Dear Readers:

You have seen the birth of many new standards, as well as standard revisions, in 2001 that will carry on into 2002. Of utmost importance are the 10 new patient safety standards and 22 standard revisions that took effect this past July. The new standards force leaders to forge a hospital-wide patient safety plan. More than ever, the JCAHO is holding leaders responsible when connecting examples of standards compliance. Ensuring compliance is a daunting job for all staff members, but this report will include some key patient safety pointers that BOJ has not yet covered. For example, we’ll tell you how to disclose medical error information to patients, collect data on patients’ views to improve patient safety, and prevent miscommunications with patients that can lead to patient care errors.

Also pertinent are the new and revised staffing effectiveness standards that will take effect this July. We’ll help you analyze your staffing levels based on your selection of the 21 new human resources and clinical screening indicators. You’ll learn why it’s important to use the indicators and be more descriptive in your variance reports to gauge your staffing effectiveness.

By now you all know about the new survey process called Individualized Centered Evaluation (ICE). ICE dictates a closer scrutiny of the individual patient care process from admission to discharge. This means you have more work in training the entire staff, since surveyors will ask more in-depth questions. We’ll tell you how to prepare your staff for ICE, since now everyone—including the janitor and receptionist—will be subject to surveyor inquiries.

We hope this “how to” special report on JCAHO changes in 2002 serves as a guide and reference as you navigate through some key standard requirements for the upcoming year.

Sincerely,

Julia Fairclough, managing editor

Briefings on JCAHO

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Employees come away with more than wages on payday at Hill Country Memorial Hospital in Fredericksburg, TX.

Straying from the traditional JCAHO inservice, the hospital set up booths for employees to collect their checks and learn about the accreditor in less than five minutes.

“We were amazed at how many employees came to pick up their check and even their [pay] stub if they had direct deposit,” says Debbye Wallace, RRT, CPHQ. “We were reaching well over half of the employees, especially night shift and weekend people who we might otherwise miss.”

Armed with similar innovative approaches, hospital administrators know they need quick, creative, and continuous survey prep skills these days to talk to staff about the JCAHO—a topic that can be as exciting as anesthesia to some harried workers. However, it’s even more important when the JCAHO changes gears and decides to probe into how you care for your patients—such as with its Individual Centered Evaluation (ICE) program, which casts a critical eye on patient care from admission to discharge.

Prepping with the pocketbook
Wallace, for example, is pleased with her educational approach. Her facility sets up two booths for its biweekly paydays. Nonclinical employees only go to one booth, where they answer questions related to the environment of care.

Clinical employees check in at a second booth and field questions on pain management, advance directive documentation, and so on. They spend about two to three minutes at each booth. Department managers help compile questions, and the employees receive small, educational flyers to take home. “When employees go through the booth, they get a small coin that they save and will be able to turn in for prizes in February. Our survey is scheduled for March 2002,” she says.

Wit and weekly messages
Georgetown (TX) Healthcare System quizzes employees via voluntary e-mail questions. The method not only teaches employees about JCAHO standards, but allows previously unknown comedians a chance to shine. For example,

**Question:** What is the emergency code for an external disaster, such as a bus accident in which the victims all come into our emergency room?
**Answer:** May I have your attention, please? There will be no FREE employee checkups in the emergency room for the next 12 hours.

“I send the answers out a few days later,” says Louis West, CHE, Georgetown’s vice president, who says he tries to create an informal atmosphere and encourage participation, even if it means receiving less-than-serious responses. Another employee provided this example of a sentinel event: “When we run out of catfish in the lunchroom on Fridays.”

Your organization could also hold a dry run and pull a random patient chart to prime staff for the “real thing.” Ask them questions such as the following:

- What are you doing to prevent complications?
- How are you coordinating care?
- Have you been oriented/trained to care for the patient?
- How do you monitor the care?
- How do you communicate to the patient and the family?

Keep your approach quick and consistent, says Pam Chesser, BA, CPHQ, LHCRM, director of quality management for Lakeview Center, Inc., in Pensacola, FL. Chesser sends out short weekly messages with tips for talking to surveyors. “That really seemed to help a lot,” she says. “I was able to field staff questions and respond quickly . . . [to] all 800 staff.”

Varied approaches work well
Chesser uses a number of ways to continue on p. 4
Prepare for survey continued from p. 3

educate the staff in her large facility. In addition to e-mail, she develops quizzes for leaders to use on their units. For example, you might ask staff the following questions:

• Which of the following best summarizes the JCAHO’s new ICE survey process?
  a. Surveyors will tour a hospital with just one staff member.
  b. Surveyors will pick one clinical area to survey.
  c. Surveyors study systems that drive operations and procedures to observe how standards compliance is evidenced in the care of each individual.
  d. none of the above
  (The answer is "c.")

  • ICE means any staff member can be subjected to surveyor inquiries.
    a. true
    b. false
    (The answer is true.)

Chesser also organizes seven mock survey teams to visit every department and evaluate readiness. She pounds the pavement—or the hallways, in this case, by showing up at staff meetings throughout the facility and talking about what to expect during surveys, handing out sheets of frequently asked questions, and giving out prizes for answers to pop quizzes.

“We have a large, complex, multi-site organization, but I really felt staff were well-prepared for the visit,” she says.

Relevant is right
Make sure your ICE-related survey prep techniques cover those accreditation hot buttons. For example, ask your frontline staff about pain management, since the JCAHO may scrutinize your facility on pain management.

The JCAHO is also emphasizing more leadership (LD) accountability these days. For example, your colleagues who underwent surveys in 2001 say a Type I in areas from housekeeping to anesthesia use can also result in an LD recommendation.

Since conscious sedation standards changes are medical staff-focused, make sure your physicians are well versed on this topic. Surveyors will expect answers from physicians.

Concerning the new patient safety standards, surveyors will most likely ask about your sentinel event policy, rather than whether your facility has experienced sentinel events. They will ask you to explain how to conduct a root-cause analysis. Surveyors will also ask your frontline staff what the policy is regarding reporting errors to patients.

Attitude is everything
Using a fun approach to staff education may help employees not only retain information, but develop an attitude that’s conducive to learning. West, for example, doesn’t view every new JCAHO initiative as just another arduous task, but rather as a challenge and “a means to provide better patient care.”

His philosophy might be responsible for what happened several months ago when he issued a facility-wide invitation for “JCAHO volunteers” to form a team responsible for maintaining a state of continuous accreditation. “I had almost 30 [staff] who responded,” he recalled. “These were directors, upper management, and regular employees.”

This new JCAHO Assessment Team’s responsibilities include reviewing standards and conducting mock surveys. This continuous approach to readiness also helps staff better understand the actual application of JCAHO standards and policies to their jobs. The JCAHO Assessment Team imitates the newest approaches used by surveyors, including the ICE philosophy. “The team is placing emphasis on surveyors spending most of the time on the patient care units rather than looking at policies and questions about our mission statement,” West says. - - -
Reluctant to acknowledge medical errors, health care providers now must not only face the facts, but, in many cases, disclose them to their patients, too.

If they do not, accredited health care organizations face noncompliance with the JCAHO’s new patient safety standards that require them to discuss the outcomes—both anticipated and unanticipated—of care with patients (see standard RI.1.2.2). The health care community has a lot of work to do to establish a new culture that encourages disclosure and dispels fears of litigation before the new standards take effect in July.

Note: The standard says hospitals must clearly define what the minimum event for disclosure is and who will inform the patient. If it’s not the licensed independent practitioner, then the medical executive committee must delegate that responsibility to someone, typically the risk manager, a JCAHO observer says.

“Disclosure of medical errors to patients remains one of the biggest challenges in the patient safety movement,” says Grena Porto, director of clinical risk management at VHA, Inc., of Irving, TX. Her organization, as well as the Pennsylvania Association for Health Care Risk Management (PAHCRM), has developed tools to assist health care providers in knowing what outcomes to disclose to patients—and just as importantly, how.

“[Health care providers] need to realize that it’s got to happen, because the people out there don’t trust us, and we really want to establish ourselves as trustworthy professionals of the healing arts. The only way we’re going to do it is this way,” says Marie Conti, ARM, CPHRM, director of risk management at North Philadelphia Health System and a PAHCRM member.

Fear in the room
On behalf of the Pennsylvania risk managers, Conti recently trekked across the state with a 72-page Patient Safety Guide that discusses and educates organizations about creating a culture of safety, including disclosing unanticipated outcomes to patients and their families.

She quickly relates the three most common concerns about disclosure that she gets from health care providers during these inservices:

- Physicians, of course, worry about litigation. “We say, ‘You’re going to be sued anyway,’ ” she says. It’s better to be up-front about an unanticipated outcome, [because it may] mitigate the amount of damages.

- One of the most common refrains is: “Well, somebody’s got to pay.” Health care workers don’t understand nonpunitive reporting, so education on this subject is crucial, Conti says. “Everyone makes mistakes. Making a mistake doesn’t mean you’re incompetent. It means you were distracted for any number [of reasons]. Somebody shouldn’t have to pay, because human error will continue. You have to put the safety net in place to prevent human error.”

- Nurses, on the other hand, worry about losing their licenses. Conti’s facility pledges its support for its staff who face loss of license in front of their nursing board.

Change will be slow, Conti says, but it must happen and happen at an organization-wide level.

What to disclose
So what medical errors should you tell your patients about? PAHCRM categorizes events into the following six levels in its guide, with levels 3–6 meriting disclosure to patients/families:

- **Level 1**: An event occurred but the patient was not harmed
- **Level 2**: An event occurred that
resulted in the need for increased patient assessments but no change in vital signs and no patient harm

- **Level 3:** An event occurred that resulted in the need for treatment/intervention and caused temporary patient harm
- **Level 4:** An event occurred that resulted in initial or prolonged hospitalization and caused temporary patient harm
- **Level 5:** An event occurred that resulted in permanent patient harm or near-death, such as anaphylaxis
- **Level 6:** An event occurred that resulted in patient death

Although your organization can use the above as a recommendation, “you determine what you want disclosed,” Conti says.

Some organizations may pull together a crisis intervention team to handle the disclosure, but PAHCRM recommends that the attending physician talk to the patient, unless the physician declines or would make the situation worse. In that case, the director of your ethics committee or another official with good people skills fits the bill.

Once you’ve discovered the event, the first priority is to evaluate the patient and remedy the situation as quickly as possible. Ensure that others aren’t at risk, then gather and sequester all relevant information, equipment, etc.

Breaking the news
Make sure you tell the patient and his or her family the news as quickly as possible. Convene all affected parties and treat the event as an instance of breaking bad news, the PAHCRM guide explains. Consider using the following guidelines to talk to the patient:

- State that you regret the incident took place
- Describe the decisions staff made, including those in which the patient participated
- Describe the course of events in nontechnical language
- Explain the nature of the mistake, its consequences, and any corrective action taken, including what you’re doing to prevent future mistakes
- Elicit questions or concerns from the patient and address them
- Express personal regret again

“Disclosure of medical errors to patients remains one of the biggest challenges in the patient safety movement.”

— Grena Porto

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Do you feel safe here?
Patients, families, and staff have their say

The JCAHO now requires you to ask patients whether they feel safe at your hospital, and, if not, why. But you just can’t come out and ask patients without possibly scaring them, or opening up a Pandora’s box to a whole host of (probably unrealistic) suggestions/criticisms.

Complying with PI.3.1—which requires hospitals to collect data to monitor their performance—requires you to ask patients, families, and staff members their opinions on patient care risks as well as suggestions for improvement. The revision, part of the JCAHO’s sweeping patient safety requirements, went into effect this past July.

The simplest way to comply is to incorporate this safety question into your hospital’s patient satisfaction survey, experts agree. But, of course, you have to consider how to pose your question.

Consider the following questions to add to your patient satisfaction survey:

• Do you feel safe here?
• Do you feel you are a partner in your care?
• Do you feel comfortable questioning a nurse or physician?

Education can play a role, too
The second question above ties in with patient education and the fact that hospitals must coordinate educational resources for patients and their families (PF.4). Hospitals can place in their admission packets additional information about patient responsibilities to ensure a safe environment, says Deb Ankowicz, RN, BSN, CPHQ, a risk management consultant for Physician’s Insurance Company Wisconsin in Madison. For example, the packet can instruct patients to ask their physicians if they have questions about medications.

“It’s about getting the word out that we have to work together and saying that, ‘We want you to be safe at our hospital,’ ” she says.

Regarding the third sample question above, it’s important that patients be able to ask their caregivers about their medications, Ankowicz says. Feeling comfortable about asking them questions relates to having the right to find answers about care plans.

At Parkview Medical Center in Pueblo, CO, staff give patients educational handouts that outline patients’ roles in preventing medical errors when they are admitted, says Robert Alsever, MD, FACP, the hospital’s vice president of medical affairs.

“It’s important that staff members educate patients up-front,” he says. The educational handouts will also help you to comply with the revised patient safety standard PF.3.7, which requires hospitals to educate patients about their care responsibilities. See Parkview’s 21 educational tips at www.parkviewmc.org/gsd_21Tips.htm.

Ease into the question
You can also seek patient safety opinions and suggestions indirectly, says Richard Kaine, MD, a consultant for Quality Management Resources in Atlanta. For example, you can add this question to your satisfaction survey: “Do you have any suggestions to improve security?”

“If you think about it, it’s a timely question right now considering what’s going on with the nation,” he says. “It’s not just a risk enhancing question as in the past.”

You can also ask patients whether they understand the educational materials on your hospital’s safety policy that they received and whether they have additional suggestions. “This puts hospitals in situations of nonthreatening compliance,” Kaine says. “You reduce the risk of creating customer dissatisfaction or apprehension in asking the question.” continued on p. 8
Feeling safe  continued from p. 7

Courtesy call
At Hill County Memorial Hospital in Fredericksburg, TX, staff members conduct follow-up telephone calls for inpatients and have added the following three questions related to patient safety, says Debyee Wallace, RRT, CPHQ, the hospital’s quality improvement coordinator:

1. Did you see your caregivers routinely wash their hands?
2. Did your caregivers check your identification band prior to administration of medications?
3. Did you feel your care was provided in a safe and effective manner?

“We just started this program [in October] but plan to trend the results to identify any problems, like [the need to improve] handwashing, and that is where we will focus our improvement efforts,” she says.

Staff opinions
When it comes to staff feedback—also a revision to PI.3.1, which requires hospitals to collect data on staff willingness to report medical/health care errors—Newman Regional Health in Emporia, KS, stringently coordinates opinions and suggestions.

For starters, supervisors ask staff members during their annual inservice whether they have any suggestions to further improve patient safety, says Kitty Frank, the hospital’s performance improvement coordinator.

“It was a good follow-up to my presentation on what types of issues to consider with the new patient safety standards,” Frank says.

To ensure that staff members’ suggestions go to the appropriate department manager, Frank collects about three months’—or eight inservice sessions’—worth of suggestions and places them in a grid (see sample grid on p. 9).

The hospital’s assistant administrator for quality services then assigns each comment to the appropriate department director to develop/implement an action plan. The director has seven days to respond to the assistant administrator.

Taking action
Any worthwhile actions implemented following a staff suggestion go into the hospital newsletter. “A few times we have worked directly with the employee to resolve an issue, so the employee knows first-hand that we took some action,” Frank says.

How you communicate with each other and with patients plays an important role in patient safety
Consider these pointers for the new IM standard revisions

Caregivers must pay attention to how clearly they communicate with each other and their patients if they want their patient safety plan to be successful.

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The JCAHO revised two Management of Information (IM) standards to promote accurate and timely communication. The changes to IM.1 and IM.5 join the 20 other patient safety standard revisions that took effect this past July. As you know, you’ll be scored on these standards in July 2002.

The revised intent statement for IM.1 has new language requiring hospitals to assess their IM needs based on the “identification of barriers to effective communication among caregivers.” The revised intent for IM.5 requires hospitals to pay specific...
Patient safety/ confidentiality/ compliance suggestions
employee inservice
Date_______________________

Please return to [appropriate staff person] with action taken within seven days.

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Source: Newman Regional Health, Emporia, KS. Reprinted with permission.
attention to the “processes for ensuring accurate, timely, and complete verbal and written communication among caregivers and all others involved in the utilization of data.”

What these changes mean is an opportunity to “identify what the barriers are to communication and then to perform a root-cause analysis on them so that people can put new processes in place,” says Jean Clark, RHIA, service line director for health information at Roper CareAlliance in Charleston, SC. And this is a positive thing, since “it never fails that anytime there’s a survey of staff communication, the lack thereof ends up being one of the top problems. Hospitals do struggle with communication,” Clark says.

Cracking down on communication
Pay specific attention to ensuring accurate, timely, and complete verbal and written communication among caregivers and all others involved in utilization of data, says Rick Sheff, MD, vice president of consulting for The Greeley Company, a division of HCPro, in Marblehead, MA. Sheff spoke about new information management focuses during a Greeley Company audioconference about patient safety standards.

“Make no mistake about it, the JCAHO is looking at both verbal orders and written communication, and that is probably where they are going to start drilling down and looking at physician handwriting,” Sheff says. Although there have always been standards that allowed the JCAHO to look at handwriting, the standard intent revision that clarifies how written communication contributes to errors will become more of a focal point during surveys in 2002.

Medication order legibility is a good example of a barrier to patient safety in regard to medication errors, Clark says. Organizations need to focus on the legibility of their orders.

“I don’t mean just focusing on physician handwriting but, for example, if there is a phone or verbal order; the person taking that down must write legibly,” she says. Note: If you look at this particular barrier and tie it back to IM.7.10—which requires hospitals to review medical records on an ongoing basis for completeness and timeliness of information—you can kill two birds with one stone, says Clark.

Relevant Sentinel Event Alert
The JCAHO’s October Sentinel Event Alert #23 states that medication errors are most often due to staff misreading abbreviations and dosages. Contributing factors include illegible physician handwriting and staff members’ failure to communicate clearly with one another.

In particular, some problematic abbreviations—such as “U” for “units”—can often look like zeroes. The root cause of sentinel events related to insulin dosage sometimes stems from the interpretation of a “U” as a zero, the Alert states. Therefore, to minimize the potential for errors, staff should avoid using these abbreviations.

Establish two tasks at once by taking into account the JCAHO’s suggested risk reduction strategies for the required Alert analysis (to comply with PL.4.2) and also IM.1 by examining the following Alert recommendations, suggests Richard Kaine, MD, a consultant for Quality Management Resources in Atlanta:

• Develop a list of unacceptable abbreviations and symbols
• Develop a policy that requires the medical staff to use the list
• Establish a policy that if staff use an unacceptable abbreviation, they must verify the order

“People tend to use the standardized shorthand when writing down medication orders, which is a clear barrier,” Kaine says. Read the full Alert at www.
Accents count, too
You can also strengthen communication at your hospital by looking at the prevalence of accents among the professional and medical staff, Kaine says. Take these two approaches:

1. If there’s any question about orders, ask staff members to repeat back what they heard. “If a physician [who has a heavy accent, for example] gives a nurse instructions or comments on lab work, the nurse may ask [him or her] to repeat that a second time,” he says. “That is a quick and easy way to enhance confirmation in accuracy.”

2. If a staff member takes information by phone and wants confirmation on the order, record the information, then fax it back to the caregiver who gave the instructions.

Take into account the quality of your phone system in terms of clarity and the ability to vary the phone’s volume for those who have mild to moderate hearing impairments, Kaine says.

“If anyone is not clear about communication, the culture of the organization ought to be to encourage anyone to ask for clarification,” adds Clark. “In other words, people should not feel intimidated to do so. It should be a safe process for anyone to say, ‘I did not understand you, can you clarify that for me?’”

The education component
Hospitals can also hold patient education classes, which help with Assessment of Patients and Patient Rights and Organization Ethics standards compliance, Clark says.

“These standards flow throughout the [hospital accreditation] manual, as far as patient safety is concerned,” she says. Hospitals should give patients informational brochures about pain management, patient safety issues, and how to obtain their medical records, Clark says.

Ensure written information is at a level patients can understand (take into account health literacy; see related story on p. 12), and offer it in various languages.

Other patient education considerations are whether there are enough interpreters on staff, if a patient has a hearing problem, and providing assistance for the deaf and blind, Clark says. “These are the other barriers to communication, and if you don’t have the proper tools, you will hurt your patient safety plan,” she says.

Communication tips
Clark and other industry experts offer the following pointers on how to break down those communication barriers that jeopardize your patient safety plan:

• Switch to preprinted medication orders so there will never be a question about handwriting.

• Offer penmanship classes to staff members.

• Implement a policy that handwritten orders will not be accepted—only preprinted orders will suffice.

• Switch to electronic medical records, which is the “ultimate answer for clear communication for any user at any time, and [is] where organizations need to be moving,” Clark says.

• Ensure that staff can access pertinent electronic records. “People store radiology, lab reports, and other dictated reports in the electronic record, so there must be instant access to break down any barriers to informing caregivers of past and current information about the patient,” Clark says.

To order the audioconference, “New 2001 JCAHO Patient Safety Standards” visit www.hcmarketplace.com or contact customer service at 800/650-6787.
Limited health literacy is another barrier to communication

Health literacy is the ability to read, understand, and act on health care information. After recognizing that limited literacy is a barrier to effective medical diagnosis and treatment, the American Medical Association (AMA) launched a multi-year initiative in 1998 to better understand the effects of low health literacy and improve the communication skills of health care providers, says Joanne G. Schwartzberg, MD, director of aging and community health at the AMA.

Schwartzberg spoke at a patient safety conference held this past summer in St. Paul, MN, on the relationship between low health literacy and patient safety.

Research shows that many patients with poor health literacy are more likely to be hospitalized, which increases the challenges of effective prescription use and compliance with treatment plans. Also, many patients struggle with reading health-related information, including instructions to take medications on time and not on an empty stomach. Health literacy also decreases with age, Schwartzberg says. In addition, low health literacy is expensive, costing about $73 billion a year, according to the National Academy on an Aging Society.

Low health literacy is often overlooked because many patients do not recognize their inadequate literacy, or they are ashamed of it and attempt to hide it.

Clinicians typically fail to ask about a patient’s health literacy because they don’t know the problem exists or how to respond to it. See the box below on how to combat poor health literacy.

Combat low health literacy with these steps:

1. Use language that the patient can understand.
2. Create a shame-free environment. “Patients don’t want an intelligent physician to know they have problems understanding the information,” explains Joanne G. Schwartzberg, MD, director of aging and community health at the American Medical Association.
3. Help patients with paperwork.
4. Speak slowly.
5. Read written instructions and materials out loud to the patient.
6. Use “teach back” techniques—physicians should ask the patient to repeat instructions and other important information.
7. Ask the patient whether there is a family member or friend to whom the physician should also relay important information.
New JCAHO staffing standards require you to demonstrate through data collection and measurement whether your staffing plan is truly effective. While in the past, staff members considered daily patient census and complexity of care when establishing staffing levels, you now have to use clinical and human resources indicators to gauge staffing levels (see story on p. 16 outlining new staffing standard HR.2.1 requirements and revisions to other standards).

It’s new for hospitals to aggregate data based on indicators to statistically quantify appropriate staffing ratios, says Steve Bryant, practice director of accreditation and regulatory compliance services at The Greeley Company, a division of HCPro, in Marblehead, MA. “This is an area where hospitals have had challenges in the past,” he says. “Hospitals tend to collect a lot of data, but often fail to aggregate and analyze the data properly.”

However, hospitals do have measures in place to quantify staffing effectiveness; you just need to aggregate the proper data and report the results, he adds. As you prepare for the July 1, 2002, effective date for new staffing standard HR.2.1, keep things simple. Don’t reinvent the wheel since “most hospitals are already collecting the data relative to the JCAHO’s 21 recommended staffing indicators,” says Bryant.

However, what hospitals need to do is decide which of the indicators will best reflect and quantify the effectiveness of their staffing. The standard, as written, helps hospitals to recognize that staffing effectiveness cannot be determined by any one measurement.

Here’s an action plan to ensure your hospital complies with new staffing requirements:

1. **Assess what you’re already doing**

   Take a minute to reflect on the JCAHO’s indicators (listed on p. 17). Before choosing the indicators for your organization, create an inventory and assess:

   • what you are already collecting data on
   • who is collecting the data
   • how staff report data and how often
   • what the results show
   • whether there’s a clear link to staffing

   **Tip:** Identify those indicators that you currently collect data on, and identify who has that data and how they currently use and report it, Eisenberg says.

   If your hospital must have a staffing plan that includes nursing care hours per patient day, then you probably are already collecting data on the following indicators:

   • Nursing care hours per patient day
   • Understaffing as compared to staffing plan

   The staff injuries on the job indicator should look very familiar since recording staff injuries is an Occupational Safety and Health Administration requirement and most likely part of your risk management program, Eisenberg says. Indicators regarding patient falls and injuries to patients most likely are in your risk management program as well, she continues. Many organizations include
measures to prevent falls as part of their restraint use improvement program.

Two clinical/service indicators—family and patient complaints—are already hospital requirements, says Eisenberg. Medicare’s Conditions of Participation for patient rights requires hospitals to address each patient compliant. In addition, the staff satisfaction indicator is not only considered good practice, but has also been a suggested measure within the performance improvement chapter for quite some time, she adds.

The adverse drug events indicators should not be new. Pharmacy and therapeutics committees have always looked at these events.

Now, with the concentration on patient safety and medication errors, many hospitals scrutinize this data even further, says Eisenberg. Utilization management typically reviews the length of stay indicator. You’re probably examining the data for budgetary reasons, too.

Do you have an infection control program? Chances are that your staff already review the rates of pneumonia, postoperative infections, and urinary tract infections, Eisenberg says. Perhaps your medical staff or nursing quality management program reviews the incidence of upper gastrointestinal bleeding and skin breakdown.

Finally, the shock/cardiac arrest indicator is most likely in action at your hospital, since PI.3.1.1 requires hospitals to monitor and measure incidence and response to cardiac arrests, Eisenberg says.

“This process will allow you to recognize what you are already doing, analyze the data, and identify the links to effective staffing,” she says. “The difficult part for all of us is that we are not as good at aggregating it and using it to impact, improve, and implement change across the organization.”

**2. Pick your four indicators.**

After completing a full inventory and assessment of data collection, determine the indicators that best reflect your organization. This is a key factor in actually impacting or improving staffing. Of the JCAHO’s indicators, identify those that you are measuring and those that can be directly linked to effective staffing, Eisenberg says.

**Tip:** Ask yourself whether any of the indicators relate to your annual goals. For example, if your overall goal is to improve patient satisfaction and you can make a connection between the data results and overall staffing effectiveness, this might be a logical choice, Eisenberg says.

Check to see whether other staff members at your hospital prepare similar analyses. For example, patient safety standard LD.5.2 requires organization leaders to implement an ongoing proactive program for identifying risks at their organizations. The standard further requires leaders to select at least one measure to improve patient safety.

**Tip:** “Talk with organization leaders to determine what that indicator is, because many proactive analyses do include analyzing the human resource factors,” Bryant suggests.

**3. Document your rationale for choosing the four indicators.**

This means you must write down why you picked the indicators that you did. Your current quality improvement structure is the best place to discuss and document the rationale for choosing the appropriate staffing effectiveness indicators, Eisenberg says.

**Tip:** Present the full indicator review and assessment to your quality oversight committee, she says.
When you identify appropriate indicators and document the rationale, think about what indicators make the best sense at your hospital. For example, if you are a smaller hospital and your incidence of cardiac arrest is low and outcomes are good, it would not make sense to choose this indicator. It will not give you a true link to staffing because of the infrequent incidence of cardiac arrest, Eisenberg says. If you are a pediatric hospital and don’t treat geriatric patients, selecting the skin breakdown indicator may not be a logical choice either since it would not provide useful feedback, Eisenberg says.

“Take some time to perform a focused analysis on each indicator to see how it links back to staffing in your hospital,” she says. “You might be tempted to select the indicator that has the best results. Ask yourself whether that is the best approach to gauge staffing effectiveness and whether it provides you with a true view of staffing.”

Highlight both direct and indirect caregivers.

Don’t just focus on the clinical staff. The big picture is important here.

“We know the focus is on patient care areas and providing quality patient care,” Eisenberg says. “Don’t forget about all of the staff who contribute to patient care but are not directly involved in providing the care on the unit.”

For example, consider environmental services. Quite often for budgetary reasons, housekeeping staff are the first to be eliminated or have their responsibilities merged into someone else’s job. But when you cut that position or merge those responsibilities, you impact patient care, Eisenberg says. “That nurse or nurse’s aid who is responsible for providing direct patient care now has to pull garbage bags or sharps containers—things ordinarily done by housekeeping or materials management—which will affect his or her other patient care responsibilities.”

Analyze the data appropriately.

Use statistical techniques and tools, such as focusing on trends over time and external comparisons (benchmarking), Eisenberg says. As mentioned, focus on the measures already in place.

Ask yourself why you are looking at this data and identify what results you are trying to achieve. Next, identify those measures with clear links to staffing effectiveness. Can you draw conclusions about staffing effectiveness when reviewing and analyzing the data already collected? Can you pull two or more of the indicators together and report the results using a performance improvement tool such as a run chart or control chart to show their correlation to effective staffing?

6. Report at least annually to leaders on the aggregation and analysis of data related to the effectiveness of staffing (PL.3.1.1).

Eisenberg breaks the reporting requirement down to the following three basic steps:

- Report
- Document recommendations
- Document action

“The intent is to make sure that organizations focus on internal processes, outcomes, results, and the link to effective staffing,” Eisenberg says. “By doing so, and taking this information into account when planning care, we as leaders can make sure that our organization is staffed appropriately and that staff deliver patient care appropriately and safely.”

Include in your reporting the leaders who can impact direct patient care. The results not only will provide a view of staffing needs but will also provide a view of educational needs.

Ensure that educational training needs correlate with staffing effectiveness, Bryant says. You must also show evidence of action taken.

“If we are collecting data, and it suggests we have variations, we need to document actions taken,” says Bryant. This standard also relates to PL.4.3, since the JCAHO added the words “staffing effectiveness” to undesirable trends to investigate.

Tip: Report annual staffing effectiveness data.

You can report it in the same manner you report ORYX data. Perhaps you report your ORYX data quarterly to a quality oversight committee. Take the opportunity to report the staffing data as well.
New staffing standard requirements

**New standard: HR.2.1**

Organizations must use data on clinical/service screening indicators in combination with human resources indicators to gauge staffing effectiveness.

**Intent:**

- Hospitals select a minimum of four screening indicators—two clinical/service and two human resources. The focus should be on the relationship between human resource and clinical/service screening indicators, with the understanding that no one indicator can directly correlate with staffing effectiveness.

- Hospitals must select at least one human resource and one clinical/service indicator from the JCAHO’s indicator list. Organizations choose two additional indicators according to their “unique characteristics, specialty, and services,” according to the standard posted at www.jcaho.org (go to “top spots” on the home page and click on “standard revisions for 2002” and then click on “revisions addressing staffing effectiveness”).

- Organizations determine the rationale for indicator selection.

- Both direct and indirect caregivers chose the indicators. Organizations define which caregivers to include in the human resource indicators based upon the impact, if any, the absence of a particular caregiver will have on patient outcomes.

- Hospitals use the data collected and analyzed to identify potential staffing effectiveness issues.

- Hospitals establish a process to analyze screening indicator data over time per measure (i.e., target ranges, trends over time, the stability of the process, external comparison data) and then in combination with other screening indicators (a matrix report, spider diagram, etc).

- Hospitals analyze screening indicators at the level most effective for planning staffing needs and in collaboration with other areas in the organization, as needed.

- The organization reports at least annually to leaders about the aggregation and analysis of data related to the effectiveness of staffing (PI.3.1.1) and any actions taken to improve staffing.

- Hospitals demonstrate action taken in response to the analyzed data.

**Intent revision: HR.2**, which requires hospitals to provide an adequate number of staff members, has the following new intent phrase:

- Hospitals use data on clinical/service and human resource screening indicators to identify staffing needs (HR.2.1)

**Intent revision: PI.3.1.1**, which requires organizations to collect data to monitor the performance of processes that involve risks or may result in sentinel events, has the following new process in which to identify performance measures:

- Staffing effectiveness (see HR.2.1)

**Intent revision: PI.4.3**, which requires hospitals to analyze undesirable patterns or trends, has the following new requirement to analyze:

- Staffing effectiveness issues (see HR.2.1)

**Intent revision: LD.4.3**, which requires leaders to measure, assess, and improve important activities, has a new intent statement phrase:

- Priorities relate to hospital-wide activities, staffing effectiveness (HR.2.1), and patient health outcomes.

The JCAHO’s 21 staffing indicators

The new staffing standards are based on 21 human resources (HR) and clinical/service (C/S) screening indicators. The new indicators are:

- Overtime (HR)
- Family complaints (C/S)
- Patient complaints (C/S)
- Staff vacancy rate (HR)
- Staff satisfaction (HR)
- Patient falls (C/S)
- Adverse drug events (C/S)
- Staff turnover rates (HR)
- Understaffing as compared to the organization’s staffing plan (HR)
- Sick time (HR)
- Overtime (HR)
- Pneumonia (C/S)
- Postoperative infections (C/S)
- Skin breakdown (C/S)
- On call or per diem use (HR)
- Upper gastrointestinal bleeding (C/S)
- Length of stay (C/S)
- Shock/cardiac arrest (C/S)
- Length of stay (C/S)

New supervision of residents’ standards means you must tweak your medical staff bylaws and policies

One of a few new standards for 2002 includes the supervision of residents’ standard, which takes effect January 2002. The JCAHO wants to hold medical staff more accountable for their residents, as evidenced in two new medical staff standards—MS.6.9 and MS.6.9.1, as well as the revised MS.2.5 (read full story on p. 1 of the November BOJ).

The standard changes mean that you have to

- add to medical staff bylaws new policies that refer to the resident supervision process when caring for patients (MS.2.5)
- make certain that resident supervisors are licensed independent practitioners (LIP) (MS.6.9)
- ensure that resident supervisors hold clinical privileges that reflect the residents’ patient care responsibilities (MS.6.9)
- forge an effective communication exists among the committee(s) responsible for professional graduate education, the medical staff, and the governing body (MS.6.9.1)

The new standards create many additions to your medical staff’s bylaws, policies, and procedures, such as spelling out which residents may write patient care orders, under what circumstances they may do so, and what entries a supervising LIP must countersign.

We do the work for you
But you don’t have to do anything other than read this article, since this special report offers the following sample forms that you’ll need to comply with the resident supervision requirements:

- Residency program letter on p. 18
- Residency policy on p. 19
- Medical student program letter on p. 20
- Medical student application on p. 21
- Medical student policy on p. 22
- Policy on visitors to the operating room on p. 23

Note: The above policies for residents and students apply to hospitals that have visiting residents and students.

Editor’s note: All the above forms are courtesy of Parkview Medical Center, Pueblo, CO. Reprinted and adapted to read as a generic form (hospital information and logos have been taken out) with permission.
Enclosed is a residency physician application to see patients in [hospital name], the policy for resident physicians, and the rules and regulations for dealing with residents in training. Please complete the application and return to [hospital name] Medical Staff Office.

As a resident, you will not be able to see patients until we receive a completed application, verification that you are in good standing in an acceptable residency program, and liability insurance by the program or by the [hospital name] medical staff member who sponsors you.

When your application is approved, you will be notified by a phone call, followed up by a letter.

If you have any questions, please feel free to call [phone number].

Thank you,

Medical Staff Services
Sample residency policy

<table>
<thead>
<tr>
<th>Hospital logo can go here</th>
<th>Number __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>Effective date __________</td>
</tr>
<tr>
<td>Medical Staff Services</td>
<td>Applies to:</td>
</tr>
<tr>
<td>Subject:</td>
<td>Cross Ref:</td>
</tr>
<tr>
<td>Resident physicians</td>
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</tbody>
</table>

Reviewed | Revised

Policy
1. Medical staff privileges may not be granted to a resident.
2. The chief executive officer, appropriate department chief, chief of staff, and vice president of medical affairs must approve all resident physician programs.
3. The medical staff office of [hospital name] must verify all affiliated resident physician programs.
4. Resident physicians or the affiliated program sponsoring a resident must provide professional liability insurance with the coverage limits in an amount required by the [hospital name] board of directors.
5. Prior to patient contact, resident physicians will complete an application form that includes [name of state] license number if appropriate. Licensure will be verified, if appropriate.
6. No resident physician may use his supervising physician’s identification number or computer access code(s) at any time. The resident physician may apply to Information Systems for his or her own computer access code.
7. According to the medical staff rules and regulations:
   SECTION 5
   RESIDENTS IN TRAINING
   Residents in training shall be under the supervision of an attending physician on staff at [hospital name]. The residents shall have no hospital privileges as such but shall be able to care for patients in the medical center under the supervision and responsibility of their attending physician. The care they extend will be governed by the general rules and regulations of each clinical department and general bylaws of the medical staff. The practice of care shall be limited by the scope of privileges of their attending physician. Any concerns or problems that arise in the resident’s performance should be directed to him or her and the director or designee of the training program to solve or clarify the problem.
   A. Residents may write orders for the care of patients under the supervision of the attending physician.
   B. All records of resident cases must document involvement of the attending physician in the supervision of the patient’s care to include co-signature of the history and physical, operative report, and discharge summary.
   C. All admissions will be co-designated in name and responsibility to include an attending physician.
   D. Medical staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone.
8. The resident is a guest of the [hospital name] and is in no way to interfere with patient care or the professional responsibilities of the hospital staff.
9. No health care benefits, workers’ compensation, or other benefits are provided by the [hospital name] in the event of illness or injury.
10. A completed application form and all additional information requested must be supplied to the medical staff office for consideration and approval prior to working in the hospital.
Enclosed is a medical student application for [hospital name] and the policy for medical students in the hospital. Please complete the application and return it to the Medical Staff Office before you begin your rotation with the [hospital name] staff member.

As a medical student, you will not be able to see patients until we receive a completed application, verification that you are in good standing with your program director at your school, and liability insurance by the school or by the [hospital name] staff member who is sponsoring you.

When your application is approved, you will be notified by a phone call, followed up by a letter.

If you have any questions, please feel free to call [telephone number].

Thank you,

Medical Staff Services
# Sample medical student application

**Medical Staff Office**

**Address**

**City, State, Zip code**

**Phone Number**

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<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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**Present Mailing Address**

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**Permanent Home Address**

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## PRE-MEDICAL EDUCATION

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<td>Graduate School</td>
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## MEDICAL EDUCATION

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**Sponsoring (hospital name) staff member**

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<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Work Phone</th>
<th>Pager Number</th>
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**Present Mailing Address**

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**Program Director**

**Address**

**Phone**

**Applicant's Signature**

**Date**
### Sample medical student policy

| Hospital logo can go here | Number ________  
|---------------------------|------------------
| Effective Date __________ |                  |

<table>
<thead>
<tr>
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<tr>
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<th>Revised</th>
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Chaired by:  
Chief Operating Officer  
Vice President of Medical Affairs  
Director of Accreditation Services

**Policy**

1. Medical staff privileges may not be granted to a medical student.
2. Medical students may be given certain privileges in an informal externship program approved through the medical staff office after approval of the chief executive officer, the chief of the appropriate department, the chief of staff, and the vice president of medical affairs.
3. The medical student must be under the continuous supervision of a member of the medical staff.
4. Medical students must wear identification badges when in the hospital. The badge may be obtained from the Human Resources Department if the student does not have one.
5. Verification of current enrollment in an approved medical school program is required.
6. The medical school in which the medical student is enrolled must be verified. The school must verify that the student is in good standing.
7. As permitted under the medical staff bylaws, a medical student may have access to various areas of the hospital and may be permitted to do the following:
   - Observe patient care.
   - Assist in the preparation of history and physical examinations.
   - Observe surgery or special procedures.
   - Generate progress notes in the medical record. All such entries must be countersigned by the supervising and attending physician.
8. Medical students are not permitted to perform surgery or special orders or to give verbal orders.
9. Medical students may scrub and assist in the operating room under the direct supervision of a supervising medical staff member; provided there is verification from their school that they have been trained in sterile technique, proper scrub, gowing, and gloving. Medical students may close skin provided there is verification of experience from their medical school and provided the patient has consented.
10. The medical student is encouraged to review laboratory studies, x-rays, and pathological specimens on patients whom he or she is following.
11. The medical student is a guest of the [hospital name] and is in no way to interfere with patient care or the professional responsibilities of the hospital staff.
12. No health care benefits, workers’ compensation, or other benefits are provided by the [hospital name] in the event of illness or injury.
13. The medical staff must receive a completed application form and all additional information requested for consideration and approval prior to working in the hospital.
14. Students may not use their supervising physician’s computer access code(s) in the hospital. Students may apply to the Information Systems Department to obtain their own password. Each student will sign a confidentiality agreement.
**PURPOSE:**
To protect the patient from potential infection, injury, invasion of privacy, breach of confidentiality, and disruptions while providing for optimum surgical care in the appropriate surgical milieu and education of medical personnel. To comply with state, federal, regulatory, and legal mandates.

**POLICY:**
1. ALL visitor requests will be referred to the clinical manager (CM) of the operating room (OR).
2. It is under the discretion of the CM, or designee, to grant FINAL approval to any of the visitors described in this policy.
3. No family member of a patient having surgery is allowed in the OR during surgery. An exception will be made for the significant other of a patient having a C-section.
4. Special consideration will be given to unique circumstances, approved by the CM.
5. Patient confidentiality will be maintained at all times.
6. Four categories of visitors, scope of participation, approval, and examples are described below.

<table>
<thead>
<tr>
<th>Visitor</th>
<th>Will be permitted to do:</th>
<th>Approval/permission</th>
<th>Example of visitor (but not limited to)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observer</td>
<td>May be in the OR itself but not participate in the care of the patient. Access to the room will be coordinated by the circulating RN.</td>
<td>Approval granted by CM of department and patient’s attending physician. Permission granted from patient and Anesthesiologist.</td>
<td>Parental Presence, SO of c-section, equipment vendor.</td>
</tr>
<tr>
<td>Physician observer</td>
<td>May be in OR, but does not participate in care of patient.</td>
<td>Approval granted by attending surgeon and CM of department.</td>
<td>PMC or visiting physicians.</td>
</tr>
<tr>
<td>Tours</td>
<td>May tour the department but may not enter any OR in which a procedure is underway (case open).</td>
<td>Approval granted by CM of department.</td>
<td>Pediatric pre-op education program.</td>
</tr>
<tr>
<td>Clinical participation</td>
<td>May scrub in and have limited participation in operative procedure at the discretion of the attending surgeon, within the scope of training and the [Hospital name] medical staff by-laws.</td>
<td>Approval granted by CM of department, attending surgeon, chief medical officer, and the director of medical education.</td>
<td>Interns, residents, visiting physicians.</td>
</tr>
<tr>
<td>Student/orientee</td>
<td>Personnel for whom OR procedure is a part of a [hospital name] approved educational program (the instructor/preceptor of the student will provide constant supervision while in the OR). Students will be allowed to observe or participate depending on their education program.</td>
<td>Approval granted by CM of department and attending surgeon. A current contract between [hospital name] and the teaching facility must be on file in the education department before students will be allowed in the OR. Medical and PA students require approval by the director of medical education and chief medical officer.</td>
<td>CST students, nursing students, PT/athletic trainer students, high school/middle school/college students. Medical, physician assistant students.</td>
</tr>
</tbody>
</table>
Some general advice
In addition to the previously mentioned tips, you can go to the American Society of Health Risk Management's (ASHRM) Web site, www.ashrm.org, and click on its recent publication, Perspective on Disclosure of Unanticipated Outcome Information, to develop a checklist that will help in drafting your organization's disclosure policy.

Consider the following recommendations:

- **Emphasize communication.** ASHRM describes communication as a “fundamental component of the caregiver-patient relationship.” Communication between a provider and patient can build trust, which in turn makes discussions regarding unanticipated outcomes easier.

  **Tip:** Consider different cultural, linguistic, cognitive, and physical challenges that might affect the best way to communicate information to the patient.

- **Use consent as a patient safety tool.** Known risks associated with a procedure can be labeled as unanticipated outcomes if you don’t communicate those risks to the patient ahead of time.

  Communicate these risks to the patient during the consent process, which should involve discussions between the provider and patient to help the patient make informed decisions regarding treatment. These discussions can also alert the provider to information that affects the plan of care.

  **Tip:** ASHRM warns against equating a consent form with a consent process. A form does not replace the importance of a discussion between the provider and patient.

- **Provide empathetic support.** Providers should listen and express concern when an unanticipated outcome occurs. Remember that expressing concern is not an admission of liability.

  **Tip:** Involve support services that address the patient's and the family's specific religious, cultural, and linguistic needs. Involve clergy and social services, if appropriate. ASHRM suggests providing help to the patient in regard to housing, long-distance telephone services, and contacting relatives.

  - Offer disclosure training to providers. Inservice training should address your organization's policy on unanticipated outcomes, individual responsibilities, and documentation requirements. In addition to your statewide chapter of ASHRM, you can learn more about Porto’s organization, VHA, Inc., which provides training, at www.vha.com.

  **Tip:** ASHRM suggests videotaping your physicians as they role-play such patient disclosure discussions. Provide individual training tips. Consider including disclosure training in your orientation programs.

- **Enlist the help of bioethical consultants.** Legal and ethical issues arise when regulatory or psychological factors require withholding information about unanticipated outcomes. An outside resource could help your organization determine the best approach.