

Healthcare Benchmarks and Quality Improvement

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HAI prevention emphasized in 2009 National Patient Safety Goals

Med reconciliation requirements, Universal Protocol revised

The Joint Commission, continuing a trend among leading health care quality organizations, has placed an emphasis on hospital-acquired infections, or HAIs, in its National Patient Safety Goals for 2009.

Among the major changes for 2009 are three new hospital and critical access hospital requirements related to preventing health care-associated infections due to multiple drug-resistant organisms (MDROs), central line-associated bloodstream infections, and surgical site infections.

This is a slight change from the proposed goals issued earlier in the year, when specific mention was made of the prevention of *C. difficile*, one of many drug-resistant organisms, and no mention was made of central line-associated infections.

"One of the draft requirements of our field review was on MRSA (methicillin-resistant *Staphylococcus aureus*) and *C. difficile*, but we decided that the problem was more basic, so we focused on multidrug-resistant organisms, which is broader," explains **Peter Angood**, MD, vice president and chief patient safety officer for The Joint Commission.

'Creating a stir'

Angood notes that these new goals are "creating a lot of stir out there, and they are important to quality managers." As is often the

Key Points

- Having an infection control program already in place does not ensure compliance with new NPSGs.
- Patient involvement, education are critical components in preventing HAIs.
- New requirements mean more levels of documentation.

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case with these goals, he notes, there is recognition that the issues are important, but that meeting the requirements can be problematic.

"It requires [quality managers] to review systems and processes of care, and change is difficult for everybody," Angood explains. In terms of compliance, while The Joint Commission often is reluctant to spell out specific steps, Angood says there are some common themes his organization tries to promote. "These include utilizing evidence-based guidelines; providing education for staff, patients, and families; conducting a risk assessment for your institution; and evaluating processes relative to your success in taking on the problem," he says.

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Editorial Questions

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The Joint Commission specifically mentioned patient education and involvement in infection control for MDROs and surgical sites. And it is the education component, along with patients' involvement in their own care, that may present the greatest challenge, says **Phyllis Voreis**, RN, BSN, CIC, director of accreditation and regulatory readiness and quality improvement for the University of Michigan Hospital and Health Centers in Ann Arbor.

"It's a nightmare," she says. "Patient involvement is obviously a safety goal, but we are being asked to not only do this, but also to document that the patient understands, which will be really tough for quality management folks," she asserts. **(For more on documentation requirements, see sidebar p. 87.)**

Voreis says this was a hot topic at a recent industry meeting she attended. "The easiest way is to check off a box, but that really does not show anything," she notes. "We have a lot of forms for assessing [patient comprehension], but when patients are really sick, you're not sure how effective these things are."

When patients are sick and stressed, she continues, their ability to understand what they are being told can be compromised. "I'm worried about where that [Joint Commission requirement] may go," says Voreis. "They say you need to demonstrate a level of understanding, but some patients may *never* understand. The best we can do in any situation is tell the patient that if they have any questions, they can call you back — and continually reinforce our message."

Angood says that in terms of meeting this goal "there's a variety of strategies out there. Most of them involve trying to get a baseline understanding of what the patient appreciates is their problem, then trying to provide them with background information through a variety of ways, to help improve that knowledge."

As for prevention itself, says Voreis, "the biggest challenge is to make sure we meet [The Joint Commission's] timelines, and that responsibility is clearly assigned for each of the programs." The emphasis you put on any one or all of the three goals, she notes, will depend on how high your infection rates are.

"You could probably look at these goals and believe you already meet them, but with The Joint Commission, you have to have responsibility assigned for each goal — although it could be the same person — along with a specific written

How much is *too* much documentation?

Patrice L. Spath, of Brown Spath Associates, Forest Grove, OR, thinks The Joint Commission may have gone a bit too far with its growing emphasis on documentation.

"We consistently see the need to document things" she says. "For example, when a caregiver communicates in the hospital during a handoff and points out to the next caregivers the updated, reconciled medication list, they are supposed to document that they did it. We see similar things when discharge instructions need to be documented." This means, she explains, that you have to make sure there is a place in your record — be it paper or electronic — where people can document such activities.

Spath also points to the revised medication reconciliation goal, which she generally regards as a good move. "They have created another documentation requirement because you will now have a list of new short-term medications," she says. "You need to make sure you have a way of documenting, providing the new list to the patient, and documenting that you did that."

The same holds true with the new requirements for patient involvement, she continues. "It says the hospital should provide information to the patient about infection control and what can be done to prevent adverse events in surgery, but it's also another example where you gotta do it and then document it," she observes. "The patient's understanding must be evaluated *and* documented; it

becomes just another check-off."

Again, she says, there is no way to determine if things have been done correctly. "If you put a brochure in with the pre-admission packet, you might conclude, 'We did it' and check off the box," she says.

The Joint Commission, she adds, "just keeps adding more and more [documentation]. People say this is just too much; *everything* seems equally important, since it all has to be documented."

But there is a bigger issue than time involved, she adds. "Just because you document does not mean the process has been done well," she says. "A good example is the Heparin overdose in Texas [see story p. 89]. Documentation does not stop mistakes if people are not doing things the right way."

Peter Angood, MD, vice president and chief patient safety officer for The Joint Commission, agrees — to a point. "There is a general notion that just communicating and documenting does not guarantee that the patient comprehends," he says. "But that's why you also need to appreciate the level of comprehension the patient has. And, if there is a comprehension deficit, the organization should work toward correcting it."

Spath says The Joint Commission "continues to be focused on standardizing the way we do things. They have become much more prescriptive in their National Patient Safety Goals — but does that eliminate mistakes?"

In the end, she says, "it all comes back to the commitment of the staff to patient safety. If they do not think it's important, they may just report that they did the right thing." ■

action plan," notes Voreis.

The new infection control goals "are very much in line with what Medicare is encouraging through threatening not to pay [for preventable adverse events]," adds **Patrice L. Spath**, of Brown Spath Associates in Forest Grove, OR, "So, The Joint Commission has given people a 'prescription' for reducing nosocomial infections."

Other goals changed

In addition to adding new goals, The Joint Commission has revised some existing ones, including medication reconciliation, which had caused such a stir that a summit was called last

fall to hear from key stakeholders. Now, in emergency departments and certain other facilities such as outpatient radiology, full medication reconciliation no longer is required where medications are "used minimally or prescribed for short duration." In these situations, it will no longer be necessary to document the dose, route, or frequency of use for the prior meds.

"This is a pullback for people in areas that do not administer a lot of medications," says Spath.

"Early feedback is that the revised goal is being well received," adds Angood.

Another change was made in the Universal Protocol. "The Universal Protocol still has the

same three core elements: verification of the procedure, marking the surgical site, and the timeout," notes Angood, "But we have clarified our expectations as to who does what, when, and where; we are more prescriptive."

In other words, says Angood, The Joint Commission is now specific about who should be marking the site, when the timeout should occur, who should participate in the timeout, and what those people should be talking about.

"This is for *all* procedures that place the patient at more than minimal risk," adds Angood.

"They have made [marking the site] specific to the surgeon or licensed practitioner," adds Spath. "In the past they used the word 'shall,' but this year it is a 'must.'"

Some hospitals have been relying on nurses to mark the site, she says. "The reasoning here is the one who owns the responsibility for doing it the right way should mark the site," she explains.

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Joint Commission issues staff behavior standard

Link drawn to patient safety and quality of care

Citing scientific research that shows a direct link between "intimidating and disruptive behaviors" on the part of health care providers and adverse outcomes, The Joint Commission has both issued a Sentinel Event Alert and unveiled a new leadership standard effective Jan. 1, 2009, to encourage hospitals to identify and deal with such behaviors.

The new leadership standard (LD.03.01.01) has two key elements of performance:

Key Points

- Medical literature provides evidence that inappropriate behaviors can cause adverse outcomes.
- The Joint Commission wants code of conduct, with consequences for bad behaviors.
- Quality managers should emphasize a pattern of behavior rather than an isolated incident.

- EP 4: "The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors."

- EP 5: "Leaders create and implement a process for managing disruptive and inappropriate behaviors."

Laying the foundation

The Joint Commission underscored the importance of such a step in a Sentinel Event Alert issued July 9, 2008, entitled, "Behaviors that undermine a culture of safety."

The alert begins with the following framing statement: "Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments." The statement is supported by no fewer than eight footnoted scientific articles.

"There is good evidence from a number of studies," notes **Peter Angood**, MD, vice president and chief patient safety officer for The Joint Commission.

In fact, he adds, such behaviors can undermine other Joint Commission standards, such as the Universal Protocol for avoiding wrong-site surgeries. **(For more on the Universal Protocol, see cover story.)**

"You may, for example, have a domineering surgeon who intimidates all the team members in the room — to the point where they do not want to point out [a potential error]," Angood says. "In effect, that surgeon will prevent others from alerting him that they are about to do a wrong-site procedure, because they won't speak up."

What was so important about this issue that The Joint Commission was compelled to put out an alert? "Our standards are one method in

which to create change, and in an effort to make sure they are met, we try to get good measurement," Angood explains. "Our National Patient Safety Goals focus on other topics and note the need for change and analysis of processes. The alerts provide a third venue in which we can profile issues that may not fall into performance measure or patient safety goals."

The Joint Commission, he continues, tries not to push too many issues in this fashion. "We have a listing of topic areas we think are important," he notes.

What The Joint Commission wants

So in terms of this new leadership standard, what is The Joint Commission looking for? "The types of things we are looking for include the organization having created a code of conduct — which is important — but then also setting minimal expectations for how the medical staff and leaders should behave, both with each other and with the patients," Angood says. "There needs to be within that code a delineation of what these expectations are, and mention of what the ramifications are if an individual does not follow the code."

These ramifications, which would likely involve disciplinary action, should be based on different levels of behaviors and different frequencies, Angood says. "There will be a relative minority of staff who exhibit this type of behavior on a consistent, routine basis," he notes. "Just because someone has had a bad day and grumps at somebody, that does not necessarily mean they should be penalized. But if you do it every day, that's a different case."

One of the leading organizations in this area, as noted in the alert, is Vanderbilt University in Nashville, TN. "They have utilized reporting of patient complaints and staff complaints, which are anonymous," says Angood. "With this method, they can track how many [complaints] come in on different staff members, and can see when they need to start moving into an 'advising' mode."

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Heparin overdose scare in 14 babies at Texas hospital

Could CPOE have prevented this tragic error?

On July 4, 2008, in one of the more tragic medical accidents in recent memory, 14 babies in the ICU at Christus Spohn Hospital South in Corpus Christi, TX, received doses of Heparin that were 100 times stronger than the recommended doses, according to the Associated Press (AP). Two of the babies died, reported the AP, which also said the hospital blamed a "mixing error" in the pharmacy.

The hospital would not respond to repeated requests from *HBQI* for comments. In a prepared statement by Chief Medical Officer **Richard Davis, MD**, it was noted that all babies who come to the ICU are seriously ill, and that "the attending neonatologist states that at this point, there are no identifiable adverse affects directly caused by Heparin."

Errors concern The Joint Commission

The problem of medication errors in children is significant enough that The Joint Commission issued a Sentinel Event Alert on the topic on April 11, 2008. In the Alert, The Joint Commission made several recommendations, including the following:

- weigh all pediatric patients in kilograms, which then becomes the standardized weight used for prescriptions, medical records, and staff communication;
- do not dispense or administer drugs classified as high risk until the patient has been weighed, unless it is an emergency situation;
- use pediatric-specific medication formulations and concentrations when possible.

Donald F. Wilson, MD, medical director, Quality Insights of Pennsylvania (the state's QIO), agrees that problems can arise when

Key Points

- Properly dosing meds for pediatric patients involves unique challenges.
- All children for whom medication is being prescribed should be weighed in kilograms.
- Be sure to test out your CPOE system thoroughly before starting implementation.

medications for children are not measured in kilograms. "It can be a source of error when the caregiver does not think in kilograms," he offers. "For example, if you are thinking in pounds, you pay base your calculation on '70', when it should be closer to '30', for kilos."

Would CPOE help?

You have to assume human errors will occur, says **Leah Binder**, MA, MGA, CEO of The Leapfrog Group, and create systems to catch those errors. "When you have 14 of the same errors, you know the hospital needs to look into it," she notes.

"Obviously, CPOE can be a definite safety net, especially if you have an advanced system that knows the age of the patient and you have built into it the appropriate dosing," says Wilson. "Then, if the system sees you are ordering what would be a dosing error, it will ask you if you really want to proceed. It's an excellent way of preventing errors."

Type of system important

Binder agrees with Wilson's qualifier about the system. "You don't just plug in a CPOE system, and boom, you are covered," she explains. "You have to go through the hospital process, look at every single item that is ever prescribed, and make decisions about what kind of alerts you should place in the pharmacy for the prescriber, for the nurse at the bedside, and for the patient."

"CPOE can be extraordinarily valuable, but you have to identify the places where errors can happen," she says.

To improve the use of CPOE, says Binder, Leapfrog has added a required component this year that says hospitals will have to test their CPOEs. Her organization, she explains, has surveyed hospitals about CPOE, "and I can report anecdotally that hospitals have been very surprised at the way their systems seem to work," she says. "They are not as 'awesome' as they thought they would be. That's because [optimal installation] occurs only when the hospital customizes installation and tests the system very carefully."

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Reduce ED violence with training, diligent reporting

Don't let staff accept assaults as part of the job

Violence in the emergency department (ED) is such a common occurrence that staff can become complacent about the risks they face daily. Nowhere else in your organization would employees accept the idea that they may be assaulted at any time, but that attitude can be common in the ED. Risk managers should emphasize to ED staff that violence does not have to be just a routine part of their work.

The Emergency Nurses Association (ENA) in Chicago recently surveyed 1,000 ENA members and found that 86% had been the victim of workplace violence in the past three years, with nearly 20% reporting that they experience workplace violence frequently. The potential for liability is enormous, not to mention the effect that ED violence has on employee morale and retention. Reducing the risk and effects from ED violence depends first on a good reporting system, says **Steve Albrecht**, PHR, CPP, a security consultant and expert on workplace violence based in San Diego.

"When it comes to health care violence, my biggest concern is that staff and physicians are reluctant to report threats or actual assaults, somehow thinking it is part of their jobs to take these behaviors," he says. "When I teach classes, the ED members all report being threatened or assaulted, because they work in the patient's intimate space, yet these are not reported."

Without knowledge of incidents, the leadership of the organization cannot respond effectively, write new policies or change existing ones, or create new protocols, Albrecht says.

"Without consequences for patient behaviors, we can expect more of the same," he says. "People who work with patients who often have high stress and high emotions, like in the ED and neonatal, tend to minimize patient actions even when it is quite severe. They get the idea that it is part of their job to be mistreated and assaulted."

Key Points

- Encourage careful reporting of all violent incidents.
- Provide training in how to recognize and respond to potential violence.
- Do not hesitate to call local law enforcement for help.

Good reporting also can improve your threat analysis, says **Amit Gavish**, a security expert with SSC Inc., a security consulting company in Shelton, CT, who previously was deputy director of security for the office of the president of Israel. He says it is easy for people to focus almost exclusively on what they perceive as the big threat — a murder or rape in the ED — and devote little attention to preventing the far more common acts of violence.

“You have to categorize the different types of threats and plan a response for each threat,” he says. “What you need to do to prevent a knife attack from a gang member is not the same thing you need to do to prevent a disgruntled former employee from walking into the ED and assaulting someone.”

It is a mistake to be hasty in implementing security improvements without knowing what the real threats are, Gavish says. EDs are not all the same, and the type of potential violence will vary, he says. Urban EDs may have different concerns than rural facilities, and pediatric EDs may have their own concerns. Each will require an appropriate prevention and response plan.

When improving security in the ED, it is important to remember that fortifying the facility is not necessarily the answer, Gavish points out.

“A lot of times we see people say they’re going to improve security, usually after a bad incident, and they spend a lot of money installing cameras and metal detectors and posting more guards,” he says. “But if you haven’t analyzed your risks and identified the threats, it can be a total waste of your money. You say you’ve increased security, but you really haven’t done anything useful.”

Promote zero tolerance

Risk managers can improve reporting by emphasizing that they want to hear about all incidents of ED violence and that those reports will

not be viewed as whining or complaining, Albrecht says. Staff must understand that the hospital leadership does not consider ED violence an unavoidable job hazard. The relatively minor incidents can reveal security issues that can help prevent more serious incidents, he says.

“Don’t wait until a nurse is beaten unconscious before you decide to act,” Albrecht says. “No matter what you identify as why that happened, I can almost guarantee that you could have identified the same issues after previous, much less severe incidents took place.”

Albrecht says ED staff also should be encouraged to call for help from the local police department whenever there is a threat of violence — without feeling as if they are being overly cautious.

“The police don’t necessarily arrest anybody, but they show up and lower the emotional temperature of the situation,” he says. “I would let ED staff know that hospital leadership will not frown upon staff calling for help when they feel threatened, before the violence occurs, whether that help comes from hospital security or the local police.”

Hospitals can reinforce the safety culture in the ED by having a formal policy and reiterating the organization’s zero tolerance for assaults on staff, says **Robert Siciliano**, CEO of NurseSecurity.com and a personal security expert in Boston.

“That policy should be posted, included in paycheck envelopes, handed out at safety and security meetings — any way you can get it in front of people repeatedly,” he urges. “If they are continually reminded, there is a better chance that they will remember in the heat of moment, when they are faced with a potentially dangerous situation.”

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Training, buddy system can reduce ED violence

Angry, violent individuals need specialized attention, and improperly handling a crisis can mean years of litigation, warns **Robert**

Siciliano, CEO of NurseSecurity.com and a personal security expert in Boston. Fail to act properly and you could face liability from either the injured staff member or the assailant who was injured by your intervention. Or both.

Siciliano offers this overview of the strategies that can reduce violence in the emergency department (ED) and ensure a proper response to incidents:

- **Create a safety culture for the ED.**

Establish guidelines that include adaptable safety and security procedures customized to the limits of the facility. Create zero-tolerance policies for violence and threats for patients, staff, and visitors. Create reporting procedures and a filing system to evaluate and quantify progress.

- **Work together.** It is essential that management demonstrate organizational duties to ensure the safety and health of their employees. Managers should offer support and “be there” when employees are in crisis.

- **Educate employees about their responsibilities.** Staff are responsible for learning their assigned duties and complying with security program guidelines. They also must be involved in ongoing procedures, committees, inspections, reporting, and dissemination of information.

- **Know your risk factors.** Employees must know what elements increase the risk. Patients’ families and friends bring in handguns, knives, and other weapons. An ED’s 24-hour unrestricted access, long waits, disgruntled family or gang members, and patients under the influence of drugs and alcohol all escalate the risk. Nurses are sometimes isolated in remote areas and are not trained to respond to physical threats.

- **Ensure premises security.** Options include security guards, metal detectors, pass keys, alarm systems, panic buttons, cell phones, proper lighting, and centralized radios. A central office to respond to distress calls is essential. Security cameras and curved mirrors assist in remote areas.

- **Coordinate with local law enforcement.** Although law enforcement usually responds after a crisis, it is important to create communications with local authorities and make them fully aware of the facility layout. Properly trained security guards usually can defuse violent situations whether by nonviolent means or with force.

- **Use nonviolent intervention.** Have sys-

tems in place to treat clients who are aggressive or acting out. Certified employee assistance professionals or social service staff should be on duty 24 hours a day to help calm angry patients.

- **Use a buddy system.** There is strength in numbers. To reduce potential threats, pairing staff can offset the chances of being overpowered. Elevators, stairwells, parking garages, home visits, and isolated areas are all potential threats.

- **Minimize jewelry and cash.** Not only is jewelry a potential target for thieves, it also can be a strangulation hazard during an attack. Carry only essential identification and cash. Beware of improvised weaponry in the form of surgical tools, keys, pens, or other items that could be used as a weapon.

- **Offer self-defense training.** Employees can be trained in assault response, avoiding assaults, personal safety, and self-defense. ■

You’ll need this data on patient QI involvement

Include patients, families on committees

The national focus on patient-centered care isn’t just about teaching patients to become more engaged in self-management of their care—it also means putting patients on committees and advisory boards to participate in the process of developing quality programs.

“Hospitals are involving patients in a variety of ways in quality and safety efforts,” says **Kathryn K. Leonhardt**, MD, MPH, patient safety officer at Aurora Health Care in Milwaukee, WI.

However, this is a big paradigm shift. “Traditionally in health care, we felt that we were the experts in creating programs because we have the training,” says Leonhardt. “But how can you create a system for patients without patients at the table? How do you create something to meet their needs if we don’t know what their needs are?”

Including patients in quality improvement and patient safety efforts is a new process for health care, says Leonhardt. “Though it seems intuitive that patients should be included because they have the experiential knowledge, the health care system is just now learning how best to incorporate the ‘patient perspective,’” she

Key Points

- Patients should be included in hospital committees and advisory boards.
- Including patients in quality improvement is a new trend in health care.
- Outcomes data should be collected to determine the impact of patients' involvement.

says.

The processes by which patients can participate in quality and safety programs are being developed now by various health systems around the world. These include advisory councils, membership on work teams, surveys and focus groups, and participation in event review committees. "However, both patients and health care providers need to be trained and educated prior to implementing these processes, to be sure they are comfortable and effective for all participants," says Leonhardt.

Outcomes data should be collected to demonstrate the impact of patient involvement, stresses **Erik Martin**, RN, MSN, clinical director of the pediatric intensive care unit at Cincinnati (OH) Children's Hospital.

"Data are awesome things because they provide objective information that cannot be debated," says Martin. "It proves that hard work and ongoing efforts pay off."

The data you collect should answer these questions, says Martin: How did parent/patient involvement improve our patients' care, quality of life, or outcomes? How did it shorten their length of stay? How did it decrease the amount of medication errors or serious safety events that occurred?

"This is something we are currently working on," says Martin. "We'd like to hardwire the system in all three critical care areas, obtain this data, and eventually roll this initiative out for all the inpatient and outpatient units."

Patient input was used to develop a quality initiative involving a parent of a chronic seizure patient. The parent raised a safety concern when the medical team wanted to do a septic workup on her son, including a spinal tap, which she thought was unnecessary. "The mother was concerned about causing undue painful procedures and exposing her son to a potential infection when it was his baseline to spike a fever after a seizure," says Martin.

Through the "Partnering with Parents" initia-

tive, the mother was able to convey her concerns and prevent the septic workup. By the next morning, the patient had returned to baseline and was ready to be transferred out of the pediatric intensive care unit.

Demonstrating the association between patient involvement and patient safety outcomes can be shown through a variety of metrics. "During one project at Aurora HealthCare, we provided tools and education to help patients become more engaged in their own medication management by maintaining their own medication lists," says Leonhardt.

By increasing patient engagement, the accuracy of medication lists in the clinic charts increased by 17%, she reports. To measure the rate of accuracy of medication lists, the patient's medication list was compared to the clinic's, to identify any discrepancies.

"This type of measurement could be done in other settings, both inpatient or outpatient, to add to the evidence-based support for patient involvement in patient safety efforts," says Leonhardt.

At Cincinnati Children's, patients and families are involved in quality improvement and safety projects in many ways. "One of the first ways is to recognize the patient as the expert, or the parents as the expert in their child's care," says Martin. "Soliciting their input and utilizing it when developing a plan is vital to the success of any quality improvement or safety project."

Here are some examples:

- **Family-centered rounds:** Families are invited to join the physicians, nurses, and respiratory therapist in discussing their child's condition and plan of care. The parent's input is welcomed and valued.

- **Family relations department:** If families feel their needs and concerns aren't being met, they are encouraged to contact this department so their voices can be heard. "Additionally, family relations is a neutral party who can facilitate communications for the common purpose of the patient," says Martin.

- **"Partnering with Parents":** This initiative began in September 2007 in the hospital's neonatal intensive care unit and has since been implemented in the hospital's three critical care areas. It is an extension of a collaborative that began on the medical-surgical floors to empower parents to call the Medical Response Team if they become concerned about their child's safety.

"The initiative engages parents in our organi-

zation's safety culture. It encourages parents to stop care if a safety concern arises," says Martin.

The staff member who is present when the concern arises contacts the "content expert," such as the pharmacist, physician, or respiratory therapist, to come to the bedside. "Care is resumed only if all parties are satisfied with the resolution to the concern," says Martin.

To make the most of patient involvement in QI initiatives, do the following:

- **Have clearly defined roles for patients.**

One pitfall is failing to have defined roles and processes for how patients will be involved in the QI process. Some patients may be concerned that their opinion won't be valued and respected because they aren't familiar with medical terminology, while staff may be worried about revealing problem areas to patients. "Make sure that everyone understands that this is a chance to work collaboratively and proactively on quality and safety initiatives. These are not intended to be complaint sessions, nor a peer review process," says Leonhardt.

- **Collect the right data.**

To measure the impact of the "Partnering with Parents" initiative, parent satisfaction surveys are used, which ask whether nurses were caring and compassionate, whether nurses listened to your opinion, and whether physicians answered questions thoroughly.

When a parent raises a concern, Martin follows up within 48 hours and uses a tracking sheet, which collects data in SBAR (situation, background, assessment, recommendation) format.

"My data collection is simple and mostly qualitative, but it helps to identify whether there are opportunities to improve our process," says Martin. "I inquire about how the process went, how satisfied the parent is with the outcome, and if they have suggestions for improvement."

- **Teach patients the benefits of adhering to guidelines and the ramifications of straying from guidelines.**

When patients remind health care providers to practice infection control measures, family members call for assistance when a patient's condition changes, and patient-friendly medication lists are provided at the time of hospital discharge. All of these measures help an organization to comply with regulatory goals, says Leonhardt.

For example, to prevent ventilator-acquired pneumonia, respiratory therapists or nurses at

Cincinnati Children's involve parents in tasks such as mouth care or keeping the head of the bed elevated. Data on the hospital's process improvement work are posted all around the unit. An outcomes board clearly lists how many days it has been since the last central venous catheter infection, unplanned extubation or ventilator-acquired pneumonia. "We are very transparent with our data and speak openly to parents about it," says Martin.

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Researchers from the Agency for Healthcare Research and Quality (AHRQ) have developed a guide for hospital leaders on how to get patients and families to partner with health care providers on community-based patient safety advisory councils. Developing a Community-Based Patient Safety Advisory Council can be downloaded free of charge on the AHRQ web site (<http://www.ahrq.gov/>). Click on "Quality & Patient Safety," "Medical Errors & Patient Safety," "Tools & Resources," and under "Implementation & Transformation," click on the publication title.] ■

Use proven strategies for error disclosure to patients

Answer the questions foremost on patients' minds

A growing number of organizations are disclosing errors to patients, but this can be disastrous if handled poorly.

"We need to train physicians and other health care professionals how to do this well," says **Gregg Meyer, MD**, Boston-based Massachusetts General Hospital's senior vice president for quality and safety. "This is a growing trend, but we need to prepare our workforce, just like we would for any critically important procedure or intervention."

At Massachusetts General, situation manage-

ment training prepares senior clinical and administrative staff to serve as disclosure “coaches.” Disclosure is built into the patient care assessment process. “We are seeing this happen much more routinely,” says Meyer. “This is a good development for patients *and* providers.”

At Virginia Mason Medical Center in Seattle, a policy requires the attending physician to disclose unanticipated outcomes, says **Cathie Furman**, senior vice president of quality and compliance. “We do not differentiate between errors and unanticipated outcomes,” she says.

The policy was developed after a provider tried to disclose an error, but did not have the skills and handled it less than optimally, says Furman.

Physicians are given a two-and-a-half-hour workshop on communication of unanticipated outcomes, given by a trained consultant. “We have a specific role titled a ‘situation facilitator’ who has received additional training and coaching by the same consultant,” says Furman.

The situation facilitators come from multiple disciplines and include nursing leaders and quality professionals. “Their role is to provide coaching to an attending physician who has not had much experience with disclosure,” she says.

The facilitator can be physically present when the error is disclosed or can coach the physician on the phone prior to disclosure, says Furman.

Good communication between clinical staff and patient/family is important for all aspects of care, says **Donald Kennerly**, MD, vice president of patient safety and chief safety officer at Baylor Health Care System in Dallas. The hospital system won the Leapfrog Patient-Centered Care Award in 2007 for its patient-centered practices, including having a policy in place for disclosing medical errors to patients and their families.

When an unexpected outcome takes place, whether or not it involves an error, the clinical team is expected to let the patient and family know what is happening and what is being done about it.

“When a serious outcome is encountered that

Key Points

- Workforce needs to be prepared and to deliver effective error disclosure.
- At Baylor, quality, safety, and risk management are involved in error disclosure.
- Quality professionals should get to the bottom of the problem.

is unexpected, we continue to emphasize the value of timely communication with the patient and family about what we do know at the time,” says Kennerly. The staff also commit to follow-up communications when more information is identified as the result of any investigation that might take place. The patient’s physician is most often the best person to make these disclosures, says Kennerly. “When that is not possible, then a hospital executive will do this,” he says.

In either case, these professionals have “just in time” training given by risk management to help them anticipate the type of questions they are going to receive from the patient and family.

Answer these questions

The key to success is to answer the questions that are always on patients’ minds, says Kennerly:

- What happened? “If this isn’t clear at the time, it is very effective to provide some information to the patient and commit to returning when more information is known,” says Kennerly.
- What does this event mean, if anything, to my health? What can I expect in terms of any change in care or expected outcome?
- A commitment on the hospital’s part to understand why the event happened, even if this information is not shared with the patient, and to use this information to try to prevent future similar events from happening.

Any time there is a serious adverse event, an investigation takes place. A hospital expert in quality or patient safety reviews the chart, talks

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to other health care professionals, and determines the specific things that took place before and during the event. "The patient and family rarely want to know all of this," says Kennerly. "So the disclosing professional will summarize the more important aspects of the situation."

If the event involves errors and/or inadequate systems of care, an apology is often both appropriate and very important to the patient. "It is controversial, however, since some states allow an apology to be used in court as an implied acknowledgement of responsibility," says Kennerly.

Improve systems

Quality, safety, and risk management professionals at Baylor's hospitals are involved with disclosure of an adverse event in several ways. First, they are at the center of the investigation to understand the facts of the incident. This information is communicated to whomever will do the disclosure, and that individual is usually coached on the most effective way to disclose what will be important for patients to know.

"Second, the quality professional's role is to begin the process of organizational learning to determine why the adverse event took place, and

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what can be done to prevent it from recurring in the future," says Kennerly.

As part of the investigation, the quality professional will try to understand why the event occurred by checking into potential contributing factors such as a poorly designed process of care, communication problems, a high workload, equipment problems, ambiguous policies, training issues, or distracting events occurring at the same time.

The information is then used to design and implement improved processes that together constitute an improved system. "Since the vast majority of adverse events are due to suboptimal systems, the improvement of the system is key to improving care in a durable way," says Kennerly.

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