The Joint Commission recently released a new chapter to the Comprehensive Accreditation Manual for Hospitals (CAMH) entitled Patient Safety Systems. The chapter is intended to encourage organizations to build more high-reliability environments, specifically working to promote and foster high-quality, safe patient care.

The Joint Commission refers to this as a patient-centered model. “But for those healthcare organizations who truly aspire to be top performers in today’s healthcare market, being merely patient-centered may not be sufficient,” says Sena Blickenstaff, BSN, MBA, principal with Compass Clinical Consulting, and a former Joint Commission and CMS deemed status surveyor.

“The pursuit of high-quality, safe patient care must be patient-centric,” Blickenstaff says. “Patient-centric moves beyond the patient being merely a participant in their healthcare. Patient-centric means the patient is the driver and intimately involved every step of the way, to the fullest extent possible, and that there are systems of care throughout the organization designed to continuously enhance quality and safety at the patient level.”

The Joint Commission announced the release of its new Patient Safety Systems chapter at its annual Hospital Executives Briefing conference in September, noting that the chapter would be a focus
for future accreditation surveys. The chapter focuses on three overarching concepts:

- Aligning existing standards with daily work to reduce harm
- Assisting with knowledge, skills, and competence of staff and patients by recommending methods to improve quality and safety
- Recommending a proactive quality and safety methodology to increase accountability and reduce fear and blame, thereby promoting an organizational just culture

While there are no new standards or elements of performance (EP) in this chapter, Blickenstaff notes, the chapter turns a sharp focus on senior leadership.

“Having a culture of safety is not a new concept. This expectation has been around for a long time,” she says. “But what The Joint Commission has done with this new Patient Safety Systems chapter is essentially codified this concept with corresponding standards and EPs that can be scored where issues are identified during an accreditation survey that suggest there are systemic deficiencies around the organization’s culture of safety.”

This means there is an expectation that healthcare leaders focus their infrastructure, their systems and processes, to enhance quality and safety throughout their organizations.

“When surveyors arrive, they will be looking more closely at those systems of care. If they identify systemic issues that are adversely impacting quality and safety, they will be looking more closely at leadership,” says Blickenstaff.

Interestingly, this may have an impact on how the top cited standards released by The Joint Commission play out in the coming year. “Currently, when you look at the top cited list of standards as reported by The Joint Commission, you rarely see leadership cited,” says Blickenstaff. “When I see this new chapter and how heavily it references leadership standards and EPs, I can’t help but wonder if we won’t see leadership show up as a more frequently cited standard in the future.”
Data collection and use

The new Patient Safety Systems chapter not only focuses on leadership, but also emphasizes how the organization collects, analyses, and uses its data to improve quality and safety.

“Certainly leadership expectations have been clearly outlined when it comes to a culture of safety and systems of care, but the new PS chapter also highlights data collection and analysis expectations when it comes to enhancing quality and safety. That is, how is the healthcare organization using data to not only improve quality and safety, but to proactively identify and mitigate risks around quality and safety,” says Blickenstaff. “Additionally, there is the expectation that the organization is collecting and analyzing data effectively. This needs to be looked at more closely and perhaps in a different light than it has in the past.”

Organizations need to consider what kind of analysis they are performing on their data and whether they are using the right analytical tools, notes Blickenstaff. Does the analysis diagnose the problem correctly, and are the appropriate, sustainable solution(s) to that problem being implemented?

Again, leadership’s role in ensuring that the organization is collecting, analyzing, and using data effectively to enhance quality and safety as outlined in the new chapter is clear.

“The Patient Safety Systems chapter references several Leadership standards that can be cited relative to how the organization collects, analyzes, and uses its data to drive quality and safety,” Blickenstaff notes. “For instance, there are leadership standards that require information be presented in a clear manner; information be shared with appropriate groups throughout the organization; opportunities for improvement and actions to be taken be clearly articulated; and the need for leadership to provide staff with the time, resources, and opportunities to participate in improvement efforts as part of daily work.”

What should organizations be aware of while preparing to address the new chapter?

“They will want to be aware of the filter with which surveyors on-site will be conducting their accreditation survey in light of this new chapter,” says Blickenstaff.

Again, if the surveyors identify systemic issues that would suggest there are problems with the culture of safety, they will bring these issues up, most likely during the leadership session. For example, “if I am a surveyor and I see low- and high-level dust, or cleanliness concerns throughout the organization possibly suggesting a resource issue, not simply as an isolated finding, my conversation would move from an isolated infection control issue to leadership’s role in providing adequate resources,” says Blickenstaff.

“Patient-centric moves beyond the patient being merely a participant in their healthcare. Patient-centric means the patient is the driver and intimately involved every step of the way, to the fullest extent possible, and that there are systems of care throughout the organization designed to continuously enhance quality and safety at the patient level.”

—Sena Blickenstaff, BSN, MBA

Healthcare leaders will want to look closely at their own data as they prepare to be surveyed under the new Patient Safety Systems chapter. They will want to look proactively, and begin having that conversation long before surveyors ever arrive on their doorstep.

“What does our data tell us? That is, are there issues the leadership team should be addressing now, prior to their next accreditation survey,” says Blickenstaff.

One specific example of this is immediate use, or flash sterilization. If a surveyor finds a high rate of flash or immediate use sterilization, the question will arise: Why? Is there a lack of equipment, or was it an anomaly on survey day? If it is a lack of equipment and therefore a resource issue, what is leadership doing to address the issue? Any data that suggests an opportunity for improvement should be scrutinized. In particular, if a goal has been set, yet the organization continues to fail in its efforts to achieve its own quality and safety benchmarks, this situation should be thoroughly reviewed.
**Balancing pillars**

Another example of leadership and systems of care that may surface during a survey can come up during discussions with staff when they talk about different organizational initiatives for enhancement of quality and safety. It’s not unusual, notes Blickenstaff, to hear staff talk about “pillars”—quality pillars, safety pillars, patient satisfaction pillars, and financial pillars.

“Under the financial pillar we’ll often see staffing and productivity,” says Blickenstaff. “With that often comes certain performance metrics for staffing and productivity.” This can often be at odds with quality and safety if not managed appropriately—fiscal responsibility has a different, competing set of interests. And while fiscal responsibility is important, so too is the need to find ways to ensure that the other pillars are fostered as well.

If surveyors come in and find, for example, systemic infection control issues, or any quality and/or safety issues, they will look at the reason for the problems, including whether they possibly indicate a resource concern—which would fall under a leadership finding.

“As a leadership team, if you’re going to cut resources to achieve a financial benchmark, you have to help your staff learn how to work more efficiently with less, without compromising quality or safety,” says Blickenstaff. “This is often where we will see a disconnect. As with any change comes the need to monitor for cause and effect.”

Data collection and analysis, especially with a reduction in FTEs, is critical to ensure that quality and safety have not been compromised. “We are again looking at how leadership is promoting and fostering a culture of safety, and effectively collecting and analyzing data, to ensure quality and safety at all levels throughout the organization is maintained with any decisions made,” she says.

And this is where the Patient Safety Systems chapter can come into play. When leadership decisions are made, under any pillar or for any reason, what is the end result for quality and safety?

The new chapter also touches on the Leadership requirement for a proactive risk assessment of a high-risk process and briefly touches upon “The Joint Commission’s preferred FMEAs [Failure Mode Effects Analyses], but that’s just one proactive risk assessment process,” says Blickenstaff.

“As a leadership team, if you’re going to cut resources to achieve a financial benchmark, you have to help your staff learn how to work more efficiently with less, without compromising quality or safety. This is often where we will see a disconnect. As with any change comes the need to monitor for cause and effect.”

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There are other proactive risk assessment methodologies out there that hospitals can use to examine their data and get ahead of the curve when it comes to proactively identifying and mitigating risks. The important thing to keep in mind is that as a high-reliability organization, it is a requirement and best practice to conduct proactive risk assessments when establishing new programs or services, when expanding existing programs or services, or when reviewing stratified data from incident reports to enhance quality and safety proactively.

While the new Patient Safety Systems chapter focuses on Leadership and Data Collection and Analysis, other key patient safety requirements are also referenced, including Accreditation Participation, Patient Rights, Performance Improvement, Medical Staff, Medication Management, and Human Resources standards, notes Blickenstaff.

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**Questions? Comments? Ideas?**

We at BOJ value and welcome your feedback and opinions. Do you have a response to any of this month’s articles, an idea for a best practice or success story you’d like to share, or a recent survey experience you would like to recount? We would love to hear from you.

Contact Senior Managing Editor Matt Phillion

Email: mphillion@hcpro.com
The human factor
Using staff narrative to identify adverse events

Continuing Education Objectives
After reading this article, you will be able to:

• Discuss methods for improving data collection in the medical record
• Describe how the storytelling abilities of many healthcare workers can help improve communication of near misses
• Identify interview questions that can improve how staff collect factors that might not automatically appear in the medical record

Is everything you need to know in the medical record? While we rely on the medical record (be it paper, electronic, or hybrid) to create a complete portrait of a patient’s care, the human factor can interfere with making sure everything makes it into the record. There are ways to make the medical record a more complete document by improving the information entered into it, however, and one organization has been able to improve its bloodstream infections, falls, and other risks by challenging practitioners to remember different components of events or incidents.

“We wanted to look for opportunities for improvement,” says Cheryl Gomez, RN, BSN, safety specialist at Promedica Toledo (Ohio) Hospital.

As Gomez and the rest of the team sat down to review their aggregated data, it was clear that the patients running into issues in the aforementioned areas were the sickest of the sick, but they wanted to look for other factors making a difference in those patients’ care.

“I started looking through some charges independently. Nurses are basically narrative people—when we chart on paper, we tell a story,” she says.

When reviewing an old chart, Gomez notes, very often there will be a comment, buried in the narrative, about family interaction or patient behavior. “The nurse might note that the patient is constantly picking at their bandages or that they refuse to call for assistance,” she says. However, this occurs less often in formats where there isn’t as much a chance to make an offhand comment, such as in a record using drop-down menus. A skilled nurse might still find a way to communicate these observations in the record, but that is not always guaranteed.

“So I started thinking, what can we do to get that intuitive, ‘Oh, I remember that patient!’ type of story to happen?” says Gomez.

She started inviting managers, nurses, and anyone who might have insight into a patient’s care to start brainstorming how to read between the lines of the medical record.

“We wanted to ask: What’s different?” Gomez says. “If a patient fell on the way to the bathroom who had been in the hospital for five days, let’s look at the incident. They made it to the bathroom numerous other times. What was different this time?”

The questions asked for infection incidents were more specific. Gomez and her colleagues asked:

• What was different about this patient?
• Did the patient have a significant comorbidity?
• Did the patient have a known immunity risk?
• Were caregivers aware the patient was inclined to picking at his or her dressings?
• Did the patient come in with a line that looked like it had been very poorly cared for?

“By asking what the caregiver remembered about the patient, we learned a lot about the line,” says Gomez. “The nurse might remember that it was nearly impossible to get a conclusive seal because of the habits of the patient, for example.”

They would also ask what nurses remembered about the overall care of the line. One specific case, for example, involved a manager remembering that one patient, due to a specific condition, had an unusually large number of tubing changes, which increased the risk of infection. “It doesn’t always give you new information, but at least it opens up new opportunities for questioning,” says Gomez.
The patients that the team investigated were inherently challenging: multiple comorbidities, septic, immunocompromised due to cancer. “We know these patients are going to get infected, but can we learn something from our most challenging patients? Should we be doing something above and beyond for this type of patient from what we’re already doing?” says Gomez.

It’s all about how you ask the questions, she notes. “We’re trying to dredge up details out of people’s memories that wouldn’t get into the medical record. These are the stories the electronic medical record isn’t set up to tell,” says Gomez.

So far, this process of enabling a more experience-based narrative to track incidents has been met with a positive response by bedside staff. “When dealing with things in the abstract—why did this person get a central line infection?—everyone is blank. We’re not used to thinking of things in that manner,” says Gomez. But once the right questions are asked, care providers open up about their recollections.

“Staff remember the human details, says Gomez. “They’ll say, ‘I knew that patient would be a challenge right away,’ ” she explains. “We’ll be able to identify things like, we should have removed that line sooner, or maybe there was a detail the physician didn’t mention in his progress note. Nurses remember those things, and they tap into them as we’re used to telling that story.” A chatty, interview-like narrative can help. Start with the basics—everything was working fine and then the patient fell. Why?

The organization is working on a retrospective basis with this practice, reviewing cases that occurred a month or two ago. “If you go into the medical record, it’s hard to glean from the drop-down menus what the issues were,” says Gomez. “Other times you can look at the record and watch the progression in retrospect. I think there’s value in both concepts.”

The multisensory approach of narrative, interview-like discussion has helped staff quite a bit so far, though. “For frontline staff, they do value being able to recall what they saw, touched, intuited,” says Gomez. “The EMR is set up so you can collect data, but not necessarily how the human mind works when telling a story.”

EMRs tend to be prescriptive, leading the narrative along a fixed path—useful for data collection, certainly, but not without an opportunity to deviate off that path and pick up on various human observations.

“There’s an opportunity if we engage in different questions or phrases to identify the why in different, more human terms rather than a very cold why or how,” says Gomez.

The “cold why and how” are still very useful, however, often illuminating equipment issues and other sterile observations. If the power went out five minutes before an incision was made, or there were no chlorhexidine gluconate (CHG) swabs, requiring the use of alcohol swabs instead, such details might lead to clinical reasons for an infection. Similarly, noting that there were no large-sized patient slings available for a patient that needed one might point to a reason for a fall.

“You’ll get these answers, and they are very valuable, but for things without a cut and dry cause and effect, it’s nice to have the story to go back to,” says Gomez.

This approach has opened the door to more organic potential changes based on observations by staff. One such example involves blood transfusions. The organization is looking into ways to use some kind of bridge device that would allow the patient to be disengaged from the central hub during a blood transfusion. No definitive solution has been determined yet, but the conversation has been started. “It’s made people think outside the box by tripping the right triggers,” says Gomez.

This approach has opened the door to more organic potential changes based on observations by staff. One such example involves blood transfusions. The organization is looking into ways to use some kind of bridge device that would allow the patient to be disengaged from the central hub during a blood transfusion. No definitive solution has been determined yet, but the conversation has been started. “It’s made people think outside the box by tripping the right triggers,” says Gomez.

One area the organization has seen results in following these reviews is CHG bathing in the ICU setting. “These are our sickest of the sick, and

“We’re trying to dredge up details out of people’s memories that wouldn’t get into the medical record. These are the stories the electronic medical record isn’t set up to tell.”

—Cheryl Gomez, RN, BSN
almost always have some kind of central line,” says Gomez. “We saw a decrease in infection rates in ICU settings as we started doing these aggregates.”

The organization looked at areas with similar patient populations. For example, ventilator patients with central lines in intermediate areas and immunosuppressed patients in the oncology department were two groups that shared many characteristics.

“We looked for populations who are similar and looked for where there were similar rates of infection,” says Gomez. “In oncology, we had a cluster of infections, so they switched to CHG bathing and there was a significant decrease in central-line infections. We made it seven months between infections.”

The biggest culture shift, however, has been seeing the change in staff when they are invited to the aggregate meetings. They come prepared to talk about the patients and what could be done differently instead of prepared to describe how they don’t own the process.

“This isn’t just in our aggregates,” says Gomez. “This has worked on our infection control, leadership, and other areas. We celebrate together and learn together.”

That leadership buy-in is key to the success of the aggregate program.

“I think our culture is shifting overall, but that’s the result of bigger changes from leadership that safety comes first,” says Gomez. “When we go a month without an infection, leadership knows it, and they celebrate with those teams. If our unit makes it a year without a central-line bloodstream infection, the president goes to celebrate with that unit. It’s much bigger than root cause analyses [RCA], but our RCA process is evolving and we really want to know what we can do to get to zero.”

RCAs are an effective tool, Gomez says, but the organization wants to continually look at the process and use what it knows about human interactions and human factors.

“We want to look at information gathering, everything we know about communication styles and skills to get the best information we can,” she says. “It’s all about learning. If you don’t have the information, you can’t fix it.”

In terms of improving communication, Gomez hopes to eventually improve the use of huddles immediately after an infection is discovered.

“It’s difficult to manage in an institution this large, but if we could get a just-in-time team to huddle as soon as someone reports an infection, I think we could learn even more,” says Gomez. “In a system with hundreds of beds and thousands of employees, it’s not an easy thing to accomplish, but we have room to grow and that’s our next big step.”

“We want to look at information gathering, everything we know about communication styles and skills to get the best information we can. It’s all about learning. If you don’t have the information, you can’t fix it.”

—Cheryl Gomez, RN, BSN

Capturing this information in real time can help lead to an even bigger leap forward in reporting and prevention.

“Even though it is challenging, even though it’s difficult, those frontline staff are the people who have the information; they know what they saw and they remember,” says Gomez. “Getting back to them is really important.”

Perhaps most importantly, the concept of leadership support and framing the RCA process as a nonpunitive opportunity cannot be overlooked.

“Making sure it’s not a punitive process is so important to information sharing, which is something Toledo Hospital and Promedica in general do very well,” says Gomez. “Leadership is focused on learning from deviations. It’s extremely important to the success of what you learn that it is received in a positive format.”

In the end, though, it is the frontline staff who can provide the most important feedback—they need to be provided the opportunity to speak their minds.

“I like to turn the tables and say, ‘I need you to get really mad for just a minute and tell me, Cheryl, if we had done this, this event wouldn’t have happened.’ You tell me what I need to do to fix it,” says Gomez. “I need you to tell me what we as a facility and organization can do so you don’t experience this again.”
Ebola update: A literature overview

Continuing Education Objectives
After reading this article, you will be able to:
• Discuss recent updates to CDC guidelines for addressing Ebola

Editor’s note: Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA, is a healthcare consultant in Trabuco Canyon, California, and a former Joint Commission surveyor. Marlene K. Strader, PhD, RN, is a healthcare consultant and former Joint Commission surveyor.

Last month, we looked at what the international community could do in the face of the current Ebola outbreak and addressed many fears and concerns in the healthcare community about what the outbreak meant for us here in the U.S. Since that time, perhaps unsurprisingly, we have had more than one traveler return to the U.S. with Ebola, though not as many as the general population has feared. Despite the small numbers, it has become necessary to look at ways to solidify our techniques for identifying, isolating, and treating potential Ebola patients who could hypothetically come through our doors.

The Centers for Disease Control and Prevention (CDC) has released an algorithm for evaluation of returning travelers that is straightforward but extremely useful in crafting an easy-to-use process. Let’s take a look at exactly what the CDC has to say.

Evaluate the patient for the following Ebola-compatible symptoms:
• Fever
• Headache
• Weakness
• Muscle pain
• Vomiting
• Diarrhea
• Abdominal pain
• Hemorrhage

Report patients to the health department as defined in the CDC guidelines.

If patients show signs of the above, the CDC recommends:
• Isolating the patient in a single room with a private bathroom and with the doors to the hallway closed
• Implementing standard, contact, and droplet precautions
• Notifying the hospital infection control program and other appropriate staff
• Evaluating for any risk exposures for Ebola
• Immediately reporting to the health department

Again, organizations should review the CDC’s most recent guidelines. (See references at the end of the article and on the CDC website at www.cdc.gov.)

Ambulatory care: Management and planning for patients with possible Ebola

• Stakeholder engagement: infectious disease physician, ED physician, infection control practitioner, security, lab, environmental services, administration, department of health, and others as determined by the organization
• Exam room and equipment
• Disposable equipment and maintenance of PPE
• Procedures: patient visits, phone triage, arrival of patient, registration and transportation room
• Diagnosis testing and collection specimens for lab
• Disposition of patient in collaboration with department of health, infection control, and others as appropriate
• Patient discharge and transport to home, ED, hospital
• Room and equipment terminal cleaning
• Education and training of staff, including demonstration/return demonstration, as applicable
• Review of lessons learned from process implementation and drills, including updates of policies/procedures/protocols
At the time of publication, the CDC listed the following categories of exposure. Because these categories are a moving target and evolve daily, we suggest checking the CDC website for updated information regarding risk exposure categories.

The four current categories as of time of publication are as follows:
- No identifiable risk
- Low (but not zero) risk
- Some risk
- High risk

The CDC is monitoring the countries with widespread transmission. A map of these areas can be found on the CDC website.

**Annals of Internal Medicine advice**

The *Annals of Internal Medicine* recently published an article that, while it specifically addresses Ebola patients in the ambulatory care setting, also provides sound advice across all programs.

As the amount of assistance provided to countries with widespread transmission grows, so does the risk to healthcare professionals and other aid workers returning home. Although many potential “persons under investigation” will present in emergency rooms, they may also make their way to ambulatory care centers.

There are many more illnesses that are likely to develop in the future, such as gastroenteritis, influenza, and malaria. Thus, the authors, in order to address inherent challenges in identifying Ebola patients, crafted a protocol with key stakeholders by “systematically considering the parts of an ambulatory encounter.” This protocol is detailed in the box on p. 8.

Meanwhile, Johns Hopkins Medicine has been tasked by the CDC to design an interactive Web-based learning program that guides healthcare workers, nurses, and physicians through government-approved protocols to aid clinicians as they provide care to patients who may be at risk of contracting Ebola.

The program trains healthcare providers in three critical areas:
- Proper donning of personal protective equipment (PPE)
- Safe removal of gear
- Active monitoring skills

All three modules will be available through the CDC’s website soon, as well as accessible through iTunes U.

**Ebola-related standards**

The Joint Commission has also addressed challenges related to the Ebola outbreak. The standards related to safely and effectively managing the infectious Ebola patient are as follows:
- **Leadership LD.04.01.01, LD.04.01.07**—Patient safety, policies, and procedures that support patient care, treatment, and services
- **Environment of Care EC.02.02.01, EC.03.01.01**—Staff knowledge of their role and responsibilities for managing risks related to hazardous materials and waste
- **Emergency Management EM.02.01.01, EM.02.02.01, EM.02.02.03, EM.02.02.05, and EM.02.02.07**—Implementation of the current organization Emergency Operations Plan specific to addressing Ebola needs and managing resources and assets
- **Human Resources HR.01.04.01, HR.01.05.03, and HR.01.06.01**—Staff orientation, training, and ongoing demonstration of competency
- **Infection Control IC.01.03.01, IC.01.05.01, IC.01.06.01, IC.02.01.01, IC.02.02.01, and IC.02.03.01**—Identification of risks for transmission of (Ebola) infection; implementation of the infection control plan as well as proper use and disposal of PPE; response to an influx of infectious patients/risks associated with medical equipment, devices, and supplies; prevention of transmission of infection to other patients and staff; use of current national guidelines
- **Nursing NR.01.01.01, NR.02.03.01**—Delivering nursing care, treatment, and services, and implementing policies and procedures
- **NPSG.07.01.01**—Compliance with either the CDC hand hygiene guidelines or the current World Health Organization hand hygiene guidelines
## Summary of Joint Commission RFIs by day, date, and year

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**DIRECT IMPACT STANDARDS**—Action plan and MOS (where applicable) due *Date, Day, Year*

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**INDIRECT IMPACT STANDARDS**—Action plan and MOS (where applicable) *Date, Day, Year*

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**Opportunities for Improvement (OFI)** *Date, Day, Year*

Source: Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA.
Editor’s note: In this new feature, BOJ advisor Jodi Eisenberg, MHA, CPHQ, CPMSM, CSHA, manager of accreditation, clinical compliance, and policy management for Northwestern Memorial Healthcare in Chicago, explains the steps and goals survey coordinators will want to take at a given point in their survey cycle. This month, Eisenberg examines month 11 post-survey.

I’ve often compared continuous survey readiness to disaster planning and preparedness. In light of the recent Ebola crisis, I thought I’d share some of my thoughts on what accreditation coordinators can learn from these events. The American Red Cross recommends five steps for preparedness. I’ve taken those steps and applied my thoughts on how they relate to continuous readiness.

1. **Commit to preparedness.** Continuous survey (patient) readiness requires a commitment by senior leadership, and by the entire organization, to prioritize meeting the patient’s needs in a safe, efficient, consistent, and compliant manner. While you likely have an accreditation coordinator, manager, or director, they are just the liaisons. The operational partners and the frontline staff have the true responsibility for being prepared.

2. **Conduct a Hazard Vulnerability Assessment.** Your Focused Standards Assessment (FSA) is your opportunity to gather information about potential risks that could impact the provision of patient care. Know your organization—by doing so, there may be findings during a survey but hopefully no surprises and no immediate jeopardy situations.

3. **Develop an emergency response plan.** Perhaps you call it “Code Survey” or something similar. This is your plan to respond to an unannounced survey. The plan should outline logistics, supplies, people, documents, communication, and additional elements based on your organization size, demographics, and geography.

4. **Implement your emergency response plan.** Work with your operational partners on a continuing basis so The Joint Commission isn’t something that causes concern every three years. Begin to build a foundation for integrating the important elements of response into operations. Conduct drills—organizational response, unit response, and staff response.

5. **Help your community get prepared.** Ensure your staff understands that compliance should be a byproduct of providing the right care to the right patient at the right time in a safe and consistent manner. Connect with frontline staff—not to practice for the survey but to find out what is happening in your organization. This outreach will get team members comfortable with the process and involved in discussing and developing the procedures that outline how they provide safe and effective care.

The key during and after any disaster is to be open to learn, to change, and to grow. Let’s learn from this latest crisis to make our healthcare organizations better. 

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**References**


- *Annals of Internal Medicine*; The Potential Ebola Virus–Infected Patient in the Ambulatory Care Setting: Preparing for the Worst Without Compromising Care; Henry M. Wu, MD; Jessica K. Fairley, MD; James Steinberg, MD; and Phyllis Kozarsky, MD; [annals.org/article.aspx?articleid=1918899](http://annals.org/article.aspx?articleid=1918899)


The importance of the environment

Continuing Education Objectives

After reading this article, you will be able to:

• Discuss cleanliness in relation to value-based purchasing
• Describe the relationship between clutter and patient satisfaction

Editor’s note: Patrick Pianezza, MHA, has worked with the Studer Group and Johns Hopkins Hospital. In his most recent role, Pianezza’s work drove organizational performance in HCAHPS to an all-time hospital best in the 90th percentile. He can be reached at ppianezza@gmail.com.

One of the many facets of any successful hospital is its environment of care and cleanliness. There are many regulations that focus on this seemingly simple aspect, yet it is one of the most difficult and costly to uphold. The environment of care not only directly impacts the safety of the patients, it also comprises an aspect of value-based purchasing in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) “cleanliness and quietness” composite score.

Along with financial implications, environment of care is the first thing by which laypeople will judge a hospital. The reason is simple: Most patients are ignorant about hospitals and their operations, but almost every patient has been to a restaurant before, and they can tell when something is clean or not.

The No. 1 reason for dissatisfaction among patients going into surgery is clutter. This is why addressing the environment of care is not just limited to paper on the floor. Organizations need to look at their units with a more global focus. Nursing stations should not have loose papers strewn about on the desks or mobile computers. Message boards must be up to date and appear professional, with messages that look like they are supposed to be there. Failure to ensure these things causes patients and visitors to lose faith in your organization’s clinical skills. This is in part, again, because they grade us on what they know, and they don’t know healthcare very well.

Over half of any interaction humans have with each other is based solely on visual stimuli. In fact, studies show that when the eyes and the ears receive conflicting messages, the brain believes the eyes more. When considering this evidence, physical plant issues should also become a priority as well. Although perfection is worth striving for, it is unfortunately a moving target that requires constant maintenance and vigilance.

Reward and recognition systems for the frontline staff who clean and maintain the physical plant are essential. At times these staff members are regarded as second-class employees, and often these services are contracted out; either way, positive messaging and validation of their constant task is as important as recognition of any other clinical role provided in the hospital.

Given the complexity of the environment of care and its impact on the patients, it is essential to keep it front of mind. Patients grade hospitals on the environment more than almost any other indicator because it’s one of the only things to which they can relate.

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