skill set and her competencies, asking how she became competent to work in that particular area," says Gee.

While the surveyor was observing a nurse giving a medication to a patient, the patient spit out the medication and refused to take it. "The surveyor was pleased to see that the nurse listened to the patient's concerns, and went back and clarified the order with the physician," Gee says.

The surveyor asked if the treatment plan was multidisciplinary, and also wanted to know the process if the patient wanted to bring in their own medications, and whether those medications needed to be cleared by pharmacy. The survey team was impressed that the hospital was one of three hospitals in the country with the largest improvement in patient satisfaction, which won them the Press Ganey Compass award. "During the leadership session, we were able to describe how we had made progress," says Gee.

FMEA on patient ID

Quality professionals proudly described several improvements that were made as a result of core measures and Institute for Healthcare Improvement initiatives. However, surveyors cautioned that internally identified areas should not be overlooked. "They said all the outside initiatives were wonderful, but that we need to make sure that we continue to focus on our hospital," says Gee.

Staff reported on the Failure Mode and Effects Analysis (FMEA), which was done on patient identification. This FMEA addressed every single area of the hospital, including same-day surgery, the emergency department, and maternal child health, to ensure that consistent approaches were used. "The surveyors particularly liked the topic of patient identification as an FMEA," says Gee.

Several changes were made as a result of the FMEA, such as one department's adding the patient's date of birth to labels that previously only listed the patient's name. On another unit, staff were in the habit of handwriting patient information on labels, so printers were purchased to eliminate the chance of human error.

Procedures for patient identification were tightened in physician clinics and outpatient areas. "Sometimes you are so focused on acute care, and clinics may not undergo the same scrutiny," says Gee. "We wanted to ensure that staff were using the same two identifiers for medication administration."

Critical test results reporting also was looked at during patient tracers and discussed during the data use session. "The surveyor saw critical test results on a patient's chart, and asked about the process and whether there was a specific time frame they needed to be reported in," says Gee. "They also asked what the next step was if the nurse didn't get an answer from the provider."

Surveyors asked how compliance with hand hygiene was measured and offered the suggestion of using a "secret shopper" methodology. "Of course, if the nurse sees the infection control officer, she will make sure to be compliant," says Gee. The surveyors suggested having a nurse or housekeeper observe to see if staff practice hand hygiene. "We currently use the secret shopper methodology to observe medication administration, to ensure that staff follow the correct steps," says Gee.

[For more information, contact:
***Sandy Gee**, Quality Improvement Director, Valley Regional Hospital, 243 Elm Street, Claremont, NH 03743. Phone: (603) 542-3414. E-mail: sandy.gee@vrh.org.]* ■

Don't overlook patients with low health literacy

Strategies to close communication gap

Patients are being put at risk because important health care information is communicated in medical jargon that exceeds their literary skills, according to a new white paper from The Joint Commission. (A copy of *What Did the Doctor Say? Improving Health Literacy to Protect Patient Safety* is available at no charge on The Joint Commission web site, www.jointcommission.org, under "Public Policy Reports.")

"I think this is a huge blind spot, and we in health care are just now waking up to it," says **Michael Leonard,** MD, physician leader for patient safety at Kaiser Permanente in Evergreen, CO.

The paper says that the communication gap between patients and caregivers involves literacy, language, and culture, and gives 35 recommendations including education and training of leaders and staff on health literacy issues. The paper also recommends use of established patient communication methods such as "teach-back," and assessment of the literacy levels and language needs of the communities served.

Ninety million Americans "have difficulty understanding and acting upon health information," according to an Institute of Medicine (IOM) report on health literacy.[1]

Originally, health literacy was seen as an issue relevant only to certain patient population groups, says **Rima E. Rudd**, ScD, MSPH, a health literacy expert at the Harvard School of Public Health in Boston. "Only recently are institutions paying attention to the IOM claim that health literacy is an interaction between the skills of individuals and the demands of the health sector," she says.

Many health care professionals have recently started looking at their often faulty assumptions about what patients actually know and can do, and the nature of the demands they make, says Rudd.

Low health literacy is associated with several adverse health outcomes, including increased incidence of chronic illness and poorer intermediate disease markers, according to an Agency for Healthcare Research and Quality (AHRQ) report.[2]

In the near future, we may be seeing new requirements from The Joint Commission to address health literacy of patients. "I think over

CE *questions*

21. Which was a result of Minnesota's requirement for hospitals to publicly report adverse events?
A. The number of malpractice lawsuits increased dramatically.
B. Hospitals are less willing to disclose near-misses.
C. Quality professionals are openly sharing error prevention strategies.
D. The number of wrong-site surgeries has markedly increased.

22. Which is recommended when implementing team training?
A. Avoid using individuals with clinical backgrounds to provide training.
B. Model interdisciplinary teamwork by having a doctor and nurse team teach staff.
C. Don't use pilot sites when implementing this approach.
D. Avoid implementing team training in emergency departments.

23. Which change was made as a result of a Failure Mode and Effects Analysis (FMEA) done on patient identification at Valley Regional Hospital?
A. Labels were revised so only the patient's name is listed.
B. Staff were encouraged to hand write patient information on labels.
C. Procedures were made less stringent for outpatient areas.
D. The patient's date of birth was added to labels in one department.

24. Which is recommended to address health literacy?
A. Written educational materials are always sufficient unless patients are non-English-speaking.
B. Teach-back methods are not recommended.
C. Providers should use pictures along with simple narratives when educating patients.
D. Health literacy is a problem only for select patient populations.

Answer Key: 21. C; 22. B; 23. D; 24. C.

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 this issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

time, some consensus will be reached about possible solutions or fixes," says Rudd. "Once a consensus is reached, then I think we will see standards." To address health literacy at your organization, consider the following interventions:

• **Assess commonly used forms, patient education print materials, signs and directions, informed consent documents, and discharge instructions.** "Evaluate signage and patient education materials to be sure they are clear to people with low reading skills," says **Patrice Spath**, RHIT, a Forest Grove, OR-based consultant and author of the book *Partnering with Patients to Reduce Medical Errors* (published in 2004 by the American Hospital Association).

Many hospitals use printed material to encourage patients to speak up when they have a safety concern, but informational brochures used to communicate this are often written at a high grade level. People with low health literacy or non-English-speaking patients don't understand what is being stated in these brochures, says Spath. "Whenever possible, use pictures along with simple narratives to educate," she recommends.

• **Provide a training and orientation program for all staff focused on health literacy awareness.** "Develop a policy to address reading level of all in-house print materials for patients," says Rudd. "Train staff in use of plain language and how to avoid jargon."

• **Ask about safety concerns verbally.** Doctors, nurses, and patient advocates should be regularly asking the question, "Do you have any safety concerns?" says Rudd. "Avoid paper and pencil measures that only capture the opinion of those who read and write with ease," she says.

Consider the following "script" for a patient interview, says Rudd: "Many people point out that hospital staff often speak a 'foreign' language filled with medical and scientific words. We have been trying to use everyday words and clear explanations and directions as much as possible. We want to know what you think about our efforts."

• First, have you been here before?

• If yes: Have you noticed any change since you were here last?

• If no: Okay, now I will make some statements and want your response. Please use this scale to rate each of the following (1 means strongly disagree and 6 means strongly agree).

1. Staff people are very clear when they give directions.

2. When staff people use a medical or scientific word, they explain what it means.

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

■ Update on emergency credentialing of volunteers during disasters

■ Proven strategies for providing heart failure discharge instructions

■ Dramatically improve core measures for pneumonia patients

■ What data you should collect for non-English-speaking patients

3. Doctors/nurses are very clear when they talk to me.

4. When doctors/nurses use a medical or scientific word, they explain what it means.

5. Doctors/nurses always ask me if they are clear or if they have left anything out.

6. Doctors/nurses always ask me if I have questions.

7. I know who to talk to if I have a safety concern or question.

8. I know where to go if I cannot understand or use forms.

"We are continuously aware of the need to communicate to all our patients both in verbal and written messages that they can clearly comprehend and understand," says **Thomas C. Royer**, president and CEO of Christus Health, which has 40 acute care facilities, located primarily in Texas and Louisiana.

Administrators at Christus hospitals verbally ask these questions of patients and family members on their daily rounds: "Have the caregivers been identifying themselves to you? Is each person you encounter explaining what he or she is trying to do for you? Do you feel a trust or confidence in your caregivers?"

Similar questions are included in patient surveys conducted for inpatient and outpatient care, ambulatory surgery, and emergency departments, with written communications appropriately geared to the literacy level and language of the population each facility or program serves.

• Evaluate your progress.

To evaluate how well your hospital is doing at communicating with patients who have low health literacy, Royer suggests the following:

• Analyze the answers to the questions above and develop corrective action plans to address any deficiencies identified.

• Monitor re-admission rates to identify causes which might be related to the lack of understanding of discharge instructions.

• Have staff call ambulatory surgery patients or their designated contact to see how they are doing and to ensure they have full understanding of their post-operative instructions.

To identify patients with low health literacy, all patients at Christus are screened after triage for their financial insurance profile. The admissions clerks identify language barriers and obtain the necessary information with the assistance of an interpreter, and assess the patient and family's ability to comprehend and answer questions. "This information should be shared with the caregivers," says Royer. "It is important to note that the income level often parallels the health literacy level, making this process very useful."

References

1. Institute of Medicine. Health Literacy: A Prescription to End Confusion 2004, Washington, D.C. National Academies Press.

2. Agency for Healthcare Research and Quality. Literacy and Health Outcomes. Evidence Report/Technology Assessment Number 87. 2004. AHRQ Publication No. 04-E007. ■