New Patient Safety Goals
focus on infection prevention
New med rec, UP requirements also released

Revised elements of performance (EP) for medication reconciliation and the Universal Protocol™ (UP) worry some in the field, but the addition of new requirements for reducing healthcare-associated infections (HAI) has so far not stirred up a lot of angst.

Some safety advocates even say The Joint Commission’s new expectations for managing HAIs may lead to wider use of the same type of medical checklist that produced dramatic results in Michigan, where hospitals reduced catheter infections to zero and saved more than 1,500 lives and nearly $200 million.

In late June, The Joint Commission (formerly JCAHO) released its 2009 National Patient Safety Goals (NPSG), which include three new requirements for infections:

- NPSG.07.03.01: Prevention of HAIs resulting from multiple drug–resistant organisms (MDRO) using evidence-based practices (this applies, but is not limited, to methicillin-resistant Staphylococcus aureus [MRSA], Clostridium difficile, and vancomycin-resistant enterococci)
- NPSG.07.04.01: Prevention of central line–associated bloodstream infections using evidence-based practices
- NPSG.07.05.01: Prevention of surgical site infections using evidence-based practices

Goals phased in over one-year period

All new infection control requirements have a one-year phase-in period, with full implementation expected by January 1, 2010.

“I do appreciate the way they’re phasing in things,” says Sandy Jones, RN, patient safety officer at Rockford (IL) Health System. “Many of the things that they’ve changed are things that we at Rockford Health System, and most other hospitals that I’m familiar with, are already working on.”

Many hospitals are already working on the Institute for Healthcare Improvement’s (IHI) 5 Million Lives Campaign and participating in the Surgical Care Improvement Project, which will put them a step ahead in the game, Jones adds.

The Joint Commission expects hospitals to use a checklist and protocol for central venous catheter insertion. That comes as welcome news to Goldmann. If an accrediting

“Universal Protocol and medication reconciliation are going to be the most challenging for the field.”
—Bud Pate, REHS

P. 6 New standards target disruptive doctors
The Joint Commission has issued a Sentinel Event Alert and a message to clinicians who bully or otherwise behave badly: Knock it off.

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The average improvement for all quality measures was 15.8%, with the biggest gains in the areas of heart failure and pneumonia, both of which improved more than 18%.

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A focus on the community leads to high employee and patient satisfaction.
body requires checklists to be used, the Office for Human Research Protections cannot deem the practice human research and try to stop their use (see “Checklist reduced infections to zero” on p. 3).

“Hospitals should look at their own experience and determine what is epidemiologically important,” Goldmann says. “That gives hospitals appropriate flexibility as to what they should work on. I like it because it goes beyond MRSA and Clostridium difficile.”

In New York City, for example, hospitals would want to look at an MDRO called Klebsiella, which is killing patients and is almost untreatable.

Hospitals should aim to reduce infections by 50%

Eliminating MRSA entirely, Goldmann says, may not be possible right now.

“That said, it ought to be possible based on what I’m seeing to reduce your MRSA rate over a year, or over a year plus, by 50%,” he says. “I think that that should be really feasible.”

That view was echoed by William Munier, MD, director of the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality (AHRQ). “The bugs are very creative and they keep mutating and changing,” Munier says. “I think, yes, it’s very difficult to eliminate them. But we can certainly do much better than we’re doing now.”

Hospitals should look at the protocols of the Centers for Disease Control and Prevention, IHI, and AHRQ, say Munier and Goldmann.

Renumbering presents a challenge

The renumbering of the goals this year may present a challenge to hospitals, Jones says, adding that, overall, she thinks the number of new requirements this year is less burdensome than other years—a view not entirely shared by some others in the field. (See pp. 4–5 for a chart of the new goals.)

The 2009 additions to the NPSGs represent the largest number of new requirements since they were announced in 2002, says Bud Pate, REHS, vice president of content and development at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

“Universal Protocol and medication reconciliation are going to be the most challenging for the field,” Pate says.

Where to find help

The Centers for Disease Control and Prevention, the Institute for Healthcare Improvement, and the Agency for Healthcare Research and Quality all have tools on their Web sites to promote safe surgery and reduce infections. They can be found at:

- www.cdc.gov/nicid/dhqp
- www.ahrq.gov/qual/pips/pstoolsbrf.htm
- www.hcapatientsafety.org/custompage.asp?guidcustomco ntentid={30E376EA-1232-4B78-9AF3-95B6E565A847}
- www.ihi.org/IHI/Programs/Campaign
Med rec requirements called unclear

The new requirements for medication reconciliation are:

► NPSG.08.01.01 (formerly requirement #8A): Any differences found between a patient’s home medication list and the list of medications ordered during a patient’s stay must be clarified and documented while the patient is in the hospital. This goal also requires that during a transfer of a patient’s care within the hospital, part of the documented handoff must concern the most up-to-date reconciled medication list.

► NPSG.08.02.01 (formerly requirement #8B): This goal reinstates the requirement that hospitals provide a list of a patient’s medications to the patient’s primary care provider, and if this cannot be done, providing that list to the patient and his or her family will suffice. It is acceptable to send the list to the next provider of care or referring provider, and this must be documented. Another area in which many new documentation requirements were added is the UP.

► NPSG.08.03.01: The patient and his or her family receives a complete list of the patient’s medications with a documented explanation of that list upon discharge.

► NPSG.08.04.01: In settings in which medications are prescribed minimally or for a short time, modified medication reconciliation processes are carried out.

The requirement that during a transfer of a patient’s care within the hospital, part of the documented handoff must include the most up-to-date reconciled medication list is especially confusing, Pate says.

“There’s a new list required, new documentation,” he says. “This will require that with every new medication order, there is medication reconciliation against current meds. This appears to mean home medications, but [the goals] aren’t really clear.”

UP revisions require checklist

The new requirements for UP include:

► UP.01.01.01 (formerly requirement 1A): The biggest change here involves incorporating a checklist when the patient moves from the preprocedure setting. In addition to the existing relevant documentation and correct diagnostic and radiology results, The Joint Commission has required a signed consent form. Any blood products, implants, and special devices that will be used must be confirmed as a part of the checklist.

► UP.01.02.01 (formerly requirement 1B): EP 1, concerning marking the site, now applies to all procedures that involve incision or percutaneous puncture. Also, this goal specifies that the surgeon or professional performing the operative procedure must initial the site. Additionally, there is added language about the way in which spinal procedures should be marked, and how facilities must have an alternative process in place to identify the surgical site for patients who refuse the site marking and for certain procedures that are difficult to mark.

► UP.01.03.01 (formerly requirement 1C): This goal on performing the timeout now includes language about the need for separate timeouts to take place when more than one procedure is being performed. Also,

Checklist reduced infections to zero

A pilot project in Michigan to reduce catheter infections by using a simple checklist produced stunning results: In 18 months, infections dropped from 4% to zero, saving more than 1,500 lives and nearly $200 million.

Indeed, the checklist, created by Peter Pronovost, MD, PhD, FCCM, of Johns Hopkins Hospital and Health System in Baltimore, was so successful, Johns Hopkins planned to expand it to New Jersey and Rhode Island.

However, in December 2007, the Office for Human Research Protections (OHRP) halted the program, saying it was a human research project instead of a quality improvement plan.

Several months later, OHRP reversed its decision, and the Michigan checklist is not only back on track, but the World Health Organization has introduced a checklist of its own.

**Patient Safety Goals**< continued from p. 3

the timeout should now include an accurate procedure consent form, address whether antibiotics or fluids will be needed, and mention any safety precautions that should be taken based on a patient’s history or medication use. All steps of the UP and timeout must be documented.

Rather than elucidate what is expected for hospitals, Pate says, the new UP requirements make it less clear what clinicians need to do.

Pate also takes issue with the EP for NPSG.01.01.01, which says that if the patient is unable to be involved in the process, the hospital will name a caregiver who will be responsible for being part of the identification process.

“I have no idea what that means,” he says.

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**New numbering for 2009 National Patient Safety Goals**

<table>
<thead>
<tr>
<th>Goal #1: Patient identification accuracy</th>
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<tr>
<td><strong>2008 requirement</strong></td>
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<td>Requirement 1A</td>
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<td><strong>2008 requirement</strong></td>
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<td>Requirement 3E</td>
<td>NPSG.03.05.01</td>
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<th>Goal #7: Healthcare-associated infections</th>
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<td><strong>2008 requirement</strong></td>
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<td>New for 2009</td>
<td>NPSG.07.03.01</td>
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<td>New for 2009</td>
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<th>Goal #8: Medication reconciliation</th>
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<td><strong>2008 requirement</strong></td>
<td><strong>2009 requirement</strong></td>
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<td>Requirement 8A</td>
<td>NPSG.08.01.01</td>
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*Editor’s note: Go to www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/09_hap_npsgs.htm to read the full list of the 2009 NPSGs.*
### Goal #8: Medication reconciliation (continued)

<table>
<thead>
<tr>
<th>Requirement</th>
<th>2008 requirement</th>
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<tr>
<td>Requirement 8B</td>
<td>NPSG.08.02.01</td>
<td>This goal reinstates the requirement that hospitals provide a list of patients’ medications to the patient’s primary care provider. However, if this cannot be done, providing that list to the patient and his or her family will suffice. It is acceptable to send the list to the next provider of care or referring provider, and this must be documented.</td>
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<tr>
<td>New for 2009</td>
<td>NPSG.08.03.01</td>
<td>When a patient leaves a facility, the patient and his or her family receives a complete list of the patient’s medications with an explanation of that list. This explanation is documented.</td>
<td></td>
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<tr>
<td>New for 2009</td>
<td>NPSG.08.04.01</td>
<td>In settings in which medications are prescribed minimally or for a short time, modified medication reconciliation processes are carried out.</td>
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### Goal #13: Patient-centered care and education

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<th>Requirement</th>
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<tr>
<td>Requirement 13A</td>
<td>NPSG.13.01.01</td>
<td>Two EPs were added to this goal that aim to encourage patients to be involved in their care. They include educating the patient about hand hygiene and respiratory hygiene measures, and contact precautions used in the facility, and when and how this should be done. Also, surgical patients should be educated about the methods the facility employs to prevent adverse events during surgery.</td>
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### Goal #16: Respond rapidly when a patient’s condition is deteriorating

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<th>Requirement</th>
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<tr>
<td>Requirement 16A</td>
<td>NPSG.16.01.01</td>
<td>This goal has been updated to state that just having a team in place to respond to a change in a patient’s condition is not enough to be in compliance with the goal.</td>
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### Universal Protocol™ (UP): The organizations meet the expectations of the UP

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<td>Requirement 1A</td>
<td>UP.01.01.01</td>
<td>The biggest change to this goal involves incorporating a checklist when the patient moves from the preprocedure setting. In addition to the existing relevant documentation and correct diagnostic and radiology results, The Joint Commission (formerly JCAHO) has required a signed consent form. Any blood products, implants, and special devices that will be used must be confirmed as a part of the checklist.</td>
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<tr>
<td>Requirement 1B</td>
<td>UP.01.02.01</td>
<td>A new EP has been added to former Requirement 1B. Marking the site now applies to all procedures that involve incision or percutaneous puncture. Also, this goal specifies that the surgeon or professional performing the operative procedure must mark the site with his or her initials. Additionally, there is added language about the way in which spinal procedures should be marked, and that facilities must have an alternative process in place to identify the surgical site for patients who refuse the site marking and for certain procedures that are difficult to mark.</td>
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<tr>
<td>Requirement 1C</td>
<td>UP.01.03.01</td>
<td>This goal on performing the timeout now includes language about the need for separate timeouts to take place when more than one procedure is being performed. Also, the timeout should now include an accurate procedure consent form, address whether antibiotics or fluids will be needed, and mention any safety precautions that should be taken based on a patient’s history or medication use. All steps of the UP and timeout must be documented, not just the timeout.</td>
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*Source: Adapted by QIR from The Joint Commission’s National Patient Safety Goals (NPSG).*
Joint Commission cracks down on disruptive clinicians

Dictatorial docs who demean, bully, or otherwise behave badly may want to get in touch with their kinder, gentler side.

Beginning January 1, 2009, new standards by The Joint Commission (formerly JCAHO) will require hospitals to have protocols to put cantankerous clinicians in their place—or else. In July, the accreditor issued a Sentinel Event Alert warning that disruptive behavior by physicians—or any clinicians, for that matter—pose a threat to patient safety.

The alert came as welcome news, says Troy Lair, CEO of the Compliance Doctor in Los Angeles and a former hospital nurse manager.

“As a former chief nursing officer, I became acquainted with the physicians who repeatedly would be rude toward me and my staff, especially those physicians that provided the hospital with the higher number of admissions,” Lair says. “These docs were the absolute worst in their behaviors, knowing the administration of the hospital would not act upon disciplinary action in fear of [their] admissions going to the local competing hospital.”

The Joint Commission’s new leadership standard, LD.03.01.01, targets inappropriate behaviors with two elements of performance (EP):

➤ EP 4: The hospital creates a code of conduct/organization has a code of conduct detailing what behaviors are acceptable and which ones are not.
➤ EP 5: Leaders implement policies to manage unacceptable behaviors.

Texas hospital reviews compliance

Days after The Joint Commission announced the alert and the new standards, leaders and the quality department at Pampa (TX) Regional Medical Center sat down to review their current policies and examine what needed to be changed. Specifically, Pampa found that:

➤ The medical staff policy is named “Disruptive Physician Behavior” and is in line with the majority of the procedural recommendations. However, it does not contain the words “zero tolerance” and the information regarding nonretaliation.
➤ Senior leadership and the medical staff follow the progressive steps in the policy when grappling with physician behavioral issues. So far, the policy has worked well.
➤ The hospital will recommend that the medical staff have an outside physician provide them with education regarding disruptive behavior at their fall meeting.

In addition to examining current policies, Pampa created an action plan that will:

➤ Propose revisions to the policies to the corporate office, and ask it to consider including a reporting/advising capacity to the hospital’s toll-free compliance hotline service, as a way to meet the recommended ombudsman process
➤ Reevaluate what materials are presented at new employee orientation
➤ Investigate resources for general familiarization regarding intimidating or disruptive behavior
➤ Examine employee satisfaction to help assess the level of intimidation in the hospital’s culture

Questions? Comments? Ideas?

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“Since the literature on the effect of disruptive behavior on patient care is well documented, I believe most hospitals have already put some type of process in place to address it,” says Sallie M. Gatlin, RN, CPHQ, director of quality resource management at Pampa, a 115-bed facility.

“Therefore, although the new leadership standards will make the need explicit to address disruptive behavior, I don’t believe it will be a hardship for accredited hospitals to comply,” she says.

The Joint Commission requires action

The Joint Commission calls on organizations to take the following actions in order to comply with the new standards:

➤ Educate all clinicians, not just physicians, on the hospital’s code of conduct, which should encourage treating each other with respect.

➤ Make all healthcare workers accountable to conduct themselves in a professional manner.

➤ Create and enforce policies that address zero tolerance for intimidating or disruptive behaviors and incorporate those policies into the medical staff bylaws.

➤ Encourage clinicians who may fear retribution to report disruptive doctors by including nonretaliation clauses in policies regarding inappropriate behavior.

➤ Respond to patients and their families who are victims or witnesses to disruptive behaviors. Hospitals should listen to their concerns, apologize, and possibly hold hearings on the matter.

➤ Create a process to address disruptive behavior with substantial input from medical and nursing staff members, administrators, and other employees.

➤ Provide training for managers and leaders in relationship building. The training should include education on giving feedback on unprofessional behavior and conflict resolution.

➤ Create a system to assess how staff members perceive the seriousness of unprofessional behaviors and the risk of harm to patients.

➤ Implement a reporting system (possibly anonymous) to encourage reporting of unprofessional behavior.

➤ Begin surveillance with nonconfrontational interventional strategies, such as an informal talk over a cup of coffee to address the problem, and move toward detailed action plans and progressive discipline if patterns persist.

➤ Document every attempt to address disruptive behaviors.

“The real challenge is to overcome our cultures of intimidation so that we address the behaviors each and every time they occur until zero tolerance is real,” Gatlin says.

Editor’s note: Go to www.jcrinc.com/29376 for more information.
Premier’s P4P program raises quality for its hospitals
Third-year results in for incentive program

Year-three results for Premier, Inc.’s Hospital Quality Incentive Demonstration (HQID) show improvements in quality for approximately 250 hospitals across the nation.

The pay-for-performance (P4P) program, launched in October 2003 by national healthcare alliance Premier and CMS, is the first national project implemented to determine the effectiveness of P4P programs and serves as a possible model for CMS’ recent value-based purchasing proposal to Congress.

Results for the first three years (October 2003–October 2006) show the average improvement for all quality measures was 15.8%. Hospitals involved in the project also averaged 7.48 percentage points higher on CMS’ consumer Web site, Hospital Compare, in March 2007. The biggest improvements came in the areas of heart failure and pneumonia, both of which improved more than 18%, according to Premier. The project has been extended for three more years and will end in September 2009.

Participating hospitals in the project implement Premier’s recommended measures in five clinical areas: acute myocardial infarction, coronary artery bypass graft (CABG), heart failure, pneumonia, and hip and knee replacement. In the first three years, hospitals in the top two deciles received financial rewards.

“We really felt this would give us an opportunity to learn … and it certainly did,” says Joyce Dambrouski, RN, MHA, vice president of nursing and chief nursing officer at St. Patrick Hospital and Health Sciences Center in Missoula, MT. “We were challenged on every single area relative to our current practice.”

Quality trumps incentives

In the project’s second year, St. Patrick ranked highest in the nation for its CABG results and received an award of about $86,000 as a result, says Dambrouski.

“That certainly does not cover the additional labor that we had to use [to implement the measures],” Dambrouski says, who also notes that the new measures meant extra training for new nurses, who have to learn new, hospital-specific protocols. But she says HQID is much more about improving quality than dollars and cents, especially as public transparency in quality gains momentum.

“The project gave us the framework and the structure to improve even more,” she says. “And we can see, like everybody else can, that we are going to have to prove our quality at some level, whether it’s CMS or the public, so we want to be in the best position to provide that quality and prove that we have that. In our minds, [HQID] is a way to do that.”

Although her hospital’s financial savings from implementing the measures hasn’t been calculated yet, Dambrouski estimates money was saved in the form of shorter lengths of stay. She says she couldn’t imagine her hospital not signing on for the project’s three-year extension, which the vast majority of participating hospitals did.

Stephanie Alexander, senior vice president for Premier Healthcare Informatics, says the feedback from hospitals has been positive, especially after the same quality measures HQID tracks now show on Hospital Compare (www.hospitalcompare.hhs.gov).

Hospitals show improvements

Premier gives hospitals about a half-dozen specific evidence-based measures to implement for each clinical area. For example, measures for pneumonia include:

➤ Oxygenation assessment
➤ Pneumococcal vaccination
➤ Blood culture before first antibiotic
➤ Adult smoking cessation counseling
➤ Initial antibiotic selection
➤ Initial antibiotic within four hours of hospital arrival
➤ Flu vaccinations

Results show that hospitals that implement these measures in bundles instead of one at a time fare better, says Alexander.
Greg Schoen, MD, medical director and vice president of medical affairs at the 54-bed Fairview Northland Medical Center (FNMC) in Princeton, MN, agrees that the quality improvements outweigh the financial rewards. He says benchmarking helps his hospitals stay on top of quality. FNMC is part of a five-hospital health system involved in HQID, and the results create some friendly competition.

Year-one results showed FNMC in the 10th decile for several measures, which alerted the hospital to the need to implement new measures.

Although the low scores were partly because of billing and documentation errors, the scores still didn’t satisfy staff members. The quality department met with the medical staff to review measures and ensure they were implemented on a daily basis. Schoen says when staff members were shown the data and the frequency of which the appropriate steps were (or weren’t) taken, the medical staff became more engaged in the project.

The challenge, says Schoen, was that at first, physicians and nurses believed they were taking the correct measures all the time, but data proved that wasn’t always so. As a result, standardized order sets and protocols were put in place. For example, when a patient presents with symptoms of chest pain, a new protocol now allows nurses to obtain an EKG and give the patient aspirin without having to contact a physician first. Now, patients with signs of pneumonia have blood cultures taken to ensure antibiotics are initiated in the ED before admission.

The measures worked. FNMC remains in the first decile for acute myocardial infarction, heart failure, and pneumonia.

“Once we started showing how we were climbing up the ladder and getting national recognition, that was a big boost,” Schoen says, adding that the key to success in the project is that you have to continue to improve.

At St. Patrick, implementing the measures for CABG was relatively easier than for pneumonia.

Working with three highly engaged surgeons, the 219-bed hospital maintained high marks for CABG, while implementing the measures for pneumonia patients—who require working with many physicians in different departments—took more effort.

“We spent a lot of time one-to-one with the physicians [who] admitted the pneumonia patients and then put both manual and electronic processes in place for a reminder for the vaccinations. We also focused on the emergency department and the timing of antibiotics,” Dambrouski says. Physician involvement was critical to seeing results, she adds.

United Hospital Center (UHC) in Clarksburg, WV, also began in the lower deciles, but by year two achieved second deciles in acute myocardial infarction and hip and knee replacement. By year three, UHC ranked in the top decile in those areas as well as in heart failure.

“What Premier hoped to accomplish has actually happened: that hospitals will progress further and faster,” says Mark Povroznik, PharmD, director of quality initiatives at UHC, which was chosen by Premier to host a quality summit in July. Povroznik says HQID brings home two important quality measures: consistency and excellence.

“Every patient counts. It’s not good enough to be 99%. The goal is 100%,” he says.

Premier extends project

Although only three years of results have been reported, HQID is currently in its fifth year of the project. The fourth year of reporting includes several changes. The initial measures in the five clinical areas will remain, with the addition of new measures, including the Agency for Healthcare Research and Quality’s patient safety measures, length of stay, and complications. New areas for testing include the Hospital Consumer Assessment of Healthcare Providers and Systems, Surgical Care Improvement Project, and ischemic stroke.

The reward model is also changing to include more incentives. Those hospitals that reach a quality threshold will receive a reward, along with hospitals that show high improvement rates.

Hospitals that reach the top two deciles will keep receiving rewards as well.
Ask simple questions to manage your data

Quality departments struggling to keep up with increasing demands to collect, analyze, and present data should first take an inventory of what information they’re already collecting and determine whether it ties into the organization’s strategy.

“The real secret is making sure every piece of data you collect, one, you know about, and two, it’s directly tied into your strategy,” says Ken Rohde, author of Making Your Data Work: Tools and Templates for Effective Analysis, published by HCPro, Inc. “Organizations sometimes are collecting a lot more data than they know about, and that data never gets used because people don’t know that they’ve collected it.”

It’s critical that the data is linked to the hospital’s goals, Rohde says. For example, if one of the organization’s strategies is to provide exemplary patient safety, the organization needs to collect information that will reflect its performance in that area.

“If you collect the wrong data, you’re wasting your time, you’re wasting your organization’s time, and you’re frustrating everybody,” says Rohde, a senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. “So you need to make sure you’re collecting the right data.”

Collect at the right speed

Hospitals also need to ensure that they’re collecting data at the right speed. For example, if you’re driving a car, you need to monitor the gas gauge on an hourly, if not minute-to-minute, basis. If you looked at the gas gauge only every month or so, you most certainly would run out of fuel.

Similarly, if your process changes daily or weekly, you need to collect data on a daily or weekly basis.

“If your data is changing on a weekly basis, taking a quarterly or semiannual sample is misleading and probably harmful to your organization,” Rohde says. “So you need to make sure the frequency with which you’re sampling the data matches up with the speed.”

Ask simple questions

Another strategy, Rohde says, is to manage your data by answering simple questions. One of the first questions should be: Do we stay the course or change direction?

“If your data can’t help you answer that question, your data is not working for you … We have to collect information that allows us to know the status of what’s happening,” Rohde says. “That’s the ‘what’ data. This is the data that will help us know falls are under control, or, uh-oh, falls are out of control, falls are in trouble.”

After collecting the “what” data, hospitals need to gather the “why” data. Those are the data that let the organization know what it needs to do to get back on track.

Examine four questions in analysis

After the data have been collected, organizations then move into the analysis phase. Once again, simple questions can help hospitals understand their data. Organizations should answer four key queries when analyzing their data, including questions about:

1. Magnitude. “The simple question here is, ‘Is the data indicating too much or too little?’ So we have 14 falls, we don’t know if that’s too much or too little. We have to be able to answer that question,” Rohde says. “One of the key tools is benchmarking; you have to compare to something. Either compare to what someone else does or compare it to our own historical performance. And that helps us answer that simple question about magnitude.”

2. Direction. “The simple question here is, ‘Are we getting better, or are we getting worse?’ ” he says.

3. Variability. The next question is about the variability of the data. “Is this data pretty steady, or is it bouncing...
all over everywhere?” Rohde says. “Control charts are a good tool there to help you answer that question. If our data has a big spike in it today, does that mean anything, or is that just a spike in the data? Be careful that our data isn’t lying to us. We would hate to change our whole organization on a blip in the data.”

4. Rate. “The last simple question is, ‘Do I have to jump on this right now, or do I have some time to think about it?’ ” Rohde says. “How fast is the process moving? Is this something that’s going to cause a terrible disaster if we wait until next Friday, or is this something we need to work on over the next two years?”

Present data in an understandable way

Once organizations answer those questions, they need to be able to present the data in a way that’s understandable and meaningful to the governing body and the outside world. One way to present data is with graphs, such as histograms or Pareto charts. These allow you to compare types of data, but they do not look at timing.

A second way to present data is with time series charts. These charts don’t compare different types of data, but rather assess how things have changed over time. Histograms and time series charts should be used during data presentation. Make sure your data presentations are answering the “simple questions.”

“You need to be able to compare risk, or importance, you need to be able to compare whether something is changing over time, and you need to be able to bounce back and forth between those presentations,” Rohde says.

The third way to present data is with a dashboard. Just like a dashboard in a car, one used for presenting data should contain only the most crucial pieces of information, not every piece of data that the organization collects.

“One of the key concepts in the dashboard is the same as in your car,” Rohde says. “In your car, you have the speedometer or the tachometer that have red lines on them. As soon as the needle hits those red lines, you know you need to pull over and do something different.”

Similarly, he says, the data need to allow you to tell your staff or your governing body, “We just hit a red line and we need to do something immediately.”

“That red line either says patient safety is now significantly at risk, or quality of service and satisfaction is at risk, cost is at risk, or perhaps reimbursement or accreditation are at risk,” Rohde says. “We’ve reached a dangerous point.”

One mistake some quality departments make is to cry wolf by having too many indicators colored red. If something is 15% or 20% off the mean, that shouldn’t trigger a red flag. Red should only be used for imminent danger.

“You can present information 100 different ways on a dashboard, but remember the fundamental purpose of that dashboard is to determine first, is it safe to operate, second, what do we have to change, and third, what are we doing successfully.”

“If your data is changing on a weekly basis, taking a quarterly or semiannual sample is misleading and probably harmful to your organization.”

—Ken Rohde

Illustration by David Harbaugh

“This patient has some questions: What is the test for? What’s with the medication you prescribed that he doesn’t need—and the surgery you suggested? And can he be discharged today?”

Editor’s note: Go to http://tinyurl.com/3v5rdj for more information about Rohde’s book.
Florida hospital values community, staff input

Focus leads to high patient satisfaction

When Sacred Heart Hospital on the Emerald Coast in Miramar Beach, FL, opened its doors in January 2003, it was mainly because of the fundraising done by the surrounding community.

“We wanted to make sure we met the expectations of our community, who raised over $20 million in fundraising,” says Roger Hall, president at Sacred Heart.

“When you start a new hospital, you have to meet the expectations of the community, and we had one chance to make a first impression and make that a positive experience,” Hall says. “The community expectation of hospital excellence is what sets Sacred Heart apart from other facilities.”

High expectations lead to high scores

Sacred Heart refined and raised its patient satisfaction scores in part through the use of outside consultants, who came in and identified problem areas. The hospital had 82% patient satisfaction when the effort began, a figure that is now at 90%.

Sacred Heart monitors its patient satisfaction and Hospital Consumer Assessment of Healthcare Providers and Systems scores daily. The hospital also scored 16th best in the nation in customer experience, as well as 93% in the net promoter score. The net promoter score is used by facilities to help them become more focused on improving products and services. It’s usually one simple question asked of customers, such as, “Would you recommend us to a friend?”

Placing the emphasis on employees

Hall says the scores are a result of improved hiring practices. “We make sure we build emphasis on the associates in our hospitals,” he says of the 53-bed facility, which has 7,000 patient encounters per month. “We have high patient satisfaction because we have high employee satisfaction.”

Hall says he’s never seen a disgruntled nurse give care to a patient and have that patient be satisfied. “It’s all combined, and that’s why we find the right associates who we can work with to improve themselves even more.”

Sacred Heart’s mission statement also places an emphasis on staff members working together: “The associates of Sacred Heart Health System and its parent organization, Ascension Health, share a common call to action. Together, we are called to deliver: Healthcare that works, healthcare that is safe, and healthcare that leaves no one behind.”

This mission statement is exemplified by Sacred Heart’s focus on its staff members. The hospital discusses the patient satisfaction scores with each staff member through various methods.

Each staff member is given a monthly report card on patient satisfaction and HCAHPS scores. Department managers also have monthly meetings to discuss scores. The results are then given back to the associates with areas the hospital and the individual need to improve on.

Recognizing achievement and raising the bar

Although promoting awareness is important, so is celebrating success. Sacred Heart rewards all nonclinical and clinical associates annually through a plaque and a $500 cash gift.

“Having resources and setting goals can help staff achieve success,” Hall says.

The facility has fewer managers and a higher nurse-to-patient ratio, which also leads to better quality care, he says. Sacred Heart nurses round hourly.

The hospital also looks at what other institutions are doing to achieve high patient satisfaction. “We have each department manager come up with ways to make patient satisfaction better,” Hall says.

“I look at [patient satisfaction] every day, as [does] the vice president of patient care. The whole team has to care about the patient experience, and then they’ll find a way for that experience to be positive,” he says. “But the No. 1 person to listen to is the patient in the community.”
New Patient Safety Goals focus on infection prevention

The Joint Commission has released its 2009 National Patient Safety Goals (NPSG), which include three new requirements for infections: NPSG.07.04.01: Prevention of central line–associated bloodstream infections using evidence-based practices, NPSG.09.03.01: Prevention of ventilator-associated pneumonia, and NPSG.07.05.02: Prevention of multidrug–resistant bacteria, including Clostridium difficile, Staphylococcus aureus (MRSA), and vancomycin-resistant enterococci (VRE).

These new requirements are part of the Joint Commission’s efforts to reduce hospital-acquired infections (HAIs). The accrediting body has seen a 36% reduction in HAIs in hospitals accredited by the Joint Commission compared to those not accredited.

The Joint Commission expects hospitals to put protocols in place and develop a plan for implementing these new requirements. Hospitals will have one year to phase in the new requirements, with full implementation expected by January 1, 2010.

Some safety advocates even say The Joint Commission has issued a Sentinel Event Alert, titled “Knock it off: Bullying and disruptive doctors.” The alert highlights the issue of disruptive doctors and the impact it has on patient care.

Many hospitals are already working on the Institute for Healthcare Improvement (IHI) tools and protocol for central venous catheter insertion. That protocol was developed in partnership with The Joint Commission.

In the case of reducing catheter-associated infections, Jones adds. “I do appreciate the way they’re phasing in things,” says Sandy Jones, RN, executive director of patient care services at Rockford (IL) Health System, and most other hospitals that I’m familiar with, are already working on it. Many hospitals are already working on the Centers for Medicare and Medicaid Services (CMS) requirements for evidence-based practices.

The Joint Commission expects hospitals to use a checklist and protocol for central venous catheter insertion. That protocol is being used in 60% of the hospitals that IHI is tracking.

The average improvement for all quality measures was 15.8%, with the biggest gains in the areas of heart failure and pneumonia, both of which are going to be the most challenging for the field, says Sandy Jones.

In one hospital, they’ve changed their protocol for medication reconciliation and the Universal Protocol™ (UP) worry went away, says Sandy Jones. The Joint Commission expects hospitals to use a checklist and protocol for medication reconciliation, too.

Some hospitals are already working on the Joint Commission’s new expectations for managing HAIs. The Joint Commission released its 2009 National Patient Safety Goals (NPSG) earlier this year, which proposed a one-year phase-in period for the new requirements, with full implementation expected by January 1, 2010.

One of the new requirements focuses on evidence-based practices. The Joint Commission expects hospitals to use a checklist and protocol for central venous catheter insertion. That protocol was developed in partnership with The Joint Commission.

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