JCAHO’s emergency department overcrowding recommendations

Recently, the problem of emergency department (ED) overcrowding has become a growing issue. More and more EDs do not have enough beds or staff available for the patients they receive. Some EDs are now finding that they have to turn patients away. In an effort to help reduce ED overcrowding, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) released some new recommendations.

During an audioconference presented by Medical Staff Briefing, Richard Kaine, MD, director of consulting services for Quality Management Resources, Ltd, Seth Guterman, MD, and Jim Smith, senior consultant, certified health care access manager, discussed ED overcrowding and presented some solutions for implementing JCAHO’s recommendations.

The results of a survey performed by the American Hospital Association found that “a majority of EDs perceive they are ‘at’ or ‘over’ operating capacity.” One third of hospitals also claimed they experience times of ED diversion, meaning there are periods of time when they cannot accept some or all patients.

Combating ED overload
The three main factors sited as having the greatest impact on ED overload are in-hospital bed assignment, inadequate staffing, and lack of a real-time communication system.

Although these problems are not easily resolved, the following solutions may help increase ED patient flow.

Bed assignments
In many hospitals, there are beds available for patients, but the facilities don’t have enough staff coverage. Often the necessary staff is available, but the hospital is not willing to pay them.

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JCAHO recommendations

Therefore, nurses are delayed in tending to new patients because they are chronically managing old ones.

Another common problem is the number of people involved in locating a bed for the patient. If a staff member is out sick or unavailable, the delay can stretch even longer. For example, to order a bed for a patient, the triage staff has to call the unit nurse, who has to make sure there is a room available. Then the unit nurse has to see whether an attending nurse is available. If a room is available cleaning staff have to be called to prepare it. If the head of the cleaning staff misses the call, the room does not get cleaned and must be cleaned by the ED nurses. The entire process can be delayed on all sides.

One solution to this problem is to preassign beds. Most hospitals know how many beds they can expect to use on a daily basis, says Guterman. This will cut out the time it takes to request a bed. Encourage staff to focus on faster bed assignments and to move patients to empty beds in the intensive care unit (ICU) instead of the ED. Discharging patients in the morning instead of the evening will also open more beds.

ED staffing

If one nurse calls in sick, the work force is depleted by 20%. However, since nurses do not get paid for sick days, they are often encouraged to take them—even if they aren’t sick. When one person is out sick, someone else has to fill in. In some cases, no one on staff is trained to do what the missing nurse does, leaving a large gap in work flow.

The greatest step in improving staff is to develop a system that eliminates advising sick calls, says Guterman. Instead, encourage staff to improve productivity by offering them some incentives such as higher wages or rewards for increasing ED patient flow.

Another way to improve the adequacy of staff is to cross-train all employees. In the event that a nurse is out sick, the other staff members can accommodate for the absent person.

Real time communication

While relying on verbal communication works well in a surgery or ICU setting, it is no longer acceptable in the ED. Handwritten charts are also an outdated and insufficient means of communication.

These two forms of communication cause large delays. For example, nurses have to wait to find out if a room is open, which can take much longer than necessary. Handwritten charts do not provide real-time information about patients and blood tests can often be delayed. In many cases the doctor’s handwritten orders are illegible to the nurse, which can cause the nurse to wait for his return and often move on to other patients in the interim.

The best way to improve communication and increase patient flow is to redesign the system and use electronic technology. According to Guterman, by entering all of a patient’s clinical information into a computer system, the computers do all of the work and the information is shared throughout the entire ED. By accessing all of the patient’s records on a computer, nurses no longer have to waste time walking around to get the information they need.

Adding computer technology is expensive, but the number of patients lost each year due to ED diversion has a much greater financial impact. The ED is a big money-maker, and every administrative loss is a $3,000 decline in collections, which easily adds up to millions of dollars. One way to save money while upgrading your ED is to create a system specially designed for your hospital.

Stop patient cruelty

ED overcrowding is a problem for everyone involved. Staff is overworked and put under excess stress and patients have to wait longer to receive care. Making these recommended changes and improvements may seem very time-consuming and costly, says Guterman. However, the final outcome will definitely benefit both your ED staff members and patients.
How do you bring a group of people together and create a team? Even when everyone is from the same discipline, it doesn’t happen on its own. Imagine how difficult the process becomes when people from different disciplines come together.

You always begin with a group of people, and you want to finish with a team. They are not the same thing.

The tools that can be used for team-building with the group that designs the process are the same tools that can be used for team-building at the unit level.

1. **Every team needs a coach.** Your goal as the team leader is to bring out the best in each team member. The leader serves as the coach, recognizing and developing the strength of each member.

2. **State your mission.** Do so in clear, measurable, and achievable terms so everyone understands. Sharing a common goal is the blueprint that guides all teams. Don’t be afraid to say what you think.

3. **Communicate your plan.** Once you’ve established your goal, plan how you will carry out your mission. It is important to include everyone in the planning.

4. **Never leave your wingman behind.** Just as pilots always have a wingman to support them, your team members need to have one, too. This requires that each team member know something about the other members’ roles. Such knowledge provides team members with a sense of shared responsibility and kinship.

5. **Embrace cultural differences.** Understanding and respecting cultural differences is very important in team building. Convey a sense of respect and contribution recognition to all team members equally.

6. **Accept individual responsibility.** When you commit to completing a task for the team, it’s up to you to guarantee it’s done—your team members are counting on you.

*Editor’s note: The above excerpt is from a new book by Brenda Gail Summers, MBA/MHA, MSN, RN, CNA, a senior consultant with The Greeley Company, who has been assisting clients in preparation for Joint Commission on Accreditation of Healthcare Organizations surveys since 1997. The book, Interdisciplinary Patient Care: Building Teams and Improving Outcomes, is published by HCPro, Inc.*

It is critical to the success of interdisciplinary care planning and delivery that all members of the clinical team involved in the care of a patient work as a team. If not, the process is doomed to fail.

Sounds easy, right? It’s not.

The primary roadblock to the process working effectively in your facility is that, often, the people who developed the process were never a team themselves, so the end result of their efforts is a product, rather than an interdisciplinary team process design.

Coping

Keep stress low for tidings of comfort and joy

Are you starting to consider how many overtime shifts you’ll need to work in order to have enough money for all of your purchases? Try these 10 steps for creating a magical holiday season. Share them with your nursing team by posting them on a bulletin board. You can also leave cards for people to post their own suggestions.

1. Imagine your perfect holiday. Who would you spend time with? Would you cook, go out, or carry out? Also, consider what you want the holidays to mean to you.

2. Do only those things that you really enjoy. Limit the amount of time you spend doing the less-than-pleasant things—you do have a choice.

3. Create new traditions that feel good. Let everyone know that this year you will be creating a new tradition.

4. Consider volunteer activities. Assist at a soup kitchen alone or as a family project. The best way to add meaning to the holidays is to do something for those less fortunate.

5. Communicate with your family, friends, and coworkers. Ask about their ideal holiday. Consider foregoing gifts this year and instead arrange to spend quality time together.

6. Plan ahead. Plan in advance by creating a list of the things you may need for your holiday. The more organized you are, the less stressed you’ll be.

7. Create a budget. Write down the total amount of money you want to spend. Create a gift list indicating how much to spend for each person. If you don’t have money to spend, consider baking or crafting your gifts.

8. Stay within your limit. Closely watch each dollar you spend. Keep track of all expenditures by creating a simple spreadsheet.

9. Limit your use of credit cards. Use cash for your purchases—you’ll be less likely to overspend.

10. Keep it simple. The holidays need not be complicated and overwhelming. If you feel yourself getting stressed, look for the source of your physical or emotional resistance.


Illustration by Carl Elbing

Questions? Comments? Ideas?

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**Best practices**

### Clarian Health takes on the ‘Synergy Model’

Clarian Health Partners, in Indianapolis, which includes Methodist Hospital, Riley Hospital for Children, and Indiana University Hospital, recently became the first health care system in the country to implement the “Synergy Model” across its system. Clarian wants nurses to sharpen their focus on patients, and it will reward those who do so under this new model of nursing practice.

The new practice model takes into consideration two sides of nursing—patient care and mentoring, according to Ramon Lavandero of the American Association of Critical-Care Nurses, who worked with Clarian to develop it.

The patient side involves more closely matching a nurse’s strengths with patient needs, Lavandero said. Many hospitals currently assign nurses based on factors such as who is on duty and who cared for a patient the last time around, Lavandero noted.

Under the synergy model, for example, a nurse, who is adept at handling complicated cases will receive those cases, and a nurse who excels at providing patient and family education will be assigned to do so.

Clarian now ties advancement to how well a nurse’s patients do and how much teaching responsibility that nurse wants to handle, said Lydia Ostermeier McCullough, the system’s director of nurse recruitment, retention and work force development.

*Source: Adapted from, Nurse.com, www.nurse.com.*

### Sutter Health counteracts chronic nurse shortages

In the midst of a chronic nursing shortage, Sutter Health in Sacramento, CA, has made great strides in recruiting qualified nurses throughout its not-for-profit network of community-based hospitals and physician organizations.

Through the first half of this year, Sutter already had hired 920 new registered nurses (RN). Sutter also reports that systemwide RN retention rates are better than the statewide average.

This means that many of the RN new hires are filling vacant positions.

Sutter Health credits these recruitment and retention gains to a comprehensive, systemwide strategy that involves expanding education and training programs, improving salaries and benefits, and making a multi-million-dollar investment in patient safety technologies that help nurses do their jobs.

Sutter Health is leading the country with a $50 million investment in the high-tech tools nurses want to help ensure safer medication delivery and improve patient outcomes in critical care units.

Despite these gains in nurse recruitment, Sutter officials acknowledge that much more needs to be done to meet the state’s new nurse-staffing requirements and to address the nationwide shortage of nurses.

Over the next decade, Sutter Health will spend at least $3.5 billion to upgrade or replace aging hospitals, as well as to construct much-needed physician care centers.

*Source: Adapted from: Sutter Health, Sacramento, CA. www.sutterhealth.org.*
Installing a modern computerized medical information management system in hospital intensive care units can significantly reduce the time spent by intensive care unit (ICU) nurses on documentation, giving them more time for direct patient care, says a case study partially funded by the Agency for Healthcare Research and Quality (AHRQ). These systems use Windows NT as the operating system for bedside workstations and servers, use a relational database to store and manipulate data, and have improved graphics and user interfaces.

A research nurse observed ICU care and recorded all of the tasks performed by ICU nurses before and after installation of the information system in a 10-bed surgical ICU at a Veterans Affairs medical center. The results showed a decrease in the time spent on documentation from 35.1% of the nurses’ time to 24.2%. This translates into saving 52 minutes in an eight-hour shift, or more than one hour in a 12-hour shift. In addition, the number of times nurses interrupted other tasks to document care decreased from eight times to less than three times per hour—thus enabling them to complete more tasks without interruption.

At the same time, researchers documented an increase in time spent on direct patient care from 31% of nurses’ time to 40% of their time. Time spent on patient assessment, considered a critical part of direct patient care, more than doubled to 9% of their total time.

“This adds to the growing body of evidence that information technology can greatly improve the efficiency, effectiveness, and quality of health care delivery,” said AHRQ Director Carolyn M. Clancy, MD. “We are committed to supporting and encouraging the adoption of information technology by health care providers and institutions.”

“Electronic information management systems similar to the one studied could be expected to reduce the amount of nurses’ time spent on documentation tasks in similar ICU settings, after appropriate training,” said the study’s lead author, David Wong, MD, of the Veterans’ Affairs Long Beach Healthcare System.

“Electronic information management systems would then allow ICU nurses to spend a greater proportion of their time providing direct patient care.”

*Editor’s note: The study, “Changes in ICU nurse activity after installation of a third generation ICU information system,” is published in the October Critical Care Medicine.*

Interim staffing. However, during this current nursing shortage, it is necessary to make the very best of the situation, stretch your dollar a little further, increase productivity, and tap into the potential that exists.


Managing right

Keep productivity high: Impart info on interim nurses

Hiring interim nurses can be challenging enough without having to worry about their productivity. Here are some suggestions on how you can increase the productivity of your interim nurses and now to help your staff foster quality working relationships with agencies that supply your employees.

Insist that each newly assigned interim nurse come in early for a brief one-on-one orientation with you or the charge nurse on the unit he or she will be assigned. In this orientation, be sure to do the following:

• Include a checklist of documentation expectations and requirements.
• Give a brief, informative tour of the unit. In the process, point out special cases and show the nurse where the treatment cart, glucometer, pulse oximeter, blood pressure cuffs, oxygen supplies, and all others are kept.
• Tell the new staff member how many nursing assistants he or she will have working with him or her, and what special duties they are able to carry out.
• Show him where the break room, staff bathroom, and pay phone are located.
• Point out fire extinguishers and alarms.
• Share the on-call telephone number list, and procedures for contacting the on-call nursing coverage.
• Instruct your own nurses to give thorough and thoughtful reports that include all patients’ diagnoses and special precautions, patients with tube feeding schedules, and so forth.
• Be hospitable to your interim staff. They are there to help and want to do a good job for you. Greet them with a smile and a handshake.
• Be grateful for a fresh set of eyes. Interim nurses often spot transcription errors, medication conflicts, signs, and symptoms because they are on alert, scanning their new environment while preparing for the task at hand.

Understandably, no health care facility likes to use interim staffing. However, during this current nursing shortage, it is necessary to make the very best of the situation, stretch your dollar a little further, increase productivity, and tap into the potential that exists.


Save the date

The new 2004 JCAHO survey process is just around the corner. On Friday, December 12, prepare your leaders—in just 90 minutes with step-by-step best practices and strategies from nationally acclaimed JCAHO survey prep experts.

The JCAHO’s 2004 survey process places considerably different demands and expectations on your hospital leaders than in past years. Like never before, surveyors will examine your leadership decisions and priorities, and the care your staff delivers—how they diagnosis, manage, and treat your patients, and how they document every facet of a patient’s experience.

During this 90-minute audioconference, you’ll receive the step-by-step advice and tools that you need to get your leaders up to speed on the survey changes and ready to take on their new responsibilities. You’ll learn how central leadership is to the 2004 survey process and you’ll know and understand the new roles of administrators, clinical leaders, and physicians.

For more information, go to www.hcmarketplace.com/Prod.cfm?id=2182.
Legal matters

ANA holds fast to the old focus of the FLSA

The American Nurses Association (ANA) and its constituent members were outspoken opponents of the proposed Department of Labor (DOL) changes to the Fair Labor Standards Act (FLSA), which would have revised overtime protections, citing concerns about the impact on nurses as well as their patients. ANA believes that under the new rules, employers would increase the dangerous practice of forced overtime for nurses since they would not be required to compensate them at time-and-a-half. In addition, such changes would further erode nurses' working conditions, exacerbating an already growing shortage of nurses.

ANA also expressed concerns about the redefinition of a “learned” professional. Learned professionals are presently exempt if they exercise discretion and independent judgment and perform office or non-manual work which requires knowledge of an advanced type in a field of science. This new definition will add many health care workers, including registered nurses, to the learned professional exempt category.

In October, the U.S. House of Representatives voted in support of a non-binding motion instructing House-Senate conferees to block a proposed DOL change to FLSA.

Although the House vote is nonbinding, it does provide instruction to the conference committee, which will be meeting to finalize the bill.

Despite consensus from the House and Senate on this issue, President Bush has announced that he would veto the Labor-Health and Human Services appropriations bill if it includes an amendment to bar implementation of the proposed FLSA revisions.

Source: Adapted from, ANA, www.nursingworld.org.

Safety

Overweight patients make for oversized equipment

To help nurses prevent injury and safely care for obese patients, more facilities are heeding the call for specialized bariatric equipment and lift teams. When it comes to back-injury risk, nurses aides and assistants rank the highest and registered nurses (RNs), licensed practical nurses (LPNs), health aides, and physical therapists are also high on the list, according to the Bureau of Labor Statistics.

The problem is that the nation’s population is getting heavier, and the added weight puts a strain on hospital systems that must install special beds, lifts, scales, wheelchairs and other equipment to accommodate the needs of the obese.

Remember the following equipment:
- Oversized bed, chair, toilet and access to an overhead mechanical lift
- Pressurized beds that rotate allow for a patient not to be physically turned and helps redistribute weight to prevent skin breakdown
- Mechanized beds help move heavy patients from a prone to an upright position
- Coordinate a “lift team” to handle patients weighing more than 250 lbs

“If the use of lift teams can prevent two or three staff injuries, this can save a significant amount of money,” said Dale Thompson, a workplace safety expert with Kaiser Permanente’s Southern California region. “The equipment is expensive, but it lasts for years.” Bulk up bariatric equipment to accommodate overweight patients.

Source: Adapted from, Nurse Week News, www.nurseweek.
Nursing assessment tests

The National League for Nursing (NLN) recently announced a new policy for nursing professional assessment, offering its practice assessment series (PAS) nurse-testing program only to point of health care delivery institutions (e.g., hospital systems and nursing facilities).

The tests, the profession’s leading standard for assessing nursing proficiency, will no longer be available for direct purchase and use by nursing recruitment agencies for their applicants.

Going forward, only hospitals and other health care institutions will be authorized by NLN to purchase and conduct PAS tests. NLN said it would honor existing agreements with staffing agencies until they expire, but will not offer renewals. NLN’s policy change is a response to discoveries of illegal copying, scoring irregularities and misadministration of the tests by a number of staffing agencies not following specified testing procedures.

The tests, which cost $6.50, are available through a secure online site. They are designed to assess nurses’ clinical knowledge and the use of medication in different settings including coronary care, emergency, maternity/child health, community-based home care, mental health and medical/surgical.


Legal matters

Documentation can prevent future litigation

How your staff documents the care they provide could prevent a future lawsuit at your facility—by providing the appropriate services.

Remind your staff to document the following information, adapted from HCPRO’s new book, Defensive Documentation for Long-Term Care: Strategies for creating a more lawsuit-proof resident record:

- Resident and family education
  Nurses educate all day long, but often forget that the educational efforts need to be recorded. A resident who is resistant to care and treatment must be made aware of the potential consequences of the refusal. If the resident is confused or deemed incompetent regarding decisions, the teaching must also involve the responsible party and be documented.

- Conversations with family
  This type of entry may be used to refute allegations that family members were not kept informed of treatment decisions or changes in the resident’s condition.

  For example, a visit can be noted effectively as, “Family visited from 8 p.m. to 9 p.m. Explained the need for IVs and antibiotics due to resident not drinking sufficient fluids and recent upper respiratory infection. Daughter Karen stated she understood.”

Source: Adapted from Briefings on Long-Term Care Regulations, www.hcmarketplace.com.

- Cues and redirection of the resident
  A great deal of supervision and monitoring that occurs each day is not captured in the resident’s record. Consider phrases such as, “Mr. Jones, the dining room is this way,” and “Let’s go lie down for a while Mrs. Smith.” Capturing these interactions will assist in defending against allegations of lack of monitoring or supervision.

Source: Adapted from Briefings on Long-Term Care Regulations, www.hcmarketplace.com.
Five methods to augment your memory

Have you ever imagined the benefits a good memory can bring you? As a manager, being able to remember important pieces of information such as names, facts and figures, directions, procedures, and quotations can give you a powerful advantage.

Here are five ways to boost your memory and keep it razor sharp:

1. **Use your imagination.** An easy way to remember something is to “take a picture.” For example, to remember where you’ve left your car keys, pretend to hold a camera to your eyes, focus on the scene and click the image into your memory when you are leaving. Then, when you want to find your keys again, try to develop the negative into positive and you’ll be able to draw out a clear picture.

2. **Practice.** Boost your memory with regular practice. There are many ways of doing this. For example, try to remember which day of the week your last birthday was, then extend this to the birthdays of all your family members. Try to remember names of all the 50 states and see whether you can do it in alphabetic order, too. It won’t be long before your daily practice pays off.

3. **Eat healthy.** The best way to protect your memory is to eat plenty of antioxidants and nutrients commonly found in fruits and vegetables. In a study published by the *American Journal of Clinical Nutrition*, researchers tested people ages 65–90 and discovered that the people with the best ability to memorize words were those whose diets included the most fruits and vegetables. Coincidentally, the same group of people ate the least artery-clogging saturated fat. Of all the fruits and vegetables studied, blueberries and blackberries contain the most potent antioxidants, anthocyanins.

4. **Get physical.** Physical exercise not only boosts memory, but also helps you think faster. A combination of mental and physical activities can protect your memory and help keep you alert.

5. **Exercise your brain.** Mental gymnastics are as important as physical ones to preserving brainpower. Take up word games like crossword puzzles and acrostics. Memorize favorite poems, read challenging books or articles that encourage you to expand your interests. Practice other-handedness. If you’re right-handed, try brushing your teeth or writing your grocery list with your left hand. Any activity that requires you to think and concentrate will challenge your brain. Your brain will thrive on the challenge.

*Source: Adapted from NurseZone, www.nursezone.com.*

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Patient Safety Goals call for better critical test results

The Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) new National Patient Safety Goals take effect January 2004. One of the key changes will be that the nursing staff must provide read-back verification of critical test results in addition to reading back verbal and telephone orders. The following five tips will help you meet this goal:

1. **Identify who should receive the results.** This should be the ordering physician. Report the test results directly to a physician who can take action, rather than a nurse or other intermediary.

2. **Identify an alternative contact if the physician is not available.** Develop procedures for whom to call if the ordering physician is not available, and create a procedure to link each patient with an alternate provider.

3. **Classify which test results need immediate communication.** Develop a prioritized list and distribute it to all physicians and nurses. Try to limit the number of test results in your highest category.

4. **Identify when tests should be reported to the physician.** Develop a foolproof plan for communicating critical results when the physician is not readily available.

5. **Determine how to notify the physician.** Develop a way to ensure and document that the physician has been notified.

Reading back critical test results makes sense and is consistent with requirements from the College of American Pathology for certain specimen results, says **Linda Pello, RN, MBA, CPHQ**, director of quality improvement at the Hospital of St. Raphael in New Haven, CT. “The hard part is coming to consensus on what to include in the read-back requirements because, as I understand this goal, it applies to all tests, not just lab results. That is a very realistic goal and should be part of our everyday practice.”

*Adapted from: Briefings on Patient Safety, and Briefings on JCAHO, www.hcmarketplace.com.*

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New JCAHO standards for 2004 state that the physician or licensed independent practitioner (LIP) who provides care, treatment, and services to the patient must be the one who obtains the patient’s informed consent (standard RI.2.4 in the Comprehensive Accreditation Manual for Hospitals).

Physicians often rely on nurses to obtain a patient’s consent, although many state laws actually require physicians to secure it themselves.

However, nurses should only verify that the physician has obtained consent, which can help protect the hospital if a patient sues for malpractice.

Informed consent should include a discussion of the potential risks and benefits of a procedure, possible side effects, and alternatives to the procedure to help the patient decide whether to go forward.

Nurses also often answer last minute questions about a procedure, but they should not be the ones to discuss potential risks and benefits of the procedure with the patient.

“The new standard is much clearer. Physicians or LIPs are the ones with the most knowledge of the procedure,” says Deloris Cooper, RN, manager of accreditation and regulatory standards for Sentara Hospital in Norfolk, VA.

“How can anyone else explain the risks, benefits, and reasonable alternatives?”

Specifically, the goal of the new standard (RI.2.40) is “to establish a mutual understanding between the patient and the physician or other LIP.” It will go into effect in January 2004.