X-rays, CT scans, and MRIs are used widely and often in healthcare facilities across the United States. Chances are, most people have received at least one x-ray at some point in their lives, whether for a broken bone or a routine dental exam, and in many cases, diagnostic imaging is necessary to correctly diagnose an issue in order to save lives and prevent further injuries or infections.

But radiation is toxic, and even though x-rays are helpful diagnostic tools, the long-term effects of radiation may be harmful. Experts are still debating the long-term risks of radiation exposure, but according to The Joint Commission’s Sentinel Event Alert 47, x-rays are considered a carcinogen by the World Health Organization’s International Agency for Research on Cancer, the Agency for Toxic Substances and Disease Registry of the Centers for Disease Control and Prevention, and the National Institute of Environmental Health Sciences.

Joint Commission Sentinel Event Alert 47 urges healthcare organizations to seek new ways to reduce exposure to repeated doses of radiation from diagnostic procedures, and says that over the past two decades, the U.S. population’s total exposure to ionizing radiation has nearly doubled. According to one study, the incidence of cancer related to CT radiation is 0.02%–0.04%.

A multifaceted issue

There are a multitude of factors at play in radiation overexposure, and unfortunately there is no one single problem with respect to diagnostic imaging. It’s an incredibly complex problem that involves staffing, accreditation organizations, administration decisions, and the equipment used to deliver radiation, as well as the manufacturers and the physicists who perform routine quality assurance/quality control on the machines.

In addition, many technologists who operate radiology equipment are not certified, and many states do not require continuing education, even though the machines are constantly being updated due to advances in
technology as well as hardware and software from differ-
ent machine manufacturers being combined.

Who’s to blame?
Tobias Gilk, M. Arch., radiation design specialist
for RAD-Planning, an architectural design and planning
consultant firm specializing in radiology, nuclear
medicine, and radiation therapy facilities in Kansas City,
MO, says that mistakes are triggered by any one of the
moving parts associated with radiation exposure. Fingers
can be pointed in a number of directions depending
on the situation, says Gilk, who also works for Med
Novice, a company that manufactures and sells safety
equipment for the MRI environment; has been involved
in providing radiology training information for The Joint
Commission; and served on the American College of
Radiology’s MRI safety committee.

“There was a case in northern California from a cou-
pel of years ago that was pretty directly attributable to
the training of the technologist, where the tech adminis-
tered a single CT exam to a pediatric patient in excess of
70 times because the patient was a 2-year-old child who
was having difficulty holding still for the exam. There
are pictures of this young boy taken after the exam, and
he has what appears to be a sunburn in a very clearly de-
fined line that begins right at the cheekbone and extends
down to his collarbone, and that sunburn is a result of
radiation burns from the repeated CT exam. That’s an
example of a staff training issue,” says Gilk.

There are also recent examples of multifaceted issues
peppered across the country involving an available soft-
ware upgrade that added a CT perfusion function (a type
of scan that allows perfusion to an organ to be measured
by CT) to existing CT scanners that were originally sold
to hospitals without such a function, Gilk says. Software
that manages the new protocol often is not fully inte-
grated into the new system, creating a separate pop-up
window that gives the recommended dosage information
associated with the perfusion exam in a place where the
technician may not be accustomed to seeing it. Techni-
cians then click through and dismiss the information,
overlooking the window alerting them that they are
giving excessive doses.

Gilk says that because there are so many moving
parts, it is difficult to say whether the training or the
technology is to blame, and in some ways, it’s an
artificial differentiation anyway. He says that although
training on these machines is absolutely essential, it
would be a misnomer to put all of the blame on the
technologist who is hands-on with the patient and the
device. “We are seeing situations where enterprises are
reducing staffing levels or reducing employee experience
to try to manage personnel costs. If that leaves more
accidents because of a ‘hurry up and scan more patients
with fewer people’ mentality or ‘do more with less,’ then that accident should justly fall at the feet of the administration.

Most of the time, these accidents are an interplay between equipment, personnel, and management, and it’s the kind of situation where if we simply broke one link in the sequence of events, we would have a good shot at preventing the adverse outcome,” he says.

**Owning up to the challenge**

While there are certainly examples of errant technicians, poor software integration, or breakdowns in quality assurance on the part of the manufacturer, Gilk says the challenge really boils down to culture and accountability. Because these systems are so complex, the healthcare workplace must adopt a professional culture that accepts shared responsibility.

What is really needed, he says, is for every party involved to not only consider their discrete job duties or responsibilities, but to assume a shared responsibility for the safety of the patient, even if that means overlapping duties with the other players in the enterprise. “It’s through these gaps in responsibility and narrow definitions of roles that these kinds of accidents are allowed to occur. The silo mentality is what ultimately injures and runs the risk of killing patients needlessly,” says Gilk.

**Taking the first steps**

Gilk says risk assessment and risk management are the first steps hospitals should take to ensure mistakes don’t happen at their facility. “Before they rush out and decide they’re going to take these steps, I think it’s prudent to say, ‘Well, where are we in terms of providing safe and effective care?’” he says.

Gilk reminds organizations that for Joint Commission–accredited facilities, measuring risk is a part of the accreditation process. Although it’s not an issue that has been enforced with any consistency in regard to radiology and radiation therapy, Gilk says it is clearly spelled out in The Joint Commission’s Environment of Care standards.

“Organizations should turn directly to EC.02.01.01,” he says, “which references Sentinel Event Alerts, and go through the 21 performance objectives identified for Sentinel Event Alert 47, and measure the facility against each and every one of those. Once they have their report card, then they can take a look at what is going to be the most effective way to manage these risks and ultimately make care for the patients safer and more effective.”

**No simple solutions**

Gilk says the issue is much more complex than just providing four hours of continuing education for technicians, hiring a medical physicist to come to the facility and check everything, or switching to an accreditation organization that provides a higher level of scrutiny in this area.

Organizations that take these steps are not necessarily making poor choices. In fact, Gilk thinks organizations that look at this problem holistically are going to choose many of these solutions; however, what he hopes to emphasize is that this problem cannot be fixed with simple band-aid solutions.

“What I don’t want is for facilities to think that the solution is ‘fill in the blank,’ ” he says. “I don’t want facilities to think that all we need to do is that one thing and the problem is solved, because in all honesty the solution is two or three or seven things done in concert.”

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Northwestern targets irregular airways to improve patient safety

“Culture of safety” has been the buzzword of the year in the accreditation world. Scrutiny of patient safety has increased under The Joint Commission’s already watchful eye, and public awareness of safety issues continues to grow.

For hospitals, targeting patient safety challenges is a unique experience for each individual facility. Targeting the right topic, garnering buy-in and support, and implementing a successful program has become a rite of passage. At Northwestern Memorial Hospital in Chicago, one recent, successfully implemented improvement project looked at a common, life-threatening, but seldom-discussed patient safety issue: atypical airways.

The decision to investigate this particular topic stemmed from Northwestern’s propensity for cutting-edge technology. “We are prone to having new technology tried out in our organization,” says Margaret Duggan, BSN, MS, patient safety leader of quality strategies at Northwestern. “New hardware can walk through our [operating room] at any time. We try to be proactive to identify these ahead of time, but we’re not always able to.”

The goal is to enable staff to log into the electronic medical record (EMR) to gain access to all the tools and resources they need to work with their patients.

“This gives physicians a chance to communicate with the nurses and other staff about what we’re doing and what we need to do to maintain a safe environment for our patients,” says Duggan.

There is a learning curve, though—the EMR allows staff to work with electronic notes in the record, which requires staff to be comfortable managing information electronically when looking at their patients.

So how does this tie into atypical airways? It’s about communication, says Alyssa Breznau, BSN, RN, CCRN, education coordinator for general surgery at Northwestern.

“Atypical airways, when staff are working with these patients, bring about a high level of anxiety and discomfort for the staff,” says Breznau. “We really want to be able to deliver safe care, and while this new process is different, the staff was very eager to find that path and get through it in a successful manner.”

—Alyssa Breznau, BSN, RN, CCRN

Physician buy-in

Northwestern’s team knew that the project’s success would depend not only on buy-in, but also
extensive feedback and advice from physicians who were experienced with atypical airways. To that end, two physicians—an ear, nose, and throat (ENT) specialist and an interventional pulmonologist—were involved from the beginning and were integral to the development process.

But the team also needed to actively engage the end users—bedside nurses would be significantly affected by this process change, so their cooperation and feedback was pivotal as well.

“Training the nurses, developing the tools that would be created for it—that needed to go through the ENT staff, as well as the surgeons placing those airway devices,” says Duggan.

“We had buy-in from key leadership to help us communicate [these needs],” says Breznau. “The more they became involved, the more we were able to identify a whole population of patients with a history of airway challenges.” And the more patients they identified, the more they also recognized staff who would benefit from

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**Figure 1**

**Improving the Management of Atypical Airways – Measure/Analyze**

A majority of patients with atypical airways have tracheostomies. Tracheostomies are performed by several surgical services and admissions come from a number of different sources.

**NMH Tracheostomy Admissions, n=97**

- Surgery: 13%
- Procedure: 3%
- External Transfer: 11%
- Direct Admission: 5%
- Home: 38%
- Nursing: 18%
- Home/SNF: 10%
- RIC: 25%

Source: ED and Nursing Documentation, May-Dec. 2010

**NMH Tracheostomy Procedures by Surgery Service, n=210**

- ENT: 49%
- General: 18%
- Thoracic: 25%
- Other Transplant: 2%
- Throat: 6%

Source: ED and Nursing Documentation, May-Dec. 2010

**Source:** Northwestern Memorial Hospital. Reprinted with permission.
this new method of communicating atypical airway challenges in the patient population.

“We weren’t noncompliant in any way,” Breznau says. Rather, the initiative was about improving upon an area that was working, but could be performed at an even higher level. “This was nursing-driven, grassroots ... we said, ‘Let’s fix it.’ ”

**Patient population**

The success of the project truly hinged on identifying that patient population, says Carol Payson, MSN, RN, NE-BC, director of patient care at Northwestern. “We wanted to make sure we addressed the issues of the patient population,” she says.

To that end, a multidisciplinary team met regularly, made up of bedside nurses, respiratory therapists, leadership, unit managers, and various physician specialists.

“It was a huge team working on a six-month process,” says Payson. “We identified what we needed to do, who the stakeholders are, got the information out to them, and leveraged our information technology [IT] department’s skills.”

The team was keenly aware of one thing: It only had one chance to launch the program properly.

“If we rolled something out in an ineffective way, it really would be hard to re-implement it and get that same staff buy-in,” says Payson. “With the EMR, you want to put something in correctly the first time. It can cause confusion if you have to go back and reintroduce something.”

Implementation was not without challenges, says Breznau. “Due to the variability in these types of patients and the infrequency that staff sees them, it’s been a process to acclimate [staff],” she explains.

Staff reaction to atypical airway notes has been extremely positive, but because of the time that would elapse between atypical airway patients, the team also had to develop methods for retraining or reminding staff of the process.

“In the beginning it was more of an issue, but it’s becoming more of a culture a year after [initial implementation],” says Breznau. “There is less time required to relearn. It’s becoming ingrained.”

The support processes and staff that the team put into place as resources for this retraining has been positively received by the bedside staff as well.

Perhaps the best change: “Atypical airway” is now common parlance among the staff.

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“We did not have the words in our verbiage at all [before], but now if you say it in a meeting, everyone knows what it means. Incorporating the terminology into the culture has been great,” says Duggan.

Once staff acclimate to the terminology and learn to use the notes technology to track specific patient needs, says Duggan, they are extremely pleased. Many have commented that the notes improve their work flow with this patient population. It’s also a good idea to have the staff educator—in this case Breznau—readily available to help staff who are struggling with the technology or who need a refresher.

“I’m the go-to person for the bedside nurses and also trying to create extensions of myself so that there is a go-to person at all times,” says Breznau.

“We do realize that Breznau has a personal life!” says Duggan. “We have training videos online, resource binders, and a nurse PhD who works with these patients who is also familiar with both the technology and the patients themselves.”

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**Figure 2**

**Improving the Management of Atypical Airways – Measure/Analyze/Improve**

In FY11 Q1, several processes were implemented to ensure safe and routine management of patients with atypical airways.

- **Original Process**
  - Patient acquires atypical airway in OR
  - Patient assigned to an inpatient unit
  - RN may or may not receive warm hand-offs from inserting MD
  - Patient’s ventilatory status declines
  - Emergency Response Team (ERT) activated
  - ERT has difficulty managing airway during emergency response
  - Lack of heightened awareness surrounding atypical airways

- **Improved Process**
  - T-tube patients may be assigned to specific nursing units: SICU 12E/W
  - Documented warm hand-offs between MD and RN
  - Emergency management instructions included in Atypical Airway Note, which is placed at head of bed and in paper chart.
  - AIRWAY CONCERN is included in PowerChart patient demographic bar
  - NMH intranet maintains up-to-minute list of all inpatients with an Airway Concern
  - T-Tube medical alert bracelets applied to patients (if applicable)
  - Modified Emergency Response Team text page for Airway Concern patients

**Source:** Northwestern Memorial Hospital. Reprinted with permission.
**Ever-changing technology**

As with any electronic update, creating the notes was, as Breznau puts it, “one technological challenge after another.”

“The note is working great now, and we continue to enhance it,” she says. Despite the challenges, “IT was committed—everyone had identified the urgency and importance of this improvement.”

The length of the implementation process had a lot to do with the tangential technological changes, Breznau says. The team had to write new medical records rules, paging rules, and so forth. “We were very inventive with this process,” she says.

The benefit to an extensive and thorough implementation process, however, is not needing to reinvent the wheel when it is applied to other areas. One of the team’s infometrics committee physicians presented the concept to sister hospitals within the network who were very impressed with what the team accomplished with the EMR.

Additionally, in-house, the use of notes in the EMR in this fashion is now being considered for other patient populations. “We didn’t have a process like this to identify these challenges previously,” says Payson.

If there was one thing the team could have done differently, says Breznau, it would have been to bring IT in on day one. “That would have been key,” she says.

Payson agrees but says that the support all along has been top of the line. “The support around this initiative has been amazing. We had senior leadership, IT, all the right people around the table,” she says.

Getting bedside nurse buy-in was not too difficult, but the team recommends using real-life, relatable stories to underscore the need for the technology.

“When you are talking about an atypical airway situation, use a story to drive home a real-life example of how this will affect the patient,” says Breznau.

The change in process is something that is almost entirely behind the curtain—patients are largely unaware of how this impacts their stay and improves patient safety. An interesting note, though, is that nurses also say they feel safer using the EMR to track atypical airway patients.

“One key word we hear over and over again is ‘safe.’ I feel safer now,” says Duggan. “That’s what we like to hear. The nurses now feel like they have a better understanding of what is going on with their patients. This is our home run right there.”

While the main thrust of the atypical airway improvement program has been internal and based in the EMR, Northwestern has also rolled out some other successful changes. For example, patients flagged as atypical airway patients are given a medical alert bracelet at discharge. If something happens to them out in the community, the bracelet will alert the first responders and all caregivers along the way to the special needs of the patients.

“We try to extend our responsibility into the community,” says Breznau.

Patients are asked during assessment about any previous problems with airways, and this information is entered in the system—now the patient is flagged for future visits to the emergency department or ENT unit, allowing physicians to diagnose them appropriately.

“It gives the nurses a sense of comfort that someone is looking into airway issues,” says Duggan.
CMS roundup: Late 2011 notifications and changes to impact 2012

Editor’s note: This article is written by Sue Dill Calloway, RN, MSN, JD, CPHRM, chief learning officer of the Emergency Medicine Patient Safety Foundation (EMPSF) and a BOJ advisory board member. Reprinted with permission from the Fall EMPSF Newsletter at www.empsf.org.

CMS issued a Survey and Certification Memo on October 14, 2011, that is of critical importance to hospitals. CMS initially created a 15-page infection control worksheet that the surveyors would complete when they made visits to ambulatory surgery centers. The idea was well received and was the inspiration to extend the worksheets to hospitals. CMS is testing three new surveyor worksheets for assessing compliance with the hospital Conditions of Participation (CoP), including one on discharge planning, one on infection control, and one on quality assessment and performance improvement.

CMS has recently been hitting hard on the issue of infection control, specifically focusing on hand hygiene, cleaning glucometers between patient use, safe injection practices, cleaning both the blade and handle of laryngoscopes, cleaning endoscopes, following instructions on immediate-use sterilization, and single-use lancets. This worksheet provides insight into what CMS will focus on during the survey.

All emergency department (ED) managers should take time to visit the CMS website and look at this tool. According to CMS, the agency will not use the tool before 2013 and we can expect some changes to it. The tool should also be shared with the infection preventionist and other senior leaders in the hospital. It will have an important impact on the survey process in the future.

CMS proposed changes to the hospital CoPs
2011 has brought many new changes to the hospital CoPs. Any hospital that accepts Medicare or Medicaid reimbursement must follow these regulations and interpretive guidelines. The ED must make sure they are followed for all patients and not just Medicare and Medicaid patients. Issues covered include private pay, workers’ compensation, and patients with commercial insurance. There have been about 150 pages of new changes in 2011 in the areas of telemedicine, anesthesia, visitation, IV medication, blood and blood products, pharmacy, respiratory, and rehabilitation.

Now CMS is proposing to eliminate or change existing regulations and interpretive guidelines. This is one of the first major revisions in more than two decades. The proposal is to cut red tape and the number of regulations for hospitals. CMS is touting that the removal of unnecessary regulations could save $900 billion annually. This could free up resources that could be used for taking care of patients.

The initiative reflects the commitment to follow the president’s Executive Order 13563, entitled “Improving Regulation and Regulatory Review,” which was released January 18, 2011. Its purpose was to reduce the regulatory burden placed on hospitals. CMS then reviewed the CoPs to determine whether it could remove obsolete, unnecessary, or burdensome provisions.

The Joint Commission must now apply for deemed status like everyone else. Many hospitals that are accredited by The Joint Commission have seen numerous changes in the past two years as they align their
standards with those from CMS. Reduction in the number of standards by CMS will result in a decreased number of standards by The Joint Commission as well as the other two hospital accreditation organizations, DNV Healthcare and the American Osteopathic Association’s Healthcare Facilities Accreditation Program.

The proposed rule would eliminate a requirement to authenticate verbal orders, which is a problematic standard for EDs. Currently all verbal orders must be signed off within the state law time frame, dated, and timed. The 48-hour time frame would be removed and instead CMS would defer to hospital policy and any state law requirements.

The rule would also amend the 50 pages of restraint standards so patients who are in two-point restraints because of being intubated or because they were trying to remove essential equipment and who died while in the restraints would not have to be reported immediately to CMS. Currently CMS requires facilities to report any patient who dies in restraints or within 24 hours of being restrained to CMS’ regional office the next business day. Hospitals could keep a log and make it available to CMS on request. Deaths would still have to be reported.

CMS is proposing to eliminate another problematic standard regarding tag 1079. This requires that there be a single director of outpatient services who oversees all outpatients in a hospital, which includes the ED.

Hospitals in systems could have one board instead of the current requirement that every hospital with a separate Medicare provider number—or CMS Certification Number as it is now called—must have a separate board.

CMS is proposing to make changes to the medical staff section to allow hospitals flexibility in granting privileges to professional staff other than physicians, such as advanced practice registered nurses (APRN), physician assistants (PA), physical therapists, speech-language pathologists, and doctors of pharmacy (PharmD). The hospital can grant privileges to both physicians and nonphysicians to practice within their scope of practice.

Medical staff conducting the evaluations would operate under their own hospital’s policies and procedures.

Another proposed change involves allowing drugs and biologicals to be ordered and administered by others that are specified in the law, such as PAs, APRNs, or PharmDs.

Nurses could also give drugs and biologicals with preprinted standing orders or protocols. This would include ED admission and triage standing orders for acute asthma, acute myocardial infarction, and stroke, but these would continue to be authenticated or signed off by the ED physician or nonphysician provider.

Standing orders, order sets, and electronic standing orders and protocols would be allowed if approved by the medical staff in consult with nursing and pharmacy leadership. They must be dated, timed, and authenticated in the medical record.

On June 20, 2011, CMS set forth the requirements for mandatory education of nurses on IV medication and blood and blood products. CMS is proposing to eliminate this requirement because it believes it is standard practice. Staff would still need to follow state law requirements and approved medical staff policies and procedures. There are also proposed changes to allow patients to self-administer medications. There are a number of other medication-related proposed changes.

One change would be to streamline the nursing care process, which is a top problematic standard. The proposed change would allow for an interdisciplinary team to complete one comprehensive plan of care and not a separate plan of care by nurses.

The requirement for a log in the infection control chapter would be revised to allow hospitals more flexibility to track infections and in their surveillance activities. Surveillance currently includes infection detection, data collection, and analysis.

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