Voice recording technology improves patient handoff process

When Kathleen Mikos, RN, MSN, CNO and vice president of patient care, came to Ingalls Memorial Hospital in Harvey, IL, she couldn’t shake the sense of déjà vu when she found that patient handoffs took an hour to 90 minutes to complete.

At her previous hospital, Mikos had dealt with a similar issue—performing patient handoffs took longer than it should have. The lengthy amount of time became an issue with incremental overtime and also got in the way of patient care.

“I was concerned because during a period of an hour, where so many nurses are tied up, who is taking care of the patients?” says Mikos.

Drawing on her past experience, in May 2008 Mikos began to develop a new, efficient method for patient handoffs that allowed for more patient-nurse interaction and reduced nurse overtime at Ingalls.

The old and the new

For years, nurses nationwide have used different methods for handling handoff reports. One technology was the use of taped records. This caused problems because if an interruption occurred while the nurse was reporting, the nurse had to make a note on the recorder where the tape left off, causing confusion later on.

There were also instances when the tape recorder broke or someone had recorded over a report, causing the nurses to take more time to rerecord each patient report.

“Between shifts, I can have up to 20 nurses tied up,” says Mikos. “Having that many nurses tied up, trying to get reports, cuts into the patient care.”
Patient handoffs

Much of the delay occurred because not all nurses shared the same patients. Mikos turned to The White Stone Group, Inc., for a technological solution to facilitate a new handoff process. This company provides healthcare organizations with software to help improve the management of healthcare communication events.

Having had experience with The White Stone Group in the past, Mikos was confident in setting up OptiVox, a voice technology program for handoffs, and made the program accessible to all staff members through any telephone in the hospital system.

Other similar programs that facilitate the patient handoff process include the PatientKeeper Sign-Out technology and Vocera’s communication systems. Physicians use the PatientKeeper program as a continuity of care tool and enter patient care details that the next shift’s physician will need. Vocera’s wireless devices enable instant communication among staff members.

Voice technology OptiVox

OptiVox is a computer-based voice platform technology that is built into the phone system, says Mikos. Nurses can dial into OptiVox and record their patient reports or listen to the patient reports from any phone in the health system.

Nurses coming off a shift and needing to report on their patients dial in an individual access code, pull up each patient’s medical record number, and begin recording a report on that patient.

In addition to using OptiVox to record their reports, the nurses are also encouraged to use the SBAR format. The SBAR technique helps guide communication between staff members on a patient’s condition.

To identify each patient in the system, Ingalls uses the patient’s medical record number to prevent confusion, says Mikos.

“You are always up against potential patient safety issues, and some patients may have the same name or date of birth, but medical record numbers are always going to be unique,” says Mikos.

When nurses arrive to start their shifts, they can access the reports from the previous shift the same way nurses record them. Using any phone in the health system, the nurse dials in with an individual access code and uses his or her patients’ medical record number in order to listen to the reports.

“To receive reports on five or six patients should take about 15–20 minutes of shift report time,” says Mikos.

Now, with extra time, the nurse can find the previous shift nurse to clear up any unanswered questions and visit his or her patients for brief assessments and introductions.

“Here at Ingalls, we believe there is a need for face-to-face, or bedside rounding,” says Mikos. “After the nurses [listen to the] handoff report, they should immediately
go out to their patients, introduce themselves, and have a brief discussion on how the previous shift went.”

**Advantages for the entire hospital**

OptiVox received a positive reaction from patients, nurses, and the management team, says Mikos.

For the nurses, there are features in OptiVox that help make recording and listening to the reports easier and more convenient than listening to a normal tape recording.

The program gives the nurses the option to slow down or speed up a recording if the nurse who recorded the report is a fast or slow talker.

In addition, OptiVox provides the capability for nurses to go back to where they left off if they were interrupted while recording any reports.

The program also allows managers and nurse leaders to leave a broadcast message there for all staff members to hear.

“Typically, if there is something of importance that I need to get out, I can have that message presented for as many shifts and days as I believe necessary to penetrate my staff,” says Mikos.

OptiVox is also beneficial to the nursing students that come through the Ingalls health system, says Mikos. The program allows the students to listen to reports and helps them become more acclimated to real-life situations, says Mikos.

Another benefit of this technology is that the records can be kept for any length of time, depending on how long the organization wants.

“We hold on to the records for two weeks,” says Mikos.

By keeping the records for this length of time, Ingalls ensures that in the event of a near miss or an error, the report is on file and can be listened to again.

**Involvement with other departments**

The OptiVox technology is also beneficial when it comes to patient throughput and alerting an area of the hospital to expect a patient from the ED, says Mikos.

Prior to implementing the technology, ED nurses had difficulty reaching nurses on other floors and units.

“We tried all sorts of things, from bringing the patient up to a certain floor to attempting to keep calling back and forth,” says Mikos.

Now, with OptiVox, when a nurse needs to transfer a patient from the ED to another unit, he or she simply voices the report into OptiVox and the system automatically sends a voice message to a designated unit telephone number. That patient’s report is then available for the receiving nurse.

The ED nurse also includes his or her name and telephone number in the event the receiving nurse has any questions.

“This has really taken away the bottlenecks that were created when giving reports,” says Mikos. “This gives us a precise process to user report and helps expedite the patients out.”

**Savings and positive thoughts**

One of Mikos’ goals when implementing the new technology was decreasing incremental overtime. “With the new process, we saw a great reduction in overtime,” she says. “And the savings helped pay for the technology.”

However, Mikos warns that there has to be a strong message sent from the leadership team about incremental overtime and backing the system.

“There are some nurses that aren’t so in tune with us managing incremental overtime,” says Mikos. “You have to monitor the time and send a message so no one resorts back to the old ways of recording incremental overtime.”

Overall, Ingalls staff members have been pleased with the new handoff process, and even the unit secretaries noted how much the noise level decreased, Mikos says.

Once, the halls were filled with nurses chattering, trying to catch up on reports. Now, the halls are noticeably more quiet because nurse-to-nurse communication for handoff reports has been replaced by telephones and computers, says Mikos. “The healing environment has improved tremendously.”

**Source**

Adapted from *Patient Safety Monitor (Briefings on Patient Safety)*, December 2009.
Patient flow

RapidView provides real-time snapshots of the facility, improves patient access

After reading this article, you will be able to:

➤ Identify departments that benefit from the RapidView system
➤ Recall the data collected by the RapidView system
➤ Explain how the RapidView system works

A small room just off the admissions area at Tufts Medical Center in Boston contains what many in the facility describe as the nerve center of the hospital. It looks like the bridge of the Starship Enterprise. Multiple plasma screen monitors blink with yellow, green, and blue squares.

Employees sit seated in front of the monitors, analyze the colors and icons as they enter new data into the computers below, and relay information to callers.

To the outside observer, the screens look like a bunch of flashing lights, but these screens are actually a snapshot of the entire facility. They are a part of Tufts' RapidView system, powered by McKesson's Horizon Enterprise Visibility™ solution.

RapidView isn't a tool that benefits just one department. The system helps improve every aspect of the facility, from housekeeping to employees to physicians.

"RapidView allows us to access timely, correct information so we can better align patient needs with our resources," says Terry Hudson-Jinks RN, MSN, vice president of patient care services at Tufts Medical Center.

Reading the board

This is where June Stark, RN, BSN, MEd, director of case management and quality support services at Tufts Medical Center starts her day—in the admission discharge transfer (ADT) center. With just a three- to five-minute scan of the screens, Stark can tell whether Tufts has enough discharges to meet the scheduled admissions.

“There is an art to it,” Stark says. “After a while you can just look at the screens and know if it’s going to be a busy day.”

Each screen in the ADT center represents a floor of the hospital and each square represents a room. The color of a room is based on what type of patient is occupying the bed—a green room means the patient is an inpatient, blue means the patient is receiving observation services, etc.

This morning Stark notices the squares on one floor are almost all solid green, which means discharge orders have not been written for those patients. She sends a page to the nurses and case managers on that floor telling them to make sure the latest data are in the system and to promote additional discharges.

When Stark checks the boards later in the day she hopes to see a few green and white striped squares where green squares appeared in the morning. Green and white striped squares mean a physician wrote a discharge order and a discharge is pending.

A striped square also displays how many minutes have passed since the physician wrote the order. This makes it easy to track how quickly patients are discharged after the physician writes the order.

Improving patient flow

RapidView system is partly a response to the Massachusetts mandate that EDs can no longer divert patients, says Melissa Culkins Bair, RN, MS, nursing director of the ADT Center at Tufts Medical Center.

“One of the reasons we came up with the bed board [RapidView] was so that we could improve patient flow because we couldn’t have the ED closing the door,” Culkins Bair says.

RapidView improves patient flow by providing up-to-the-minute information for healthcare professionals,
admitting staff members, and housekeeping staff members. Before RapidView, there was no mechanism to track such information.

“We worked in silos before centralizing patient access with RapidView. We didn’t always have up-to-date information on unit-based throughput, leaving us uninformed on the clinical priorities,” Culkins Bair says.

Electronic timers within the RapidView system keep track of everything.

For example, when staff members discharge a patient, this is communicated automatically by messages fed from clinical information systems to all employees by turning the green and white square brown, which means the room is dirty.

The housekeeping staff members and all other hospital employees on that floor see the brown square on one of the many LCD screens mounted in the common areas. Housekeeping goes to the brown room and signs in that he or she has begun cleaning. This turns the square brown and white and also starts the clock. Once finished, the crew member signs off that the room is clean and moves on to the next brown square.

This time-keeping feature makes staff members more accountable because it allows administrators to see how the patient moves along the continuum in real time. If it took three hours longer than expected to clean the room, managers can investigate the reason for the delay and take steps to improve the process.

RapidView also makes the ADT Center staff members’ job a lot easier. With a scan of the screens, they can determine whether the hospital has any open beds, when beds will be open, whether a patient has an infectious disease, along with other patient information.

“The key to RapidView is that it is correct and it is timely,” says Hudson-Jinks. “Because the variables keep changing minute to minute, your information cannot be 20 minutes old.”

According to Hudson-Jinks, this access to timely information allowed Tufts to lower length of stay, treat more patients in 2009, and turn away fewer patients in acute need from surrounding communities.

Improving patient quality

“The thing that makes this system different is that it’s not just a bed tracking system. It has clinical features,” Culkins Bair says.

RapidView allows the medical staff to get an idea of the patient’s case at a glance. For example, if the patient is on fall precaution, deidentified text appears on the screen that communicates this information to healthcare professionals. Healthcare professionals see this information on their floor’s screen.

Icons also help healthcare professionals track where a patient is in the facility. If a patient is in radiology for testing, an icon appears on his or her room, and a timer starts. This way, staff members can tell family, visitors, and other healthcare professionals where the patient is and when he or she is expected to return.

There are also icons that appear to tell healthcare professionals that lab work has come back. A trained observer can even tell whether the results were normal or abnormal based on the icon’s color.

In addition, RapidView has changed the way Tufts structures its ADT process. An RN works alongside an ADT Center staff member to ensure that patients are placed properly on the front end according to their condition.

Saving time

The RapidView system is also saving the Tufts staff a lot of time. The ADT Center staff no longer needs to make as many calls to each floor asking how many discharges are expected for the day or how many beds are available.

“Before, we relied on too many people to call and tell us information, whereas now, the information comes to us,” says Hudson-Jinks.

As a result, the hospital’s processes are streamlined and that in turn allows staff members to handle high volumes with relative ease.

Source
Adapted from Case Management Monthly, January 2010.
Mentoring

Developing the next generation of leaders

Mentor programs promote both individual and organizational growth and development

It takes a special person to be a mentor. It takes time, energy, and commitment. “I became a mentor from a desire to see other people grow and develop and to assist them to do just that,” says Barbara Brunt, MA, MN, RN-BC, NE-BC, director of nursing education and staff development at the Summa Health System in Akron, OH.

Brunt has been recognized nationally for her ability to mentor others. She is a recipient of the National Nursing Staff Development Organization’s Outstanding Mentor Award, which is given to recognize the dedication and commitment of a nurse to mentoring other nurses and assisting with their professional development. She has also served as a mentor for her organization’s Mentoring Aspiring Professionals (MAP) program.

Before Brunt discusses MAP, it will be helpful to differentiate between a preceptor program and a mentor program. Some organizations use the terms interchangeably, and this can become a real problem for the organization and employees alike.

Differences between preceptors and mentors

There are some similarities between preceptors and mentors. Both need to have a sincere desire to help their colleagues succeed. Both need a strong commitment to their organization and to their colleagues. And both require some training and education to be successful in these roles.

However, the types of training and education required differ. The figure describing characteristics of preceptors and mentors on p. 8 outlines these differences.

Preceptors need job expertise because their role is to accomplish specific, measurable tasks in a certain amount of time. The objective is usually to facilitate the successful orientation of people to their new job and role responsibilities.

In order to do this, preceptors must comprehend and implement the principles of adult learning, evaluate orientees’ job performance, and offer and receive constructive criticism.

The objective of a mentoring relationship is to facilitate professional growth and development. Mentors must also be leaders who are willing to help others advance in their chosen career path.

Mentors must be knowledgeable about resources for such advancement and be able to act as objective sounding boards.

The preceptor relationship has a definite, fixed beginning and end, whereas the mentor relationship is more fluid. It is of indefinite length and has no clearly expected conclusion.

Authority is another important difference. Preceptors are authority figures who have input into the success or failure of orientees.

Mentors function as facilitators who have no formal authority over those who are being mentored. Mentors work to help people realize their career potential.

This type of relationship can be invaluable to an organization that wants to groom leaders who will contribute

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to organizational success. Such organizations establish a mentor program for the specific purpose of identifying employees who possess leadership potential and helping them develop this potential.

**Identifying future leaders**

Summa Health System’s MAP program is a “leadership development program for employees who possess leadership potential and want to prepare themselves to compete for management positions within the organization,” says Brunt.

The program is open to employees from all departments, not just clinical areas. Those who want to be mentored (referred to as protégés) must make a formal application for acceptance into MAP. They must have been an employee for at least three consecutive years working full-time or on a regular part-time basis.

Applicants must possess a bachelor’s degree or be enrolled in a bachelor’s degree program. They must not have received any disciplinary actions on file for the six months prior to application and must not have received a rating of “needs improvement” or “does not meet some expectations” on their most recent performance evaluations.

Brunt explains that MAP was born as the result of senior management’s belief that there was a need to identify persons within the organization who have leadership potential and a desire to offer such employees opportunities to enhance their leadership potential.

**Setting goals**

Selected protégés must commit to a year of being mentored. Applicants may request a specific mentor or be assigned to a mentor who best complements the protégé’s goals as identified on the application.

It is expected that the mentor and protégé have at least monthly meetings at times and places convenient to both.

They jointly determine goals and experiences that will help the protégé achieve those goals.

Summa offers quarterly educational lunch meetings.

Education topics are selected based on protégé and mentor input. Examples of classes include panel discussions with senior management staff and discussions pertaining to quality improvement. Protégés also have the opportunity to attend the organization’s leadership institute classes.

At the conclusion of the 12-month mentorship process, there is a graduation ceremony with formal acknowledgment of the work accomplished by mentors and protégés.

Although the formal mentorship process concludes with the graduation ceremony, mentors and protégés may choose to continue with the mentorship process.

**Professional growth**

Brunt mentored a nurse who was in the process of exploring various career options and roles and who was currently working as an obstetrics case manager.

As part of their mentorship process, she and Brunt worked on writing an article about their organization’s case management program.

Brunt is pleased to note that the article has been accepted for publication in a professional journal.

“These kinds of successes, where you can actually ‘see’ that mentoring made a difference, is one of the key ingredients to organizational success. Such organizations establish a mentor program for the specific purpose of identifying employees who possess leadership potential and helping them develop this potential.”

—Barbara Brunt, MA, MN, RN-BC, NE-BC

> continued on p. 8

**Online access to nursing CE quizzes**

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true rewards of participating in the mentoring process,” she says.

Mentor and preceptor programs, although different, both have the potential to enhance individual professional growth and development as well as organizational success. It is important to differentiate between the two.

Some mentorships occur naturally and informally. Others, such as those initiated by Summa Health System’s MAP program, are more formally planned and implemented, with a definite purpose and even a proposed (although not required) conclusion.

The important point is that mentorships can and should be rewarding for mentors and those who are being mentored.

The outcomes can be professionally exciting not only for the mentor and protégé, but for the entire organization.

If your organization is looking for ways to facilitate professional growth and development with a desired outcome of improved organizational outcomes, consider developing and implementing your own mentor program.

Reference


Source

Adapted from The Staff Educator, January 2010.

Questions? Comments? Ideas?

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Characteristics of preceptors and mentors

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Preceptor</th>
<th>Mentor</th>
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<tbody>
<tr>
<td>Objective</td>
<td>Facilitate successful orientation</td>
<td>Facilitate professional growth and development</td>
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<tr>
<td>Education and training</td>
<td>➤ Job expertise</td>
<td>➤ Job expertise</td>
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<td></td>
<td>➤ Principles of adult learning</td>
<td>➤ Leadership expertise</td>
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<td></td>
<td>➤ Evaluate against a set of measurable criteria</td>
<td>➤ Provide opportunities to facilitate professional growth and development</td>
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<td></td>
<td>➤ Offer and receive constructive criticism</td>
<td>➤ Serve as a sounding board</td>
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<td></td>
<td>➤ Supervisory training</td>
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<tr>
<td>Length of commitment</td>
<td>Relatively brief, fixed time period</td>
<td>Open-ended relationship, generally without a fixed conclusion</td>
</tr>
<tr>
<td>Authority</td>
<td>Preceptor is an authority figure who has influence over the success or failure of the orientee</td>
<td>Mentors generally act as peers who have no formal authority over those who they mentor; they are facilitators, not authority figures</td>
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Source: Adrianne E. Avillion, DEd, RN.
FDA warning forces alternative sterilization methods

STERIS problem is one of many worries for ASCs preparing for CMS and accreditation surveys

On December 3, 2009, the FDA issued a safety alert to healthcare providers concerning adverse reports from users of the STERIS System 1 (SS1) processing system, a device most commonly used for surgical and endoscopy equipment disinfection. The FDA advised healthcare facilities using the device to find an alternative method and transition to that alternative as soon as possible to ensure patient safety. If facilities cannot find an acceptable alternative, steps should be taken to obtain legally marketed substitutes for the SS1.

More than 23,000 SS1 units have been used safely in more than 5,000 hospitals and other healthcare facilities, sterilizing approximately 30,000 medical devices per day, according to a STERIS press release.

“STERIS Corporation has significantly modified the SS1, and FDA has not approved or cleared this modified product. Thus, FDA has not determined whether the SS1 is safe or effective for its labeled claims, including claims that it sterilizes medical devices,” according to the alert.

On an FDA conference call December 10, 2009, FDA representatives said that facilities would be expected to find an alternative within three to six months, says Rose Seavey, RN, BS, MBA, CNOR, CRCST, CSPDT, president and CEO of Seavey Healthcare Consulting, Inc., in Arvada, CO.

“My feeling with all of this is if there is a silver lining in regards to this STERIS System 1 issue, and also the FDA’s issue on steam sterilization and CMS’ focus on infection control and surgical instrument reprocessing in ambulatory surgery centers [ASC], is that finally the spotlight is being put on surgical instrument reprocessing and the need to clean,” Seavey says.

What you need to do now

Seavey says she has seen a few types of reactions to this warning. Initially, some people panicked. They wanted to stop surgeries and treat it as an emergency.

Then there is another group of professionals that is methodically looking at what devices they have, what alternatives are available to them, collecting manufacturers’ written instructions for verification, and adjusting patient schedules to accommodate the necessary adjustments.

Seavey says healthcare professionals in charge of sterilization at their facility should be in the latter group.

The warning is not a reason to panic, rather to reevaluate your processes if you are using the STERIS system.

“Over the years, I have heard many ambulatory surgery people say they like this because you don’t have to wrap,” Seavey says. “But it’s still a liquid unwrapped device afterwards, so really it’s equivalent to a flash sterilizer.”

Rescheduling patients

One thing many ASCs can take advantage of is the ability to reschedule noncritical patients.

Many facilities may be under pressure because alternative disinfection methods take longer to reprocess and patients are scheduled back-to-back, or the facility has limited equipment.

“Don’t schedule 20 eye patients in one day if you only have two sets of instruments,” Seavey says. “Or you could schedule other cases in between that don’t use that specific set so you have enough time to turn it around. It’s all about the patient; it’s not about the bottom line.”

Source
Adapted from Briefings on Infection Control, February 2010.
More than 90% of companies have instituted some form of cutbacks of late and, as a result, employee morale, motivation, and productivity have dropped precipitously.

In a recent survey of 1,400 CFOs from U.S. companies with 20 or more employees, the staffing giant Accountemps asked: “Which of the following has the most negative impact on employee morale?”

The results:
- Lack of honest communication: 33%
- Failure to recognize employee achievement: 19%
- Micromanaging employees: 17%
- Excessive workloads for extended periods: 16%
- Fear of job loss: 14%

They followed up by asking executives: “In your opinion, which is the best remedy for low morale?” The executives’ responses:
- Communication: 48%
- Recognition programs: 19%
- Monetary rewards for exceptional performance: 13%
- Unexpected rewards: 11%
- Teambuilding events or meetings: 3%
- Additional days off: 3%

The following ideas discuss how some of the elements cited by the respondents can be more readily implemented in your workplace:

**Communication.** The most important tool for improving employee morale and motivation is communication. Employees need information about their jobs, but they also want to know more, such as what’s going on in the organization. These times demand more communication on a personal level from managers.

**Recognition programs.** Companies need to make a concerted effort to raise the awareness of managers as to why employee recognition is more critical than ever. They need to understand why employees expect to be recognized for their good work, how that recognition can further drive the goals of the organization, and what their roles are in making recognition happen.

**Unexpected rewards.** Most people think spontaneity means acting without planning, yet it is very possible to plan for spontaneity. For example, have the resources ready for spontaneous recognition: eCards for Starbucks or Amazon, party supplies, confetti, balloons. Host an ice-cream social, a pancake breakfast, a barbeque, or bring in a pizza.

**Teambuilding events or meetings.** A sure way to build morale is to spend time together. Doing a group activity that is fun, such as a field trip, attending a professional conference together, or getting “behind the scenes” passes to entertainment events, can all go a long way. If your group doesn’t respond well to doing a team activity, start afresh and challenge the group to come up with something new, fun, and creative.

**Additional days off.** Don’t overlook the use of time itself as a form of reward. This is an excellent option when more costly forms of recognition and reward are less available due to budget constraints. Work with leadership and HR to develop a policy. Perhaps an additional day off could be a reward for a project completed or outstanding performance.

Editor’s note: Bob Nelson, PhD, is president of Nelson Motivation, Inc. He is a frequent presenter to management groups, conferences, and events, and a best-selling author of 1001 Ways to Reward Employees. His latest book, Keeping Up in a Down Economy: What the Best Companies Do to Get Results in Tough Times, from which this column is drawn, is available from Amazon.com, BarnesandNoble.com, or your favorite bookstore. For more information, visit www.KeepingUpBook.com.
**Accreditation**

**Simplifying medication storage**

In November 2006, CMS changed its requirement for security of medications, stating that nonscheduled drugs must be stored in a secure area and locked when appropriate. All schedule II through V drugs must be locked in a secure area. CMS defined a “secure area” as one in which medications are stored to prevent “unmonitored access by unauthorized individuals.”

CMS also states that medications cannot be stored in areas that are readily accessible to unauthorized individuals. This means that areas restricted to authorized personnel are generally considered “secure areas” under the Conditions of Participation (CoP).

The Interpretive Guidelines provide examples of “secure areas,” highlighting areas that are staffed around the clock with entry and exit limited to appropriate staff and authorized, supervised visitors. These types of secure units include labor and delivery suites and critical care. In its April update to the 2009 standards, The Joint Commission aligned itself with CMS, allowing for medication storage to fall under the “secure” definition as outlined by CMS.

**What you can do**

If a secure area is defined as one that prevents unmonitored access by unauthorized individuals, then who are “authorized’ individuals? In accordance with state and local law, a hospital can determine who has access to secured areas of medications. Organizations do have the flexibility to determine what personnel can have “authorized” access and must describe these categories of individuals in its policies. Policies should note how authorized personnel are defined as related to access of these locked areas. Consider identifying how authorized personnel function by including this language in written job descriptions.

**Make it work for you**

These relaxed requirements can work for you by educating your staff and ensuring that all scheduled drugs (i.e., basically narcotics and other controlled substances) are kept locked. Unless your state regulations differ, “double locking” scheduled medications is not required by either CMS or The Joint Commission. The CoP mandate that all scheduled (i.e., controlled) medications remain locked.

Assess the various medication storage areas on patient care units and determine whether there is constant supervision and authorized access. If so, you don’t have to lock up those drugs. Normal saline, antibiotics, or other nonscheduled medications can be stored in a cabinet, shelf, or open rack, provided that area is under supervision at all times. If not, lock them up.

**Invest the time**

Review current policies and procedures governing the security of drugs and biologicals for your staff. Don’t underestimating the value of talking to staff members, obtaining their input, and observing daily practice in the patient care and procedural areas.

Use this discussion to determine the following:

- How well is the policy understood and executed?
- Does it meet the current clinical and operational needs of patients and staff members?
- Does it define authorized access and contain categories of staff that represent “authorized” access?
- Are medications stored within the line of sight of the staff? Are the medications still secure when staff leave the area? Do visitors have unsupervised access?

Discussion and observation also serves to identify additional educational training needs of staff. Remember that drug security is an essential element to patient safety.

*Editor’s note: Laure Dudley, RN, MS, is a consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.*

*Source*

Adapted from Briefings on The Joint Commission, January 2010.
No manager wants to terminate an employee, but sometimes performance issues require you do so. As a manager, you must determine what behavior you will and will not tolerate. Define specific standards to which you will hold staff members accountable. These should mimic standards already detailed in the mission statement or the employee handbook materials.

If you end up in a situation in which you have to terminate an employee, the following are a few tips to consider:

➤ Never terminate an employee unless you can do so face to face; however, there may occasionally be extenuating circumstances if an employee simply does not show up.

➤ Consider the need to have a witness present for the termination notification meeting. This can be another manager or someone from HR.

➤ Keep it short. If you have been documenting the employee’s performance and providing feedback all along, there is no need to repeat details from previous encounters when you have the conversation to terminate the employee. Stick to the point and say something such as, “You and I have previously discussed the specifics of your performance issues. We are terminating your employment due to your inability to meet the standards of this organization.”

Source
Shelley Cohen, RN, MSN, CEN, Health Resources Unlimited, www.hru.net. Adapted with permission.