Revised Leadership standard LD.03.01.01
How accreditation professionals can take the lead on creating a culture of safety

In 2009, The Joint Commission added Leadership standard LD.03.01.01, “Leaders create and maintain a culture of safety and quality throughout the hospital,” to recognize that behavior that intimidates others and affects staff morale and turnover can also be damaging to patient care, and to require a formal process to manage unacceptable behavior in accredited hospitals. Elements of performance (EP) 4 and 5 of this standard contain language about “acceptable, disruptive, and inappropriate behavior” of individuals working in healthcare organizations.

Effective July 1, the term “disruptive behavior” in the glossary and in the two EPs in the Leadership standard will be revised to say “behaviors that undermine a culture of safety.” The revision will be applicable to ambulatory care, behavioral healthcare, critical access hospitals, home care, hospitals, laboratories, long-term care, and office-based surgery accredited facilities, and will reflect a broader range of unacceptable behavior that healthcare facilities currently face.

Behaviors that undermine a culture of safety

“Behaviors that undermine a culture of safety” is a bit more all-encompassing than “disruptive behavior.” In fact, Bud Pate, REHS, practice director for The Greeley Company in Danvers, MA, says that disruptive behavior is just one behavior among a number of others that could undermine a culture of safety.

“Disruptive behavior is only one of the kinds of behaviors that leaders need to address.”

—Bud Pate, REHS

After reading this article, you will be able to:

➤ Identify behaviors that undermine a culture of safety
➤ Recognize ways to overcome barriers to implementing a culture of safety
➤ Explain to leadership how revised standard LD.03.01.01 can affect the hospital’s bottom line

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Reports continue to demonstrate the negative effects of worker fatigue in healthcare. Read the latest on this topic from BOJ advisor Sue Dill Calloway, RN, MSN, JD, CPHRM.
While the primary reason behind this change in language is for clarity, Pate says that the change is not really anything new, but rather an extension of what is already being defined as a culture of safety in healthcare today. Over the past four or five years, he says, expectations have already been placed on hospitals to establish a baseline measure of their culture of safety and take steps to improve it on an individual and collective level, using resources like the Agency for Healthcare Research and Quality’s (AHRQ) patient safety tool and definitions in Sentinel Event Alerts released by The Joint Commission. Pate says that among those steps are expectations for behaviors for both leaders and physicians in particular.

So what exactly are these expectations and behaviors that undermine a culture of safety that leaders should be looking out for? “Behaviors that undermine a culture of safety can be verbal, nonverbal, may include the use of rude language, possessing a threatening manner, or even physical abuse,” says Sue Dill Calloway, RN, MSN, JD, CPHRM, chief learning officer of the Emergency Medicine Patient Safety Foundation in Dublin, OH. In addition to the obvious behaviors such as violence, yelling or shouting, profanity, insults, bullying, or harassment, Calloway says some examples of behaviors that undermine a culture of safety could also include less obvious things like:

➤ Inappropriate comments written in the medical record
➤ Blatant failure to respond to patient care needs or staff requests
➤ Personal sarcasm or cynicism
➤ Deliberate lack of cooperation without good cause
➤ Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety
➤ Insensitive words or actions directed toward another person
➤ Rude responses to patient needs or staff requests
➤ Disruption of meetings
➤ Uncooperative or defiant approach to problems
➤ Refusal to complete a task or carry out duties
➤ Repeated violations of policies or rules
➤ Nonconstructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity or incompetence
➤ Threatening to get someone fired
➤ Refusing to answer someone’s questions
➤ Criticizing other caregivers in front of patients
➤ Behavior that disparages or undermines confidence in the hospital or its leaders
➤ Public derogatory comments about quality of care being provided by others

This isn’t exactly a ‘tomato, tomato’ situation

Generally speaking, the term “leader” throughout the years has been used to define everyone from the

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**Briefings on The Joint Commission**

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board of directors all the way down to department or unit heads, and although this change in language might not seem to affect the processes that hospitals have put in place to deal with behaviors that undermine safety in care settings, it in fact further emphasizes the dire need for such processes to change.

Pate says that the wrong thing to do would be to just take the Joint Commission language and develop an isolated policy that defines “behaviors that undermine a culture of safety.” In fact, he says, making a policy that broad would be impossible to implement.

“It’s difficult enough to define what disruptive behavior is, much less the much broader definition,” Pate says. “And that’s not the intent. The intent is to align those leadership standards with the other expectations around safety, and to keep on keeping on. If they haven’t really truly started embracing a culture of safety, they need to do that, and that’s not a new expectation, that’s been an expectation for some time. This [standard] dovetails into that expectation; it doesn’t really layer anything on top of it.”

**Breaking the barriers, step one:**
**You’ll need a bigger pan**

Even though culture change is an entirely separate fish to fry, and a huge one at that, it’s a fish that everyone seems to be coming back to. Healthcare professionals have a lot on their plate already, and when it comes to completely overhauling an entire culture, where do you start? How do you fry a fish that big?

Pate says that one of the biggest barriers to truly achieving a culture of safety is the sheer size of the issue.

“A lot of the folks will do the AHRQ culture of safety survey, and then they’ll do the survey again, and then they’ll do the survey again, and the survey is so broad that, unless the hospital is very sophisticated, they sort of take a broad approach to it and don’t really get down to the cultural issues,” Pate says. “I mean, you’ll know when you have a culture of safety when all surgeons react to a scrub technician who shuts down a procedure because they’re concerned about something: the sterility of the equipment, the readiness of the survey, the identity of the patient.

“And if that scrub tech has not only the ability to stop the procedure, but to stop the procedure and then say, ‘No, everything’s okay, we’re going to go forward,’ and the surgeon says ‘thank you,’ he continues.

“That’s not the behavior that we have. When a nurse calls a physician about a problem with a patient or a question about an order and says, ‘It looks like you ordered this, can I clarify that with you?’ and the doctor says, ‘Yes, I wanted that, but thank you for calling.’ When the folks who have the power start doing that, you’ll know we’ve begun to have a culture of safety,” says Pate. “But that is huge change.”

**Breaking the barriers, step two:**
**Reverse the food chain**

There’s a saying that goes, “Culture eats process for lunch.” When the culture of an organization is deeply engrained, change becomes very difficult. Pate says that this is another barrier to creating a culture of safety, and that too much time and attention is being devoted to putting out fires and monitoring skipped measures.

Safety programs, such as the management of incidents and medication errors, are often robbed of attention and resources because there are millions of dollars in the value-based purchasing program that is taking those resources and putting them into outcome measurement, Pate says. “A medium-sized hospital is at risk for many millions of dollars in the next three or four years if they don’t make significant improvements in patient satisfaction and performance in certain predefined indicators,” he says.

Patient safety indicators are part of value-based purchasing, but it doesn’t really take a culture of safety to implement them. However, value-based purchasing is something that the C-suite, particularly the chief financial officer, is very focused on, and although value-based purchasing is a leadership issue, it’s also an area where the responsibilities of accreditation professionals and
survey coordinators can have an impact on creating a culture of safety.

**Accreditation professionals can take concrete action**

One thing accreditation professionals can do to help foster a culture of safety is to start looking at the behavior of physicians and other leaders and defining what is and is not acceptable—i.e., identifying what supports safety and what detracts from it—and start dealing with such behavior at their quality council, says Pate. “The accreditation professional, although a leader, is not in the operational chain,” he says. “They don’t lead the medical staff, they don’t lead the nursing or the other support departments, and they don’t make the financial decisions. But if they could queue up unacceptable behavior along with the results of the culture of safety survey and somehow find a way to put that in the framework of value-based purchasing, that’s one thing that they can do that’s really concrete.”

Something possibly even more concrete that Pate suggests is for accreditation professionals to adamantly point out the numerous vulnerabilities and adverse events that occur on a regular basis and bring them to the attention of leadership. Facilities across the country are being hit with adverse event findings left and right by state agencies; the findings include nursing service issues, patient rights issues, and quality assessment or performance improvement. Pate says these citations—which frequently arise from individual patient events that are brought to CMS’ attention—could threaten a facility’s financial well-being and certification.

“It’s not because they come by if they don’t have anything better to do that day, it’s because an adverse event happens, and CMS comes out and looks at it,” he says. “So it compels the accreditation professional to bring this to the attention of leadership and say, ‘Hey, we are vulnerable. As long as we have adverse events that are happening and we haven’t drilled down and addressed the underlying issues that are causing these events, we are vulnerable to being distracted from our core mission.’

One hundred percent of the time, Pate says, the root of those issues involves the need to improve the culture of safety and the behaviors that the leadership standard is more clearly addressing.
ISMP medication administration guidelines
What your hospital needs to know about scheduled medications

Editor’s note: BOJ advisor Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA, is a healthcare consultant in Trabuco Canyon, CA, and a former Joint Commission surveyor.

Recently in this space, we talked about CMS’ changing stance on the so-called “30-minute rule.” To follow up, we thought it was time to take a look at the Institute for Safe Medication Practices (ISMP) and its recently developed Acute Care Guidelines for Timely Administration of Scheduled Medications, a three-page report the institute released earlier this year.

A little background: ISMP developed these guidelines following extensive research in late 2010. The organization surveyed nearly 18,000 nurses about CMS’ oft-challenging Conditions of Participation Interpretive Guidelines, which require that medications be administered within 30 minutes of the scheduled time of administration.

Given the results of that survey, it looks like times really have changed—respondents indicated that the 30-minute rule has become problematic due mostly to the evolution of medication administration. According to the ISMP, nurses who responded to the survey felt that a one-size-fits-all concept like the 30-minute rule was “inflexible” and led to nurses making error-prone decisions in order to maintain compliance, thus increasing patient risk.

The guidelines are broken down into four sections.

Time-critical scheduled medications

The first step identified by the ISMP is to create a hospital-specific list of time-critical medications. The ISMP acknowledges that this will involve a limited number of medications, but flags the concept as needing to involve a hospital-specific list (not a universal one) because each type of facility will need to look at its own needs based on patient population. Think of the range of medications needed for a mental health facility versus a pediatric or oncology facility.

In fact, the ISMP suggested that hospitals with particularly diverse needs in terms of patient population consider unit-specific lists of medications in addition to a hospitalwide list.

But what is a time-critical scheduled medication? The ISMP provides the following factors for identifying time-critical medication:

➤ Does the medication require dosing more frequently than every four hours?
➤ Is it a scheduled opioid for chronic pain or for palliative care?
➤ Is the medication an immunosuppressive agent for preventing solid-organ transplant rejection or treating myasthenia gravis?
➤ Does it need to be administered separate from other medications?
➤ Is the medication related to meals? Does it need to be administered within a certain time before, during, or after food is taken?

Examples of the last bullet include rapid-, short-, or ultra-short-acting insulins, some specific oral anti-diabetic medications, alendronate, and pancrelipase. These meal-related medications, because so many factors are involved in specific timing, require nurses’ judgment.

These medications really belong on all hospital lists, regardless of patient population.
However, this list is not exhaustive. Some medications actually become time-critical based on the patient, his or her condition, and the diagnosis. For example, if you are treating a patient for sepsis, anti-infective medications are going to be much more time-critical than other medications.

The ISMP suggests giving medical professionals—pharmacists, physicians, nurses, and other prescribers—the responsibility and power to make a medication time-critical based on the needs of the individual patient. This should be identified in the medical record.

Next, the ISMP recommends hospitals establish guidelines for the identified medications. These guidelines should help staff administer said medications at the “exact time indicated when necessary or within 30 minutes before or 30 minutes after the scheduled time,” the report states. For certain medications, such as the previously mentioned fast-acting insulins, this timing may be more precise. The previously discussed medical record entry should serve as a reminder for staff regarding the requirements of these time-critical medications.

Non-time-critical scheduled medications

Now we turn our attention to non-time-critical medications. Falling under this auspice are less time-sensitive scheduled medications, whether they are daily, weekly, or monthly administrations. The ISMP guidelines state that these medications should be administered within two hours of their scheduled time.

The report does acknowledge that such medications are generally safe to administer with a deviation in administration time of more than two hours, but this time frame is more to help prevent human error—when the deadline extends out to more than a two-hour time frame, there is a risk of forgetting the medication entirely, which grows the longer the deadline is pushed back.

There’s also a middle category—medications that are administered more frequently than daily, but no more frequently than every four hours. The ISMP guidelines state that these medications should be administered within one hour before or after the scheduled administration time.

These multiple-dose-a-day medications come with their own challenges, unique from time-critical and less frequently administered medications. Technology systems come into play here. According to the guidelines, a vendor update may be needed to answer any of the following questions:

➤ Does the technology, in a bar-coding system, accommodate multiple time intervals in order to trigger an alert for early or late dosing?
➤ Does it indicate a delayed dose in an electronic medical record system?
➤ Does it treat scheduled dose removals from an automated medication dispenser?

In fact, the ISMP states that it has been pushing vendors to address these challenges independently, particularly when tracking doses.

Final steps

The ISMP guidelines urge facilities to get medical staff approval for all timely administration of scheduled medication policies and procedures.

Lastly, the institute takes the time to address first doses. “Although not associated with the timing of scheduled medications, hospitals should also define targeted timeframes for administering first doses and loading doses of key medications,” the report states.

These medications, which are typically administered in situations where timeliness is key, such as to emergency department patients with potential sepsis, include:

➤ IV anti-infective agents
➤ IV anticoagulants
➤ IV antiepileptic medications

The criticality of dosing often declines after that first administered dose, which is another factor for hospitals to be aware of when determining administration procedures.

Editor’s note: For the complete guidelines, visit www.ismp.org/Tools/guidelines/acute/acute-care/tasm.pdf.
Tracers 2011: How are you using tracers?

Editor’s note: Periodically, BOJ’s sister association, the Association for Healthcare Accreditation Professionals (AHAP), shares an excerpt from one of its quarterly benchmarking reports with us. For more information on AHAP and its quarterly benchmarking surveys and reports, visit www.accreditationprofessional.org.

During summer 2011, AHAP surveyed hospitals coast to coast to gauge how tracer methodology has evolved in recent years and how effective hospitals are finding this challenging, but often pivotal process. Seventy-two percent of respondents reported that they maintain formal tracer teams. Most (75%) said their tracers are regularly scheduled.

Sixty-seven percent of respondents said they aggregate the data collected by these tracer teams (See Figure 1). Regarding use of the data obtained, AHAP crafted a matrix for determining the most valuable use of tracer data. Respondents were asked to rate the following five categories on a scale from least to most valuable (or not applicable, where appropriate):

➤ Identification of new issues
➤ Validation of existing issues
➤ Progress toward compliance as a result of quality initiatives in place
➤ Increase staff comfort with the tracer process
➤ Increased awareness of standards and expectations for compliance

Respondents were instructed to rate these components not in comparison to each other, but on their own individual merits and benefit to the organization.

All of these categories scored most valuable by a significant margin, although there was some variance across categories. In the lead were identification of new issues and validation of existing issues, with 43% of respondents rating these categories a 1 on a scale of 1–5 for value. By assigning scores of 1 and 2 (scoring above “moderately valuable”), 66% of respondents said tracers were valuable in identifying new issues, and 65% said the same thing about validating existing issues. Sixty-two percent of respondents rated increased awareness of the standards as either a 1 or 2 in importance. While this category ranked second lowest of the five in terms of top (1) ratings, the combined score of those who rated increased awareness of the standards as either 1 or 2 in importance demonstrates that the majority of respondents do find tracers useful in this area.

An equal percentage (60%) of respondents scored both progress toward compliance and increasing staff comfort as 1 or 2, or above “moderately valuable.” Interestingly, increasing staff comfort received more 1 ratings (40%) compared to progress toward compliance (32%), but another 28% rated this category as a 2 in importance.

The numbers of respondents who ranked tracer usefulness on the lower end of the scale (4 or 5) were fairly consistent, with combined responses for these two scores steadily measuring within the low- to mid-20% range.

Among the low scorers, a noticeably significant (17%) number of respondents rated increased staff comfort level as the least significant value added by tracers. Also receiving ratings of 5 were increased awareness of standards (13%), identification of new issues and validation of existing issues (11% each), and progress toward compliance (9%). Only 1%–2% of respondents listed each category as not applicable.
How many and how often?

In terms of frequency, the largest percentage (48%) said they conduct monthly tracers. An ambitious few (2%) said they hold daily tracers, and a moderate number (18%) perform weekly tracers.

With 68% reporting that they conduct tracers at least monthly, it appears the trend is to go with a higher frequency. In fact, the numbers dropped off significantly for those conducting them less often—12% quarterly and only 4% annually.

Data is only as good as what you do with it. So where is all the information being gathered in these tracers going? Most respondents (86%) report back to committees, but many (a solid 64%) also bring the data back to individuals for a variety of purposes, whether for additional research or as educational opportunities.

For those reporting the data back to committees or leaders, a large percentage (39%) have a regular monthly reporting process (See Figure 2). More than a quarter of the survey takers (27%) report back quarterly, and another 24% said they report “as needed.” Smaller percentages said they report data on a much higher or lower frequency (5% weekly and 2% annually). Respondents were asked to describe whom the data was going back to, both in terms of committees and individuals. The range was, unsurprisingly, far-reaching. Examples include:

- Accreditation committees
- PPR teams
- Department and unit managers
- Survey readiness committees
- Senior leadership
- Joint Commission committees
- Pharmacy
- Practice councils
- Performance improvement committees
- Quality committees
- Medical executive committees

![Figure 1](image-url)
Infection control managers
➤ Chiefs of medical staff or medical affairs
➤ Vice presidents of nursing
➤ Medical records committees

The titles of individuals and committees varied, but the outcome is clear: Organizations are sharing their tracer data. Some individual responses went into detail about how this process works:

➤ “We do tracers every Thursday at 1 p.m., and have a standing leadership ‘report out’ scheduled every Thursday at 3 p.m. All of leadership is invited and they come as they are able. We report out any findings at that time, much like an exit conference, and follow up with a written report to all of leadership by the end of the day.”

➤ “All tracer results are reported at the Performance Improvement Team level first, then posted to our intranet for all staff to see. The results are also posted to the facility newsletter and hard copies are posted in each patient care area.”

➤ “We report findings first to unit or department managers in real time. Then summary reports are given to the executive leadership team. In addition, when appropriate, we report to the department managers meeting, the clinical quality committee, and the quality and safety forum.”

➤ “We used to submit a report to the CNO [chief nursing officer] and department director for the unit surveyed with the expectation for a follow-up response of actions taken to address noncompliant issues as well as communication/education with staff. The follow-up reports were not being done, and due to the work behind putting the reports together it was decided that the department director of the unit would attend the wrap-up session and take notes of findings. I do not feel this is the most effective method, and does not have any accountability measure.”
Errors and error prevention: A look at recent developments

After reading this article, you will be able to:
➤ Discuss what constitutes worker fatigue in terms of comparative number of hours

Fatigue has recently been recognized in the medical literature to increase the incidence of adverse events. Fatigue is a widely recognized patient safety issue. Nurses who worked over 12 hours per day or 60 hours per week were found to have made three times the number of medical errors compared to those working standard hours. Many hospitals stopped rotating nurses between days and nights because of the issue of fatigue. Some hospitals quit scheduling nurses for a double shift of 16 hours and then having them back in eight hours to do another shift.

Fatigue has also been associated with cognitive problems, mood alterations, reduced job performance, increased safety risks, and physiological changes. One author said that a review of several hundred studies showed no positive effects from insufficient sleep.

Fatigue is also known to increase residents' risk of making medical errors. The Accreditation Council for Graduate Medical Education (ACGME) in July 2003 implemented reduced work hours for residents. The hours were reduced to a maximum of 30-hour shifts and not more than 80 hours per week.

The ACGME published its final version of resident duty hours July 1, 2011, and included a requirement for honest and accurate reporting of duty hours and patient outcomes. The program must educate residents and faculty on the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. The ACGME also recognizes fatigue as a patient safety issue.

Residents who worked a traditional 24-hour shift made 36% more serious errors than residents who worked 16 hours. These residents also made five times as many serious diagnostic errors.

The Joint Commission issued Sentinel Event Alert 48 on December 14, 2011, titled Health Care Worker Fatigue and Patient Safety. The accreditation organization is warning hospitals and others about the potential dangers of healthcare worker fatigue with extended hours and excessive workloads.

The Joint Commission cited several articles supporting the fact that fatigue increases the risk of adverse events and is a patient safety issue. The alert discusses the impact of fatigue. Irritability, impaired communication, lapses in attention and inability to focus, and diminished reaction times are just some of the effects of inadequate sleep or insufficient quality of sleep. Hospitals and other healthcare facilities have been slow to adopt changes to prevent fatigue.

The Joint Commission offers a number of suggestions to reduce fatigue, including creating a fatigue management plan. Staff should be educated on sleep hygiene, which means getting enough sleep, taking naps, and practicing good sleep habits. Assess your schedules and make sure staff members have enough time between shifts to get adequate sleep.

Sources
ACGME duty hours 2011 standards. Available at www.acgme.org/acWebsite/dutyHours/dh_index.asp.
Social media: Patient friend and foe
What goes online, stays online

By now, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is well known to the healthcare community. Hospital staff and physicians have long been practicing a strict standard of patient privacy.

HIPAA was put in place for a number of reasons—to protect patients from extortion, abuse, embarrassment, discrimination, and pain and suffering. But it was enacted just as the Internet was beginning to become the force we now know it to be. Now, more and more hospitals are finding that they need to explicitly tell staff and physicians that HIPAA applies to the World Wide Web as well.

Anne Huben-Kearney, RN, BSN, MPA, CPHQ, CPHRM, likens social media sites like Twitter and Facebook to a virtual hospital elevator, implying that you never know who might step on and be listening. Huben-Kearney is vice president of risk management at ProMutual Group, which focuses on risk identification, management, and litigation in many types of healthcare settings.

Social media provides the opportunity to share at any time, and it creates a permanent record that cannot be erased. “It has to be clear to staff that they never stop being a nurse, physician, or hospital staff when it comes to patient privacy and confidentiality, even in off-hours,” says Huben-Kearney.

Dangers of social media

The permanent record created by social media can lead to repercussions for those who use it. For example, in April 2010, four staff members were fired and three were disciplined at St. Mary Medical Center in Long Beach, CA, after using social media to post pictures of a man on the brink of death who had been savagely stabbed several times. In addition to the obvious HIPAA violation, it can be argued that the staff neglected patient care because they were busy taking pictures and posting them rather than treating the patient.

This is an extreme example, says Huben-Kearney, but it proves a point. “Many of these concerns are already addressed within the patient rights and leadership standards.”

—Anne Huben-Kearney, RN, BSN, MPA, CPHQ, CPHRM

Patient privacy breached through social media

Hospital staff and physicians must understand the dangers and consequences of using social media. The following are a few specific example of clear HIPAA breaches through the use of social media over the past few years:

➤ In November 2008, nurses at a Fargo, ND–based healthcare system began using Facebook to provide unauthorized shift change updates to their coworkers. (Journal of AHIMA, January 6, 2010)

➤ In June 2010, five nurses were fired at Tri-City Medical Center in Oceanside, CA, after hospital managers discovered they had been discussing patients on Facebook. (Los Angeles Times, August 8, 2010)

➤ In April 2011, an emergency physician at Westerly Hospital in Charlestown, RI, was fired and had her medical privileges revoked after posting about a patient on Facebook. She did not include the patient’s name, but her post gave enough information for others in the community to identify the patient. (The Boston Globe, April 20, 2011)
She also warns that social media is not the place to communicate critical information about a patient. Such information needs to be subjected to rules such as appropriate abbreviation, and it needs to be documented—that means even closed communications such as texts aren’t a good idea. “It will impact patient care and safety,” says Huben-Kearney. “Just don’t do it.”

**Policies and training**

Social media policies should be clear, simple, and give examples.

“I think hospitals that are doing this well have a very short and succinct policy,” says Huben-Kearney. “Everyone who works at the hospital should sign the policy. If the policy is zero tolerance, it has to be clear and it has to apply to everyone.” Training should be given at orientation and should include real-life examples to help explain the importance of the policy, says Huben-Kearney.

Of course, the Internet can help as much, if not more, than it can hinder. Physicians can log into physician-only social media sites and discuss cases. Patients are given diagnoses and advice online all the time. Providers have begun to use programs like Skype™, a videoconferencing platform, to help diagnose stroke and other illnesses for which visual cues are often instrumental.

Because social media and new technology has the ability to both help and hurt, many hospitals and associations are giving guidance on how to use it appropriately. The AMA has released physician guidelines for social media, which can be found at [www.ama-assn.org](http://www.ama-assn.org). The guidelines suggest that physicians should maintain professional relationships with patients online, should not rely on privacy options on social media sites to protect them, and should call out colleagues who may be using social media inappropriately.

“I wouldn’t be surprised if, in time, The Joint Commission comes out with a Sentinel Event Alert on social media,” says Huben-Kearney. “But many of these concerns are already addressed within the patient rights and leadership standards.”

Whether social media is ever specifically addressed in Joint Commission standards, Huben-Kearney says the idea of being careful how and with whom you share information isn’t new.

“The concept isn’t new, it’s just that the vehicles for providing information have evolved,” she adds. “They’ve become more casual as well. It has an instantaneous and spontaneous nature.”

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**Social media helps treat, educate**

Social media certainly has its benefits when it comes to patient diagnosis, treatment, and education, although in the case of an online diagnosis, it can be difficult to determine whether information given was advice or treatment.

Still, social media can help providers share information and educate newcomers to the field. Here are a few examples:

- A pediatric nurse spotted a white glare in a toddler’s eye on a picture posted on Facebook, and warned the family that it could be a sign of eye cancer. The nurse’s suspicion was correct. ([Daily Mail](http://www.daily-mail.com), October 20, 2010)

- A 4-year-old boy’s picture was posted by his mother after she had taken him to the pediatrician. Three friends, one a physician, posted a diagnosis of Kawasaki disease and suggested she take him to the emergency department. The diagnosis was correct. ([Slate](http://www.slate.com), July 13, 2011)

- In February 2009, surgeons at Henry Ford Hospital in Detroit Tweeted a surgery live with the patient’s consent. Other physicians and medical students could follow the surgery. ([CNN](http://www.cnn.com), February 19, 2009)