JCAHO

JCAHO announces new 2005 National Patient Safety Goals

Preventing patient falls and patient identifiers targeted

The JCAHO recently approved the new 2005 National Patient Safety Goals, which focus on patient falls, look-alike/sound-alike drugs, and communication across the care continuum. The 2005 goals also include improving the accuracy of patient identification.

The JCAHO clarifies that organizations must use at least two patient identifiers. This requirement not only applies when administering medications, blood products, and taking blood samples and other specimens, but also for any other treatments or procedures.

Improve communication among caregivers

This new requirement for reporting critical test results and lab values calls for organizations to measure, assess, and take action to improve the timeliness of reporting these results to the appropriate licensed caregiver.

Improve medication safety

To improve medication safety, the JCAHO will expect organizations to identify, and at a minimum, annually review a list of look-alike/sound-alike drugs, and to take action to prevent errors involving the interchange of these drugs.

Reconcile medications

By January 2006, the JCAHO will require facilities to develop a process for involving the patient in obtaining and documenting a complete list of his or her current medications upon admission.

The JCAHO requires organizations to communicate the patient’s complete list of medications for the next provider of service when referring or transferring the patient to another setting, service, practitioner, or level inside or outside the organization.

Reduce the risk of patient harm resulting from falls

Organizations must reduce these risks by assessing and periodically reassessing each patient’s risk for falling. Check the patient’s medication regimen and decide if it places him or her at greater risk of falling, and take action to address these risks.

The following goals remain unchanged:

• The staff member who receives an order verbally, by telephone, or who receives a
2005 goals

critical test result by telephone, should do a complete “read-back” of that information.

- Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.

- Remove concentrated electrolytes (e.g., potassium chloride and potassium phosphate) from patient care units.

- Standardize and limit the number of drug concentrations available in the organization.

- Ensure free-flow protection on all general-use and patient-controlled analgesia intravenous infusion pumps used in the organization.

- Comply with Centers for Disease Control and Prevention’s hand-hygiene guidelines.

- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a healthcare-acquired infections.

The JCAHO will likely put the new goals into effect January 1, 2005; by this time surveyors will assume organizations have addressed the goals, and will expect organizations that are surveyed in February and beyond to have complied with them since January 1, 2005, according to a source from the JCAHO.

Nursing retention

Get a bird's eye view on bed capacity and available resources in your organization

In the past, staff at Overlook Hospital in Summit, NJ, referred to the neuroscience unit as the “cry baby unit.” Staff on that floor complained that they were understaffed and couldn’t take on any more patients. Other units didn’t understand why they were having so many problems with the influx of patients, until Overlook developed a new system that manages the demand of that unit’s capacity.

The system is called “demand capacity management,” said Linda Kosnik, RN, MSN, CS, chief nursing officer at Overlook. When staff from all areas of the hospital sat down to develop the system, they learned that the neuroscience unit had 12–15 stroke patients each day who needed to be fed. On average, this task took between 45 minutes to one hour per patient.

“You’re taking up 12 hours of nurses’ time for one meal,” said Kosnik, during a recent HCPro audioconference about nurse retention. “When we identified that problem we found ways to support the unit so they could take more patients. Now we send an aide or a tech to them [during] mealtimes so they don’t have to strip their unit of needed resources.”

Overlook adopted the demand capacity management system in 1999 to improve customer satisfaction, recruitment and retention, interdisciplinary collaboration, and resource management.

Retention efforts flourished because the system empowers staff to identify and solve the stressors that they encounter on their units each day. “In real time nurses can create their own solutions to problems on the unit,” said Kosnik.

It also increases safe practices by ensuring consistent collaboration between departments. “If a staff nurse doesn’t have to worry whether the medications will be on the floor when its time to give it to her patient it, she has the opportunity to look up the medication in the PDR [Physicians Desk Reference] to see what the drug interacts with,” said Kosnik. “Given those opportunities, staff will follow through and create a safer system.”

One tool Overlook uses to enhance collaboration between departments is what Kosnik refers to as the “bird’s eye view,” (see form on p. 4). This form is faxed to all inpatient units four times a day and informs everyone on the census on that unit, bed availability, and acuity.

The form is helpful because sometime the census is not always an accurate indicator of how busy a unit is, Kosnik said. “You might have five isolation patients on a unit, but when you first look at the census and see it’s a 40-bed unit with 35 patients, you think they have five beds. This tells us how hard they’re working.” Some units are capped because they are diagnosis-specific floors that are driven by pathways, such as the neuroscience unit that uses the stroke pathway.

So far the system has been a success at Overlook. Their retention rate is consistently 92% and their admission cycle time is between 60–75 minutes. Before the facility adopted the program five years ago, its ED went on divert three or four times a week because the facility was overwhelmed and the inpatient units could not support the ED, she said.

After adopting the system Overlook went for two years without going on divert. “This doesn’t mean we never go on divert now,” said Kosnik, “But when needed everyone is at the table—radiology, environmental, the ED, and inpatient units—and the decision is made collectively.”

The bird’s eye view: Sample census and bed availability form

<table>
<thead>
<tr>
<th>Unit</th>
<th>Census</th>
<th>Beds Available</th>
<th>Tele Available</th>
<th>APO/ MDS</th>
<th>Capped</th>
<th>Census</th>
<th>Acuity</th>
<th>Others</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>10CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5AB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4AB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3AB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICU 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICU 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal/ Child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6AB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L&amp;D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NICU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Linda Kosnik, RN, MSN, CS, Overlook Hospital, Summit, NJ. Reprinted with permission.
How an interdisciplinary team solved ED patient flow without breaking the bank

Improving your patient flow doesn’t have to be expensive. Just ask the ED staff at St. Rose Hospital in Haywood, CA.

Patrick Evangelista, RN, MBA, clinical nurse manager, who oversees the ED at St. Rose Hospital, says that within the past year the department has worked together to improve their patient flow problems.

Their hard work has paid off. The hospital has opened up emergency beds, improved its diversion rates, reduced employee stress levels, and increased patient satisfaction.

To address patient flow and bottlenecks, the hospital created an Emergency Performance Improvement Committee (EPIC), a multidisciplinary team composed of nursing staff, medical staff, licensed practical nurses, ER technicians, clerks, radiologists, laboratory technicians, and housekeeping staff.

The team took the following steps which improved patient flow without draining the department’s budget.

1. Use colored sticks to identify tests ordered
This simple idea allows nurses to immediately see when physicians ordered tests without directly asking them. The department purchased three dozen, multicolored popsicle sticks that they use to identify when a physician ordered a lab test, respiratory test, or an electrocardiogram (EKG).

Once a physician orders a test, the unit assistant puts in the order and places a corresponding colored stick in the chart.

“Now I can sit in my office and from a distance see a red stick or purple stick and know that a patient needs to get an EKG done or a lab drawn,” says Evangelista.

2. Purchase a grease board to track patient status
The team also bought a large grease board to track patient status for $500. The board keeps track of each patient and costs far less than the $350,000 software tracking program the hospital was purchasing. “We can see by looking at the board whether a patient is having an EKG or if she needs a lab,” Evangelista says. “It’s really improved the flow because we can look at the board and see that a patient doesn’t necessarily need to take up a bed, but can stay in the holding area while waiting for a lab.”

3. Make better use of dead space
St. Rose has also created a “medical express unit.” Patients are moved to the unit, which used to be dead space in the hospital, when they no longer need to be in the ED, but still need to be monitored. Moving these patients creates available beds in the ED. The OR manager allots Evangelista one to two beds in the morning and five beds in the afternoon. “This way I can move five monitored patients to this floor where there is a nurse with no patient load. The only cost is one nurse and it frees up space.”

Once the patients are out of the hectic, chaotic atmosphere of the ED, they are much happier, Evangelista says. “They are in a calm environment and they have a nurse that can give them medication, feed them, and care for them,” he says.

“Our satisfaction is up, and the express units eliminate much of the need to divert. We’ve made effective use of our dead space and we’ve maximized our resources. It’s worked very well because it’s opened up beds for the ED and reduced the stress loads on nurses,” says Evangelista.

Source: Briefings on JCAHO, August 2004, HCPro, Inc.
Scenario: A few years ago, you reported an incident on one of your units to your organization’s quality and risk management department. You suspected that it might come back to haunt you and your staff, and your prediction has come true. You have been subpoenaed to give your deposition in the case, which is being prepared for trial. One of your staff nurses is also cited in the case.

Being called into a deposition is never a pleasant experience. As the nurse manager, you should assist your staff nurse, your employer, and yourself to help the hospital’s attorney develop the best defense possible.

Meeting with your organization’s attorney/risk manager
As soon as you learn you’ve been subpoenaed, immediately notify your hospital attorney or risk manager. If you have nursing malpractice insurance, you will need to notify the insurance company as well, and they may put a claims investigator in contact with you. Be sure to ask for identification before discussing the case with this person.

Do not discuss the case with anyone unless you are in the presence of an attorney or insurance representative. You cannot discuss the case with other nurses from the unit, even if they are codefendants.

Also, never call the patient or family involved in the case: You may strengthen their case if you say something revealing during the conversation.

Meet with the attorney who will be representing you as soon as possible. You have to be honest about the case and candid about any past infractions or disciplinary action. The attorney will need to be aware of these facts prior to the deposition.

There should be no surprises. Keep in mind that your attorney—or the organization’s attorney—is on your side. His or her professional oath requires that the information you disclose remain confidential to the greatest extent possible. Therefore, it is in your and your employer’s best interest for you to be forthcoming with information.

What to focus on when reviewing medical records and all associated policies
When reviewing the medical record, pay close attention to the patient-care plan, nurses’ notes, and any entries you made. Be sure you are familiar with any relevant policies that were in place at the time of the incident.

For example, if there is an official statement advising nurses to use independent nursing judgment, you may be able to refer to this statement at the time of the deposition.

Some organizations also have “nursing protocols” or “independent nursing actions.” Review all of these organizational procedures and standards and share them with the attorney.

Source: This excerpt is from the book Managing Documentation Risk: A Guide for Nurse Managers, written by Patricia A. Duclos-Miller, MS, RN, CNA, and published by HCPro, Inc. Call 800/650-6787 to order.
Training

Five steps to a more effective and exciting nurse training program in your organization

Training nurses is difficult—especially when you’re training staff who can barely spare a minute away from their core responsibilities during a 12- or 16-hour shift. David Jensen, MS, is a leadership and training expert, and author of the article “The Soul Reason Training Doesn’t Stick,” which offers solutions to help get your staff excited about training.

To boost the effect of training programs on-site, online, or over your intranet, consider these principles and share them with trainers:

1. **Tell your staff the purpose of the training and why it’s important for them to complete it.** If you are open and honest with employees, they will learn to trust you and willingly partake in the activities you develop.

2. **By nature, nurses are caring and compassionate.** If the training program will improve the quality of care for their patients, convey that message and you might be surprised by their cooperation.

3. **If you’re introducing new initiatives, be there to support them.** This means more than delivering a speech from behind a desk—be interactive, promote dialogue, and get feedback from your employees about your plans.

4. **A brainstorming session about nurse training with your staff could yield some wonderfully creative ideas.** Yes, a manager’s time is precious, but if a nurse leader isn’t enthusiastic about training, how can he or she expect the nursing staff to be?

5. **When developing new procedures, explore the negatives as well as the positives.** Consider problems you might face with execution (e.g., computer glitches, lack of time, etc.) and be well-prepared if something goes awry. At the same time, when staff make small achievements during training, celebrate those successes.

Editor’s note: The above excerpt is adapted from the article, “The ‘Soul’ Reason Training Doesn’t Stick,” published in The Yearbook of Experts, Authorities and Spokespersons®. Jensen is a recognized authority, author, and professional speaker in the areas of sales, success, and leadership.
Nursing in the news

Nurses’ long hours contribute to medical errors

Stating what many nurses have already known, a University of Pennsylvania study found that when staff nurses work 12 or more hours consecutively they are more likely to make medical errors.

The survey analyzed 393 RNs and their work patterns. Researchers concluded that nurses more often than not work longer shifts than originally scheduled. The majority of nurses in the study reported working longer than scheduled 10 times or more in a 28-day period. Researchers also determined that double shifts were not reserved for emergency situations—almost one-sixth of those surveyed said they worked 16 or more consecutive hours at least once a month.

The study reflects that work duration, overtime, and the number of hours a nurse works in one week, significantly affect medical errors. Risks to patients start to increase when a nurse’s shift exceeds 8.5 hours, and the likelihood of a nurse making a medical error triples when he or she works a shift of 12.5 hours or longer.

Nurses working overtime also increased the likelihood of committing an error, regardless of how long the shift was originally supposed to last. The RNs in the study reported making 199 errors and 213 near-misses, more than half of which were medication administration errors.

According to the study, “The long and unpredictable hours documented here suggest a link between poor working conditions and threats to patient safety.” The study also called for the end of 12-hour shifts and overtime after long shifts.

Source: The Working Hours of Hospital Staff Nurses and Patient Safety, Ann E. Rogers, Wei-Ting Hwang, Linda D. Scott, Linda H. Aiken, and David F. Dinges.

Management tips

Change gears and get staff excited about organizational change

Often nurse leaders are called on by senior management to quickly change gears when their organization makes major changes in the culture of the work environment. Your nursing staff may resist change, especially when you’re changing what staff will refer to as “how we do things around here.”

When you are faced with scenarios of corporate restructure and major shifts in organizational policy, the following tips will prove helpful:

- Don’t waste energy on how things used to be. You cannot bring back the past.
- Be obvious about adopting the new changes. This is not the time to be “low key.”
- Recognize and admit to staff that there is added stress with culture change.
- Always consider the big picture and the long term goal that is driving the change. Regularly discuss this “big picture” viewpoint with staff so they don’t get caught up in the daily annoyances and inconveniences the change may cause.
- Don’t be afraid of setting high standards.

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

Know thyself: Look within before leading others

As a leader, your goal should be to be respected, not necessarily liked. Many decisions that effective leaders need to make may be unpopular with staff. Learning to accept that your employees will not always be happy with your decisions, and being attuned to your own feelings will make you a valuable leader and manager.

Increase self-awareness
Self-awareness is without a doubt the most important leadership attribute. Unfortunately, it is difficult to develop a keen awareness of your own feelings and emotions. Highly effective leaders are acutely aware of their own feelings, emotions, strengths and weaknesses, and are able to tune into those emotions and cope with them in a nondefensive and constructive manner. They are also aware of how their moods and emotions affect others.

Take ownership
Tuning into your own emotions is not an easy task. Of course it’s even more difficult to take ownership of those feelings. Leaders must develop the ability to deal with the ups and downs that come with their position by always looking for the positive—even during stressful and anxious moments.

Leaders who have not mastered this skill are frequently depressed, worry incessantly, and suffer from seemingly insurmountable obstacles and stressors. On the other hand, those who know how to manage their emotions experience just as many "downers" but they are able to focus on what needs to happen and bounce back.

Recent research from the University of Pennsylvania makes a strong case for the importance of developing a positive explanatory style (PES). People who have PES as opposed to NES—a negative explanatory style—have developed the unique ability to reframe their setbacks and disappointments by finding the good in the bad.

To manage your emotions more effectively take the following steps:

- Actively seek out the positive. Make a decision to always look for the good in a situation, no matter how dire the circumstances. You’re sure to find what you’re looking for.
- Reframe your bad experiences. You will perceive all experiences differently depending on how you frame them. It’s easier to learn from negative experiences when you put them in a positive context.
- Tune into the triggers that cause you to feel bad. Interrupt them or turn them off by substituting a different trigger that makes you feel better.
- Help your colleagues who are worse off than you and having a difficult time.


Calling all nurses!

As part of HCPro’s continued commitment to quality, we will be conducting several pilot tests on our nursing education products. We are looking for staff nurses, nurse managers, and case managers to test our nursing continued education courses and provide valuable feedback. As a thank you, those selected to participate as pilot testers will receive free nursing contact hours.

If interested, please contact Robin Flynn at 781/638-1872, Ext., 3249 or e-mail rflynn@hcpro.com.
Blood-transfusion errors are among the top 10 sentinel events that have occurred at accredited organizations since the JCAHO began reviewing sentinel events in 1995. They are also among the more complex processes in healthcare. This complexity, coupled with the significant communication that is involved in the process, makes blood transfusion an excellent target for a failure modes and effects analysis (FMEA).

The ultimate goal of the following FMEA is to reduce the risk of a devastating blood-transfusion error within an organization. For this case, a transfusion error is defined as a complication involving an immune response against the transfused blood cells or other components of the transfusion.

The following is a step-by-step recreation of a FMEA that was performed on a blood-transfusion process.

**Step 1: Organize the team.** The core team of this FMEA included the

- risk manager, facilitator
- administrative director of laboratory
- chief of pathology
- blood-bank supervisor
- chief nursing officer
- clinical manager from the ED
- nursing supervisor

Ad-hoc team members include

- ED RN
- RN, intensive-care unit
- OR RN
- safety officer
- director, information systems
- director, plant operations
- licensed practical nurse, medical/surgical

**Step 2: Flowchart the process.** Using software, the team charted the entire blood administration process.

**Step 3: Identify potential failure modes.** The facilitator reviewed the flow chart with the FMEA team to identify steps in the process where errors might occur. They recorded these potential failure modes into a flow chart. The potential failure modes that they uncovered included

- communication breakdowns between the nurse and transporter who picks up the blood
- illegible tags on blood
- transcription errors on the original order

The team entered the potential failure modes into a matrix. They reviewed each mode individually to determine the frequency, severity, and detectability of each potential error. Next, the team computed a risk-priority number.

**Step 4: Identify the potential effects of each failure mode.** The team identified the ultimate effect that each potential failure mode would have on each patient. For example, the team determined that patients were very likely to suffer harm if a communication breakdown occurred between the nurse and the transporter. Using a 1–10 severity scale, they rated the potential for harm by this failure mode as a 10.

**Step 5: Redesign processes/underlying systems.** Next, the team brainstormed potential improvements to the existing processes. One idea focused on reducing the risk of communication breakdowns between the nurse and the transporter. As a result, the organization revised its process so a direct handoff of the blood card occurs at the nurses’ station between the nurse who transfuses the blood/blood product and the nurse transporter who picks it up.

The handoff may occur only after the nurse transporter enters the patient’s name, medical-record number, and type of product being picked up into the transportation log. The blood/blood product is then
Hand-delivered to the nurse who hangs the product.

**Step 6: Test and carry out the redesigned processes.** The team test-piloted each risk-reduction strategy to determine its effect on patient safety.

**Step 7: Measure the effectiveness of the redesigned process.** The team gathered patient-outcomes data to determine the effectiveness of their changes.

---

**Technology in Nursing**

**MA hospital achieves buy-in from staff and successfully develops a CPOE system**

One Boston health system eliminated almost 50% of medication errors by establishing a computerized physician order entry (CPOE).

Beth Israel Deaconess Medical Center (BIDMC) reduced transcription and call-back errors and has not used a handwritten order since 2001, when it put CPOE in place, says John Halamka, MD, chief information officer for CareGroup health system, the healthcare organization that includes BIDMC.

CareGroup began planning its CPOE system in 1999, around the same time the Institute of Medicine came out with its report *To Err is Human: Building a Safer Health System*, which noted that medication errors cause 7,000 deaths annually.

**Foster grassroots support to prevent resistance**

Halamka credits the hospital’s success with CPOE to the work it completed in the time prior to launching the system. BIDMC created a team of 35 physicians, nurses, pharmacists, and other providers to determine what components the CPOE system should have.

The interdisciplinary team is crucial to the success of a CPOE system, Halamka says, because staff feel comfortable using a system they helped design.

“The system came from the users,” he says. “They’re not saying, ‘Look what administration did to us.’ ” For example, Cedars-Sinai Medical Center in Los Angeles began using a CPOE system in October 2002, Halamka says. The hospital took the system offline in January 2003 because of staff resistance.

**Roll out and train gradually**

The CPOE system holds nine million patient records. The large volume creates a need for an appropriately designed system, which is easy to use and navigate, Halamka says.

The day the hospital launched CPOE, it began to train staff at each nursing station, Halamka says. Information technology staff spent three weeks at each station training physicians, nurses, and other providers how to use the system. The gradual roll-out through each station helped ease the hospital’s transition into CPOE, Halamka says.

To learn more about how to implement new technology in your facility and achieve buy in from your staff, listen to the audioconference “Adopting new Technologies: Clinical How-To’s for Nursing and Other Clinical Teams” on September 16. Call 877/727-1728 or go to [www.hcmarketplace.com](http://www.hcmarketplace.com) to register.

**Source:** *Hospital Pharmacy Regulation Report, July 2004, HCPro, Inc.*
Medical errors are the third leading cause of death

According to a recent study medical errors are the third-leading cause of death in the United States, behind heart disease and cancer. The study found that the number of patients who die from medical error is twice as high as previously estimated.

“The United States loses more American lives to patient safety incidents every six months than it did in the entire Vietnam War,” wrote researchers from HealthGrades, a healthcare quality ranking company in Lakewood, CO. Researchers reviewed Medicare records nationwide and concluded that there were 195,000 deaths due to errors annually between 2000 and 2002—almost 100,000 more than estimated by the Institute of Medicine’s (IOM) report, To Err is Human released in 1999.

The study included some medical errors that the 1999 IOM report did not, including failure to diagnosis and treat in time, and infection leading to the death of a low-risk patient.