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FEBRUARY 2008
VOL. 33, NO. 2 • (pages 17-28)

Report: Hospitals still struggling with many core measure requirements

Quality now has 'direct impact on bottom line'

There is much room for improvement for the vast majority of The Joint Commission's standardized national performance measures, according to data reported in *Improving America's Hospitals: The Joint Commission's Annual Report on Quality and Safety 2007*. A 90% compliance level was achieved for only four of 22 quality-related measures tracked during 2006.

For example, hospitals offered angiotensin-converting enzyme (ACE) inhibitors at discharge for patients with congestive heart failure (CHF) or heart attack only about half of the time. However, there is strong evidence that compliance with core measures does impact the quality of care and patient outcomes, according to the report.

Low compliance with measures required by the Centers for Medicare & Medicaid Services (CMS) is another growing concern for hospitals. "Hospitals will have little choice in reporting on core measures because of the changes in reimbursement issued by CMS," says **Patti Muller-Smith**, RN, EdD, CPHQ, a Shawnee, OK-based consultant who works with hospitals on performance improvement and regulatory compliance.

Quality measures multiplying

CMS is expanding the quality measures that will be required during 2008 to include 30-day mortality for Medicare patients with pneumonia. Additional quality measures will be required in 2009. "All of the CMS measures can have a direct impact on the bottom line of the hospital," says Muller-Smith. "Hospitals that fail to report quality information will be subject to provision of penalties in payment."

The impact of low performance includes poor patient satisfaction, reduced case volume, and less revenue — both in terms of reduced Medicare payments and being non-eligible for bonus payments, says **Kristin Vondrak**, MSN, ARNP, BC, AOCN, CAN, system director of quality at Baptist Health in Jacksonville, FL.

"The Medicare and Joint Commission measures are intertwined — both focus on efficiency and effectiveness of care provided," says Vondrak. "As a result of the quality services provided, reimbursement and payment are impacted, thus allowing hospitals to stay in business to best serve our com-

munity. So I see them both as equally important."

Lack of support devastating

"The findings in the report are not surprising, because of the lack of support from administration and physicians," says Muller-Smith.

In the past, some hospital administrators and physicians have viewed quality professionals as necessary individuals they had to communicate with, she says. However, the report's findings underscore the growing clout of quality. "You can expect that quality professionals will be an important part of the financial stability of an institution," says Muller-Smith. "In the future, the information that they will provide will be imperative."

Quality professionals often lacked direct access to the decision makers of the organization and did not really have a power base from which to make the changes necessary to be in compliance with regulatory requirements. "Without the full support of administration and physicians, they could collect and present data but there was little else they could do to require compliance," says Muller-Smith.

According to The Joint Commission report, in facilities where quality holds a high level of importance, where support for the quality professional is present, and where all hospital staff are held accountable for complying with the required activities associated with core measures, there is a definite improvement of patient care and outcomes.

"Noncompliance is really no longer an option if the organization intends to remain viable," says Muller-Smith. "Public reporting of quality data will add to the pressure placed on the organization. Quality professionals should see an increased recognition and value for the work they do. It now has dramatic financial implications."

At Virginia Mason Medical Center in Seattle, a major effort has been made to identify patients with disease-specific events in real-time, says **Rosemary Tempel**, RN, project manager for quality and patient safety. Here are some changes made by the organization:

- Instead of retrospective auditing, there is now real-time identification of disease-specific cases.
- Providers are encouraged to declare the diagnosis early to the care team, to ensure timeliness of interventions before discharge. This information is communicated via text pages, face to face, and telephone.
- Order sets are used to ensure that nursing staff complete patient education. Flow sheets document that the teaching was provided. "Bedside nurses are assisted by clinical nurse practitioners to identify patients and deliver education before discharge," says Tempel. "Discharge checklists have been used to ensure completion."
- Patient handout materials were simplified and improved.
- Disease-specific template progress notes list the evidence-based interventions required for disease-specific care and/or list contraindications to document the provider's rationale for non-compliance.

Every day, a list is created of patients identified as potential inclusions for AMI, CHF, and stroke

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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measures, based on test results for cardiac markers, brain natriuretic peptide levels, chest X-rays, CAT scans, and MRIs.

Charge nurses on each unit identify these patients on a communication board with a colored magnet. Then the project manager verifies that staff are aware of the patient's inclusion, that the magnet is in place, and that patient education is done before discharge.

A daily report tracks use of disease-specific order sets, with charts abstracted to determine why elements of care are missing.

Then, direct feedback is given to providers by nurse practitioners in cardiology and neurology, who act as care coordinators. This gives providers the chance to explain their rationale and debate whether certain patients should have been excluded from the measures, says Tempel.

In addition, clinical pathways, guidelines of care, provider order sets, and patient education materials were developed by multidisciplinary teams to standardize care delivery for many core measures.

Core measures for CHF and community-acquired pneumonia (CAP) presented a special difficulty, says Tempel, because such patients are diversely located across the medical center, and are cared for in the ED, critical care units, and general medical/surgical wards.

"Centralizing patients to geographical locations, educating staff, and keying in on identifiable risk factors or presenting signs and symptoms has reduced the challenge," says Tempel.

At University of California at Los Angeles Medical Center, several measures had been challenging, including the CAP measure requiring antibiotic administration within four hours. "We initially tried a number of approaches that weren't as successful," says **Tod Barry**, MHA, CPHQ, RRT, director of quality management. "We finally achieved significant improvements by doing some things that we hadn't previously tried."

One of those changes involved earlier identification of patients who fall within the core measures. An analysis is now done with every pneumonia case as soon as possible, to see if criteria are met. "If not, we drill down on what specific issues were responsible," says Barry. "That is a strategy that we have applied across a number of the core measures, particularly for heart failure and myocardial infarction."

Data are shared with physicians much more quickly than the official data that are sent back from CMS or The Joint Commission. "By the time they are officially released to the facility, they are anywhere from four to six months old. When the data are that old, it really isn't very useful to changing practice," says Barry.

Data are now shared within weeks, not months, and with individual physicians, to show how they compare against their peer group. "We have found this to be the best method to achieve practice change," says Barry. For example, a physician might be told that, of the seven heart failure patients he has seen in the past month, several records did not reflect documentation that they received all drugs within the proscribed time frame.

"Once we started drilling down, we not only saw practitioner issues, but more often identified systemic reasons why an order hadn't been administered," says Barry.

Changes made for problem areas

At Baptist Health, a multidisciplinary discharge process team was formed to ensure that CHF patients received discharge instructions. A standardized discharge summary form in triplicate format was created to assist with the abstraction and verification process, and a customized discharge summary tab was added to the electronic medical record. "We also assigned a CHF clinical outcomes specialist to focus on this patient population," says Vondrak. Surgeons, internists, intensivists, hospitalists, and general medicine physicians — not just cardiologists — were alerted about the importance of all CHF patients receiving ACE inhibitors at discharge and documentation of contraindications. "Also, physician dashboards are used to identify improvement opportunities," says Vondrak.

At UCLA, order sets for CHF, AMI, and pneumonia were standardized and updated, making it more difficult for someone to omit an order or not document a specific contraindication. "We set out to make it as easy as possible, by putting checkboxes on order forms and various other places where a physician would chart in the medical record," says Barry.

Another difficult measure was ensuring all appropriate patients are given the opportunity to receive pneumococcal vaccine. "We were able to resolve this by making some significant process changes that heavily involved the pharmacists," he says.

A pharmacist now sees virtually every patient within the first 24 hours of coming to the hospital in order to perform medication reconciliation, and as part of that process, also checks to see whether the patient has received or needs the vaccine. "Just as importantly, we empowered the pharmacist to order these vaccinations. That made a dramatic difference," says Barry.

As part of the effort to improve compliance with the requirement that pneumonia patients receive antibiotics within four hours, a new ED protocol was established allowing triage nurses to order chest X-rays and basic lab tests for patients presenting with certain symptoms. If the test is indicative of pneumonia, that information is immediately relayed to an ED physician who can rapidly assess the patient and start antibiotics.

"We saw our compliance improve to over 90%," says Barry. "It's essential to keep sight of the big patient care picture as well — we're careful not to sub-optimize our improvement efforts and ensure deployment of these systemic changes across all clinically relevant patient populations."

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Physicians may not report their impaired colleagues

Over half keep concerns to themselves

If a physician at your hospital observed that a colleague's substance abuse was putting patients in danger, would you expect that this information would be reported?

More than half the time, it would not, according to a recent survey of 1,662 physicians conducted by researchers at the Institute for Health Policy at Massachusetts General Hospital and Harvard University. Although 96% of respondents agreed that physicians should report impaired or incompetent colleagues to relevant authorities, 45% of respondents who encountered such colleagues had not reported them.

"Hospitals can't manage what they don't know about," says **Eric G. Campbell**, PhD, the study's lead author. "If hospitals don't know about half of the cases that are happening, they can't take steps to prevent it from happening again."

Physicians may think a medical error was a one-time incident that won't occur again, when in reality, there are underlying systems problems that need to be fixed. For instance, a doctor may give a medication that causes a patient's severe allergic reaction, because systems aren't effectively flagging allergies.

If a doctor suspects a colleague is incompetent, there should be a way to report this concern without being identified, says Campbell. "If people feel they are putting their careers on the line, that is a significant disincentive," he says. "We've got to make sure that people are not punished for reporting. Mechanisms should be put in place to make sure that this gets done — maybe not universally, but pretty darn close. Certainly more than half of the time."

Problem is 'tip of iceberg'

The study's findings are just "the tip of the iceberg" of a much bigger problem jeopardizing quality — that of conflict of interest, says **Skip Freedman**, MD, executive medical director of AllMed Healthcare Management in Portland, OR.

Judgment calls about impaired physicians should not be left to their colleagues, argues Freedman. "Why don't physicians report impaired colleagues? Because they are friends with them, they are business partners or in fact because they are competitors, and they would be accused of doing it for their own economic gain," he says.

Whatever the case, there is a conflict of interest, says Freedman. "The doctors' interests are for their own patients, but the hospitals' interest is for all of their patients. If you are a bad heart doctor and I'm a bone doctor, I protect my patients by just sending them to someone else," he says. "The hospital's interests are not parallel with the physician's."

Anonymous reporting systems aren't enough protection if a physician really wants to keep the report confidential, adds Freedman. "If you work in a small community hospital, do you really think I can keep anything secret in there? It's just not realistic," he says.

External peer review is the best solution when there is questionable care due to either impairment or a knowledge deficit, says Freedman.

"Specialists who don't suffer from these conflicts of interest can speak to the standard of care, and whether the care is up to snuff," he says.

Physicians are losing their reluctance to report incompetent or impaired physicians — but only slowly and somewhat grudgingly, says **Frederick P. Meyerhoefer**, MD, a quality consultant based in Canton, OH. "In part, it is because they are also loath to accept that their professional colleagues can be less than adequate clinical physicians."

The reporting track must be clear, such as through a knowledgeable and involved vice president of medical affairs, chief medical officer, or other senior medical staff leader, says Meyerhoefer. "Depersonalize reporting by taking it from the 'ratting out' aspect to putting it in terms of the quality of patient care and patient safety," he says.

Physicians also want assurance that if they do report an incident or an individual physician, it will be taken seriously and followed through on, even if the final resolution may involve no specific findings or corrective action. "There can be no shooting the messenger or any implication that it is a witch hunt," says Meyerhoefer.

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Reference

1. Campbell EG, Regan S, Gruen RL, et al. Professionalism in medicine: Results of a national survey of physicians. *Ann Ital Med Int* 2007; 147(11):795-802.■

Abbreviations: They're a definite threat to safety

'Do not use' list may not be enough

During 2006 surveys, about 22% of organizations were found to be out of compliance with The Joint Commission's "do not use" list of abbreviations, a requirement of the National Patient Safety Goals since 2004 — one of the most frequent non-compliance findings during surveys. Now a new study underscores that abbreviations pose a significant threat to patient safety.[1]

The study collected and analyzed data on nearly 30,000 medication errors resulting from abbreviations, which were reported to the United States Pharmacopeia's Medmarx, a national database for medication errors, from 2004 through 2006. Here are key findings:

- The most common abbreviation resulting in a medication error was the use of "qd" in place of "once daily," accounting for 43.1% of all errors.
- The other most common abbreviations resulting in medication errors were "U" for units, "cc" for mL, "MSO4" or "MS" for morphine sulfate, and decimal errors.
- Eighty-one percent of the errors occurred during prescribing, while errors during transcribing and dispensing were much less frequent, representing only 14% and 2.9 % of errors, respectively.
- Abbreviation errors originated more often from medical staff in comparison to nursing, pharmacy, other health care providers, or non-health care providers.

The study's findings suggest that even more abbreviations should be added to the "do not use" list. Candidates for an expanded list include drug name abbreviations, stem abbreviations (such as "amps," "nitro," and "succs"), µg (used for "mcg"), cc (used for "mL"), and dose scheduling ("BID," "TID," and "QID").

"I don't think that the study's findings are surprising to anybody. They mirror our own experience and the experience of organizations throughout the nation," says **Kevin Tabb,** MD, chief quality and medical information officer at Stanford (CA) Hospital & Clinics. "I think you would be hard pressed to find an organization at this point who would disagree with the findings."

After Stanford adopted all the required "do not use" abbreviations, an internal task force looked at whether any others should be included. The abbreviation for micrograms was added, and a "no abbreviation" policy was implemented for chemotherapy orders.

"We are constantly on the lookout for other abbreviations that have caused errors here that are not on the list. We haven't come up with anything else, but we're open to hearing about the experiences of others," says Tabb. "If there is something

potentially dangerous that we have not picked up on, we sure would like to hear about it."

Habits hard to break

At Metro Health Hospital in Wyoming, MI, a list of symbols and acronyms that may not be used anywhere in the medical record was adopted several years ago. "This list is revised as new recommendations are given regarding abbreviations and symbols," says **Cindy Allen-Fedor**, vice president of outcomes management. "We monitor medical records to ensure unacceptable abbreviations are not being used."

The most difficult part of adopting the "do not use" abbreviation list was breaking old habits. "Many of the unacceptable abbreviations have been used by practitioners for several years," says Allen-Fedor. "It takes time and reminders to help practitioners unlearn routine behaviors."

It's easy to see that physicians who have been using the banned abbreviations for decades would have a tough time changing, but surprisingly, new physicians also have bad habits to unlearn. "We are amazed to find that newly graduated students continue to be trained in schools to use the abbreviations," says Tabb. "We still find gaps, which is very frustrating. So we are not only educating, we are undoing bad practices. And that's very difficult."

At the University of Kentucky, the "do not use" abbreviations are hard wired into the organization's computerized physician order entry (CPOE) system. "There are regular reminders on every chart. We perform chart audits and have excellent compliance," says **Joseph Conigliaro,** MD, MPH, director of the University of Kentucky's Center for Enterprise Quality and Safety. "These abbreviations and audits are reviewed by our pharmacy and our patient safety committee. As new recommendations are added, we make changes."

A full electronic medical record, which Stanford is currently implementing, has the "biggest bang for its buck," says Tabb. "That means more than just CPOE. It means including nursing and physician documentation, not just orders," he says. "We have had CPOE for many years, and about a year ago switched to full nursing documentation."

Compliance improved when nurses began using preapproved templates for documentation, which don't allow the use of unapproved abbreviations. "And in terms of orders, we really have not had problems with unapproved abbreviations because we've had order entry for many years," says Tabb.

But until now, the organization has not had a full electronic record including physician documentation. "All respiratory therapists, all orders, all pharmacists — everybody will be using it. While we don't believe that will be a complete panacea, it will go a long way toward helping us go toward the goal of zero use of unapproved abbreviations," says Tabb. "We expect to see a similar decline in their use for other pieces of the medical record."

The idea is to have multiple safeguards in place to prevent poor outcomes from occurring, instead of relying solely on education or a single piece of technology. "You want to combine a bunch of different things to be sure that the holes in the Swiss cheese don't line up, to prevent an accident from coming through," says Tabb.

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Reference

1. Brunetti L, Santell JP, Hicks RW. The impact of abbreviations on patient safety. *Jt Comm J Qual Patient Saf* 2007; 33:576-583.■

Publicly reported data are misleading, says study

Researchers find inconsistent ratings

Data were old, inconsistent, and incomplete. The same hospital was rated both best and worst for colon removal.

Those are two things researchers found when they compared hospital ratings on six Internet sites for three common procedures: laparoscopic gallbladder removal, hernia repair, and colon removal.[1]

The researchers evaluated the Centers for Medicare & Medicaid Services (CMS) Hospital

Compare site (www.hospitalcompare.hhs.gov), The Joint Commission's Quality Check site (www.qualitycheck.org), the Leapfrog Group's Hospital Quality and Safety Survey Results site (www.leapfroggroup.org), and three sites run by private companies.

A growing number of web sites rank hospitals, but since there is no standard way of calculating quality differences, different results are listed for the same hospitals.

For accessibility and data transparency, the government and nonprofit sites were the most reliable. However, the private sites were best for appropriateness, because they compared surgical procedures using a combination of information, including patient outcomes.

Another problem was that data were at least one year old on all the sites tested, and many had data that were two or more years old.

The study demonstrates the wide array of quality information that is now available to patients regarding hospitals and surgical departments, but it also shows that this information can be very inconsistent, says lead researcher **Michael J. Leonardi**, MD, faculty in the department of surgery at David Geffen School of Medicine at University of California at Los Angeles.

There is a bright spot, though, says Leonardi: "Hospital-based quality professionals should be encouraged that the quality measures they are working hard to implement, such as Medicare's Surgical Care Improvement Project, are actually being used to measure quality," he says. "The reality of public reporting may assist in encouraging compliance with such measures."

However, quality professionals are "in a difficult position" when it comes to the validity of publicly reported data, says **Albert Wu**, MD, MPH, a professor of health policy and management at Johns Hopkins Bloomberg School of Public Health in Baltimore.

Guidelines are needed

"This is not something they can do on their own," he says. "One thing they can do is make sure that they collect data using standardized definitions. And also, they need to lobby their state medical boards to agree upon and adopt standard definitions of the most important quality indicators."

"The drive to make quality data public and make it transparent is long overdue and much needed. But it's only going to be helpful if it's truthful," says **Peter Pronovost,** MD, PhD, medical director of the Johns Hopkins Center for Innovation in Quality Patient Care.

To clear up misleading comparisons, Pronovost and other experts at Johns Hopkins have developed guidelines to standardize hospital safety ratings. Without this standardization, safety problems may not be fixed and the public may be misled, he says.

The Johns Hopkins researchers adapted elements of the American Medical Association's *Users' Guide to the Medical Literature: A Manual for Evidence-Based Clinical Practice* to create guidelines that hospitals can use to ensure validity and accuracy in patient safety reporting.[2]

The guide has been used successfully for years to help clinicians evaluate the validity and accuracy of research data. The same principles can be used to evaluate the validity and accuracy of the methods used by an institution to gauge patient safety, says Pronovost.

The guidelines address three key questions: Are the measures important? Are they valid? Are they useful to improve safety in health care organizations?

An assessment tool asks such questions as: Is the measure required by an external group or agency? Is the measure supported by empiric evidence or a consensus of experts? Do clinicians believe that improvement in performance on the measure will be associated with improved patient outcomes? Is the risk for selection bias minimized?

The problem with patient safety reports, such as those required by CMS and The Joint Commission, is that they are "snapshots" instead of long-term system analyses, says Pronovost.

Increasingly, hospitals are also using these "snapshots" as marketing tools, but this could be misleading to the public, according to another study by the Johns Hopkins researchers.[3]

Researchers found that one institution advertised on its web site that its rate of staph infection is zero, but it didn't say how many people were sampled or whether this represents one month of results or a decade's worth. Another hospital reported that it saved 242 lives over 18 months, but the sample size, methods of risk adjustment, and a measure of precision for the mortality estimates were not given. A hospital's web site stated that 90% of pneumonia patients were screened and given pneumococcal vaccination, but on the same day, CMS' Hospital Compare site reported the statistic as 64%.

To more accurately assess patient safety, all the elements that "make up the big picture" are needed, says Pronovost.

"Health care workers and physicians need to

make sure that the data that are put forth are indeed accurate and any biases are made transparent. And also, that it's not being used solely for marketing activities," says Pronovost.

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References

1. Leonardi MJ, McGory ML, Ko CY. Publicly available hospital comparison web sites: Determination of useful, valid, and appropriate information for comparing surgical quality. *Arch Surg* 2007; 142:863-869.

2. Pronovost PJ, Berenholtz SM, Needham DM. A framework for health care organizations to develop and evaluate a safety scorecard. *JAMA* 2007; 298(17):2063-2065.

3. Pronovost PJ, Miller M, Wachter RM. The GAAP in quality measurement and reporting. *JAMA* 2007; 298:1800-1802. ■

Your hand hygiene data may soon go 'public'

Most organizations using secret observers

If Consumer Union, the nonprofit publisher of *Consumer Reports* has its way, all hospitals will soon begin publishing their hand-washing compliance rates — information that for most organizations, would not be flattering.

Only 35.6% of 1,256 hospitals surveyed by the Leapfrog Group, as part of its Hospital Quality and Safety Survey, have policies on compliance with the Centers for Disease Control and Prevention's hand hygiene guidelines.

"Hand washing, as we all know, is our best defense against infection," says **Claire Davis**, vice president of quality at Norwalk (CT) Hospital. "To that end, we have our hand washing dispensers appropriately installed. We also recently switched to a more expensive product, as we found that staff were more likely to use that particular product."

Compliance is monitored via visual surveillance by infection control, nursing staff, and "secret shoppers." "There is much to be done and it takes constant vigilance," says Davis. "The inclusion of infection reduction initiatives in the strategic plan of the hospital has been key in keeping focused on this and in resourcing the initiatives appropriately."

At Henry Ford Health System in Detroit, an infection prevention specialist observes staff for compliance, says **Sue A. Lloyd**, MT(ASCP), CHSP, CIC, the hospital's manager of infection prevention.

"The staff is re-educated at the time if lack of compliance is observed," she says. "Monthly rates are published and supplied to senior leadership, nursing, and our infection control committee."

At Mission Hospitals in Asheville, NC, hand hygiene compliance is currently around 85%. "We are utilizing secret observers and doing well with this," says **Tom Knoebber**, director of performance improvement. "We are able to break down data by skill type and location. We have also created public posting of the results and hope to improve what we measure."

Oakland, CA-based Kaiser Permanente implemented a National Hand Hygiene Program in 2001, with employee education, standardization of products and product placement, elimination of artificial nails, and widespread increase of alcohol degermer.

Compliance is measured through direct observation and soap and degermer product utilization rates. "This was found to be helpful as an adjunctive method of indirectly measuring hand hygiene compliance," says **Alide L. Chase**, senior vice president for quality and service. "It generally matched what was reflected in the observational studies when comparing one unit or department to another."

Cookies are incentives

At McKay-Dee Hospital in Ogden, UT, unit representatives from every department monitor hand hygiene compliance by conducting monthly monitoring of staff, usually done secretly, says **Doe Kley**, RN, BS, CIC, infection control coordinator.

"It typically only takes them 20 to 30 minutes per month to complete the compliance monitoring," she says. The observer documents the time frame, how many times the staff member actually performed hand hygiene, and the number of times they should have performed hand hygiene.

"Completed forms are turned in to me at month's end for tabulation," says Kley. "I then come up with a compliance percentage for each

unit, and share the findings with the unit and hospital leadership."

Cookie coupons are given out as rewards when staff are caught in the act of performing good hand hygiene practices, especially when they think that no one was looking.

"Administration gave me several hundred dollars worth of the cookie coupons," says Kley. "The observers hand them out to staff who exemplify meticulous hand hygiene practices or who are good role models for the other staff. They have enough to give out one or two coupons per week. Staff and physicians love them."

A staff member from each unit is assigned to be the "secret observer" for that area, and completes hand hygiene education. "They will either sit at the nursing desk as if auditing charts where they can see patient rooms, or they roam about the unit with a clipboard as if conducting unit checks. They don't always go unnoticed," says Kley.

In fact, the observer will frequently approach staff and say something like, "I was noticing that you just missed an opportunity to perform hand hygiene. Why is that?" The secret observer role is alternated between various staff members several times per year.

Although there has been a steady increase in community-acquired MRSA cases seen in the ED at St. Joseph Medical Center in Towson, MD, over the last several years, the number of hospital-acquired cases remains steadily low. "This is due in large part to the staff practicing careful infection control measures," says **Leigh Chapman**, BSN, infection control practitioner.

"Our hospital policy is hand hygiene before and after every patient contact," says Chapman. "We have an outstanding hand hygiene program and have been statistically higher than the national average for hand hygiene for over two years."

Getting tougher

AT OSF Saint Francis Medical Center in Peoria, IL, both employees and medical staff are held accountable for performing hand hygiene before patient care. Monitoring is done through two processes: Each unit has identified individuals to anonymously observe and report 10 hand hygiene observations per month. Also, designated staff from throughout the medical center have volunteered or have been recruited to observe and report compliance with hand hygiene.

If hand hygiene was performed correctly, the staff member or physician is given acknowledgement. If hand hygiene was not performed, the manager or physician leader will follow-up with the employee or physician.

"The observations are entered into a database with the employee or physician name," says **Patricia Ham**, RN, MS, CIC, manager of epidemiology, infection prevention and control. "Repeated non-adherence to hand hygiene could result in disciplinary action."

In addition to using "secret shoppers" to monitor hand-washing in all patient care areas, a "stop the line" mentality exists at Baptist Hospital in Miami. "Anyone can intervene if they see someone not adhering to our hand hygiene guidelines," says **Jill M. Szymanski,** RN, MS, CHE, CPHQ, manager of quality.

"Since January 2006, we have consistently sustained hand hygiene compliance at or above 90%. However, we know that for patient safety we need to be at 100%," says Szymanski.

A new approach to hand hygiene was recently developed, created by a hospital-wide multidisciplinary task force. "Our monitoring data will no longer be blinded. Now, when we observe someone not washing their hands, we will internally report the data including the non-complier's name," says Szymanski.

If it's determined that there is not a process issue related to non-compliance, then there will be standardized, consistent consequences for any employee who does not wash their hands starting with corrective action and leading up to termination. "We also have non-compliance with hand hygiene as one of our clinical indicators for physician peer review," says Szymanski.

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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. ■

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THE QUALITY - CO$T CONNECTION

Implementing changes, overcoming resistance

Being specific with direction is paramount

By Patrice Spath, RHIT
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Every day it seems there is another process change that caregivers are asked to make. These changes may come as the result of an improvement project or root cause analysis or may be needed to

CNE *questions*

5. Which is a characteristic of organizations which showed improvement with patient care and outcomes as a result of quality measures, according to a new report from The Joint Commission?
A. There is a general lack of support for quality professionals.
B. Individual staff are not held accountable.
C. Quality professionals lack direct access to administrators.
D. Quality professionals are supported.

6. Which is recommended to encourage physicians to report impaired colleagues?
A. Allowing physicians to make their own judgment calls about whether colleagues are impaired.
B. Asking physicians to report only those incidents that are likely to recur.
C. Relying solely on anonymous reporting systems.
D. Having a clear reporting track for physicians to report concerns.

7. Which is a finding of a recent study on medication resulting from abbreviations?
A. The use of "qd" in place of "once daily" resulted in few errors.
B. Most errors occurred during prescribing.
C. Almost all errors occurred during dispensing.
D. Nurses made most of the abbreviation errors.

8. Which is an effective method of improving hand hygiene compliance?
A. Re-educating staff at the time of noncompliance.
B. Using fewer hand washing dispensers.
C. Avoiding use of secret observers.
D. Failing to discipline staff for non-compliance.

Answer Key: 5. D; 6. D; 7. B; 8. A.

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. ■

Figure 1
Diagnostic Checklist for Process Change Failures

	Yes	No
Have people been given sufficient time to adjust to the new process and let go of the old ways?		
Have people had to change too many things in too short a time?		
Did we fail to understand the stages of change and the importance of a transition period?		
Have other priorities gone in the way?		
Did we have unrealistic expectations?		
Have people lost interest in making the change?		
Has resistance to the process change been too high?		
Do people understand what exactly is expected of them?		
Has the change been aligned with the performance management and accountability system?		
Did we expect too much too soon?		
If our approach to implementation was different, could we have achieved better results?		
Was the timing of the process change right?		
Does everyone understand how change is being measured?		
Did we wait too long to recognize that the process change was not on track and do something about it?		

meet accreditation standards. Whatever the reason, it is often challenging to get people to permanently adopt new processes or behaviors. By understanding the factors that inhibit change you'll be better able to deal with resistance.

There are many reasons people oppose changing the way they've always done things. It could be due to a lack of direction, lack of skills, or lack of pressure to change. The known way of doing things often feels better to people than the new way that has been proposed. When developing improvement strategies, it's safe to presume some people might not make the changes. This resistance should be anticipated and dealt with during implementation.

Resistance to change can arise simply because the expectations are unclear. For example, the directive "improve communication among caregivers" contains no information on the new behaviors that are expected. Does it mean: more talk or less talk, more handwritten notes or less, better listening, more face-to-face dialogue or less? When planning change, start with clear objectives and how you'll measure them. Without specificity, people often lack agreement on what changes are needed. What appears to be resistance may simply be a misunderstanding or a disagreement about the expectations.

Change sometimes fails because people are not provided with the skills needed to implement the change. Perhaps the new caregiver communication initiative requires that staff use the S-BAR model for passing along information. Schemes such as this will fail if they are introduced simply as a form that is distributed and staff members are told essentially, "get on with it." Instead, there should be formal training, allowing people to practice communication skills using the model before it is a daily habit.

Successful implementation also requires pressure of some kind. It might be recognition for correct behavior change and/or reprimand for incorrect behavior change. Ideally, the pressure will come from a message from management that they want the change and are determined to see it implemented.

Sometimes people resist a new process because of the danger that, in making the change, present levels of performance might decrease. It is true that introduction of an additional process step or a new way of doing things often results in a short-term decrease in staff performance while new skills are being learned or while errors in introducing the change are eliminated. It is important to convey to those being asked to change that these problems will be short-lived and no one will be reprimanded for decreased

COMING IN FUTURE MONTHS

- What to track for 'present on admission' conditions
- How to handle multidisciplinary peer reviews
- Use hourly rounding by nurses to improve safety
- Proven strategies to cut heart failure deaths in half
- Use safety scorecards to assess intensive care units

performance during the implementation period.

Diagnose the resistance

When you run into resistance to a process change, get the people affected by the change involved in diagnosing the cause. Do this by asking, "What are the major problems you are encountering that we could solve if we worked together?" This question leads to an increased awareness of what is wrong and naturally leads to potential solutions. The discussions that occur surrounding this question often unfreeze the people concerned, and they begin to talk about issues that may not have been brought to the forefront before. Just talking about the issue causes people to gain new perspectives. They may sometimes come to perceive that they themselves are the prime cause of the improvement failures.

Usually when people understand why they have been resisting a change, their resistance decreases or, at least, becomes more rationally based. Not following the required steps of a process is often a symptom of something else — perhaps unwillingness to give up the old way of doing things or perhaps the new process is unworkable. Uncovering these reasons and discussing them with the people involved can help get at the real cause of the problem.

Overcoming resistance to change works best when it is tackled by the group affected by the change. One person, such as the manager or quality director, has little influence without the wholehearted cooperation of the others. The best way of obtaining such cooperation is to engage staff members in developing the improvement actions so they have ownership of the process changes and the results. If you can, separate the process change ideas from the improvement project. Try to make them the property of the group expected to adopt the changes.

The success of any process improvement or change initiative depends on the extent to which employees view it as legitimate and likely to be beneficial. All improvements have associated benefits but some of these benefits may not personally affect staff members. For instance, complying with Joint Commission standards has value for the organization. This value may not be readily apparent to the people being asked to implement changes required by the standards. Some process changes, such as externally imposed mandates, require a certain degree of trust on the part of staff. In some situations it may not be possible to obtain group buy-in for a change. In these circumstances, managers must create pressure — by holding people accountable — to ensure that required tasks or behaviors are adopted.

When faced with a failed improvement project, it can seem that staff members have irrational motives for not implementing the desired changes. Or perhaps it's just that people commonly reject anything that management wants to introduce. Yet there are often very logical reasons why people don't embrace the new behaviors. Use the check list in figure 1 to evaluate why a desired process change was not successful. Once the cause of failure is understood, alternative change strategies can be developed. ■