How Congressional criticism of JCAHO will affect your next survey

Six patient safety areas you should examine today

Expect JCAHO surveyors to look more closely at your infection control, quality assurance, anesthesia, and environment of care practices now that a government report has criticized the accreditor’s ability to sniff out problems in these key areas.

The 31-page report, CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals, (GAO-04-850), was published in July by the Government Accountability Office (GAO), an investigative agency for Congress. The GAO recommends that CMS should have greater authority to oversee JCAHO assessments of hospital performance and safety. Representative Pete Stark (D-CA) and Senator Charles Grassley (R-IA) responded to the findings by introducing legislation on July 20 that would accomplish this goal.

GAO’s findings
The GAO compared the findings of CMS’ validation surveys against JCAHO’s survey findings. CMS identified 157 hospitals with 241 total deficiencies in their compliance with JCAHO’s new patient safety goals. Expect JCAHO surveyors to look more closely at your infection control, quality assurance, anesthesia, and environment of care practices now that a government report has criticized the accreditor’s ability to sniff out problems in these key areas.

Ten ways to comply with the 2005 National Patient Safety Goals

Editors note: BOPS subscribers received a special fax alert—HCPro Express—on July 16, ahead of the JCAHO’s announcement of its new goals. If you didn’t receive it, call our customer service reps at 800/650-6787.

By now you’ve heard about the JCAHO’s new National Patient Safety Goals for 2005, but do you know what you need to do comply with them?

Don’t reinvent the wheel. Heed these tips from colleagues who have already have systems in place to comply:

♦ Medication and communication: The JCAHO wants you to communicate the patient’s medication list to the next provider of service, regardless of whether that clinician works for your organization.

Research has shown that information hand-offs and transitions of care are vulnerable to error. This goal will help organizations improve communications with
the patient’s next care provider, says Cherri Hobgood, MD, director of education in the emergency medicine department at the University of North Carolina (UNC) School of Medicine in Chapel Hill, who researches barriers to effective communication.

✓ **Tip:** Assign a pharmacist to the ED who can take each patient’s complete medication history and reconcile it with the patient’s next provider, suggests Hobgood.

She’s noticed a significant increase in the accuracy and thoroughness of medication lists for patients since her facility started the practice.

The pharmacist can dedicate more time to a patient and may be able to write a more detailed medical history than a provider, she says.

In addition, ED pharmacists may also recognize medication interactions or duplicate doses that a clinician might otherwise miss, she says, noting that patients who present to UNC’s ED often turn out to be unwittingly taking two different beta blockers.

“A pharmacist can understand how the patient actually takes the medicine as opposed to how the patient is supposed to be taking it,” she says. “That helps when you’re evaluating a patient who may be on multiple medications.”

♦ **Patient identification:** In 2005, the JCAHO wants your staff to use at least two patient identifiers not only when administering medications/blood products or when drawing blood samples, but also when taking other specimens for clinical testing or providing “any other treatments or procedures.”

This new goal formalizes a safety measure that many hospitals already practice, say your peers. Be prepared to show JCAHO how you monitor staff adherence to this measure.

✓ **Tip:** Ensure that two identifiers are readily available—and clearly legible—to staff for verification, suggests the Institute for Safe Medication Practices (ISMP).

✓ **Tip:** When entering orders, require pharmacists and pharmacy technicians to compare each patient’s name and identification number in his or her computer profile to the order. Likewise, require unit secretaries to compare the information on the order form and medication administration record when transcribing orders, the ISMP suggests.

✓ **Tip:** Label cardiac monitors that display multiple patients’ rhythms with patient names by using a standardized verification process that involves two individuals. “In these settings, patients’ lives could very well depend on rapid—and accurate—patient identification and treatment,” the ISMP notes.

♦ **Look-alike/sound-alike drugs:** Get ready to identify and annually review all look-alike/sound-alike drugs used in your organization.

The U.S. Pharmacopeia (USP) received 31,932 reports related to look-alike/sound-alike drug names to its MEDMARX error-reporting database between January
2000 and March 2004, says John Santell, MS, RPh, USP director of educational program initiatives. Of those errors, 2.6% resulted in harm to the patient.

No doubt, your pharmacy will face a Herculean task in keeping up with all of the drug labels and names that look or sound alike, but it will reduce medication errors in the long run.

✓ **Tip:** Conduct a Failure Modes and Effects Analysis—an analytic tool used to identify potential problems before they occur—to categorize look-alike/sound-alike drugs in your facility.

✓ **Tip:** Use “tall-man” lettering to differentiate similar-looking/sounding drugs—such as writing PredniSONE and PrednisoLONE, suggests Priti Merchant, PharmD, clinical pharmacy coordinator for Warren Hospital in Phillipsburg, NJ.

♦ **Medication reconciliation:** You must also accurately and completely reconcile medications across the continuum of care, including developing a way to obtain and document a complete list of each patient’s current medications upon admission by January 2006.

This will be challenging and may require some investigative work, says Hobgood.

✓ **Tip:** Get into the habit of calling your patients’ providers, caregivers, pharmacists, family members, and any others who may be familiar with patient’s medications.

♦ **Critical test results:** You’ll be required to “measure, assess, and, if appropriate, take action to improve the timeliness of reporting and the timeliness of receipt by the responsible licensed caregiver of critical test results and values,” according to this new goal.

✓ **Tip:** Identify which test results are critical and who should receive them, suggests the Massachusetts Coalition for the Prevention of Medical Errors.

The clinician who receives the results should be able to take immediate action to treat the patient. When this person is unavailable, create a call schedule or system that will identify to whom the results should go.

✓ **Tip:** Define acceptable notification-time parameters for communicating the results—such as within an hour, the shift, or three days, depending upon the test result, the coalition suggests.

♦ **Patient falls:** Prepare to assess each patient’s risk for falling, including how his or her medication contributes to that risk, and take steps to prevent falls.

✓ **Tip:** Require staff to do toilet checks on high-risk patients every one to two hours, suggests Sharon Eddy, MSN, director of nursing for Natchez (MI) Regional Medical Center.

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**Expect more Medicare validation surveys**

In a report to Congress, the Government Accountability Office (GAO) recommended that CMS not decrease the number of validation surveys they conduct annually.

CMS is gradually reducing the number of validation surveys its state surveyors conduct each year from a target of approximately 5% of all JCAHO surveys to a target of only 1%. **Translation:** CMS verified only about 227 JCAHO surveys in 2002, 75 in 2003, and expects to conduct just 72 validation surveys in 2004.

“This reduction is of additional concern because it coincides with the implementation of JCAHO’s new [tracer] accreditation process, which has an unproven capacity to detect deficiencies,” noted the GAO.

The oversight agency urged Congress to keep the target at 5%.

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Criticism of JCAHO

ance with Medicare’s Conditions of Participation (COP). JCAHO surveyors missed 167 (69%) of these deficiencies, detecting them in only 34 (22%) hospitals. (See p. 6 for more about the COP.)

“A single serious deficiency in a Medicare requirement can limit a hospital’s capability to provide adequate care and ensure patient safety and health,” notes Janet Heinrich, the GAO’s healthcare and public health issues director, in the report.

CMS conducts annual on-site validation surveys of a sample of JCAHO-accredited hospitals and reports its findings to Congress.

The validation surveys are performed by state surveyors and help CMS determine whether JCAHO-accredited hospitals meet Medicare’s quality and safety requirements. In 2002, the JCAHO accredited 82% of all Medicare-participating hospitals.

Expect a crackdown in these six hot spots

The following are COP deficiencies that JCAHO surveyors failed to identify, according to the GAO. Expect your next JCAHO surveyor to focus more closely on these areas:

physical environment: The hospital’s construction, layout, and maintenance must protect

example: A CMS validation survey found that an Alabama hospital did not annually inspect its fire extinguishers, fire alarms, and sprinkler system.

Infection control: The hospital’s sanitary environment must prevent the transmission of infections and communicable diseases. The facility must have an active program to prevent, control, and investigate infections and communicable diseases. (Note: This is a National Patient Safety Goal for 2004 and 2005.)

Example: JCAHO surveyors failed to notice one California hospital’s infection control lapses, including improperly sterilizing medical instruments.

Quality assessment and performance improvement: The hospital must have an effective, hospitalwide quality assurance program. It must also ensure the competent performance of physicians and nurses.

Nursing services: Hospitals must provide 24-hour nursing services that are supervised or per-

Medicare surveyors can be sloppy, too

The true patient safety problems at hospitals “may be understated” because JCAHO and Medicare surveyors fail to uncover serious deficiencies during surveys, the Government Accountability Office (GAO) noted in the report.

In related examinations of skilled nursing facilities and home health agencies, the GAO found that the number of serious deficiencies uncovered varies widely by Medicare state survey. For example, state survey agencies in California, Illinois, and Ohio found serious deficiencies in more than 45% of the surveys they conducted between fiscal years 2000 and 2002.

In comparison, Florida and New York surveyors found serious deficiencies in less than 10% of their surveys, while surveyors in Louisiana didn’t find serious deficiencies at any of the hospitals they visited.
formed by registered nurses.

**Example:** State surveyors found serious deficiency in the nursing services at one Texas hospital that included failure to prepare and administer drugs in accordance with federal and state laws, inadequate supervision, and nursing care and procedures that were not within the scope of accepted standards of practice.

- **Patients’ rights:** The hospital must protect and promote patients’ rights, such as their privacy and safety.

- **Pharmaceutical services:** The hospital must have pharmaceutical services that meet patient needs.

**Example:** Deficiencies at a Texas hospital included medications administered without physician orders and dispensing a double dose of narcotics in the ED without an explanation for the extra dosage.

**Brace for change: Three actions to take today**

The GAO report could potentially lead to big changes when it comes to your next JCAHO survey. Here are steps you can take to prepare:

1. **Get your hands on the report.** The report takes about an hour to read and describes the scrutiny the JCAHO is under regarding patient safety.

   “This isn’t just about Joint Commission accountability; it’s also about [our] accountability,” says Dale Woodin, deputy director of advocacy for the American Society for Healthcare Engineering (ASHE). The report available for free at the GAO’s Web site (www.gao.gov).

2. **Get the inside scoop from JCAHO’s trainers.**

   As part of an agreement between ASHE and the JCAHO, ASHE will provide further instruction to administrative surveyors about safety concerns as well as train special part-time engineering surveyors who will accompany the regular survey teams to certain hospitals, he says.

**Bonus:** The training that ASHE provides will also be open to safety officers and facility directors. “There’s no secret here,” Woodin says. “Everybody gets the same stuff.”

3. **Gear up for a longer building tour.** The time it takes for surveyors to walk through a hospital depends on a building’s size, age, and sprinkler protection. An electronic assessment tool proposed by the JCAHO and ASHE will add those and other building characteristics to the survey application.

   A source close to the JCAHO says surveyors will allow additional time for the tour using a sliding scale of one to four hours.

**JCAHO’s angry response**

JCAHO President Dennis O’Leary, MD, blasted the GAO’s findings as “inflammatory, grossly inaccurate” conclusions based on “flawed study methodology and erroneous, alarming statistics that seriously mislead the public.”

He points out that although JCAHO surveyors did fail to catch 167 of the Medicare COP deficiencies, that number represents only about 2% of the 11,000 COPs that JCAHO and CMS surveyors examined and found in compliance.

“[This] is testimonial to the positive impacts of the effective working relationship between the Joint Commission and the CMS over the past four decades,” he says.

“It is irresponsible to alarm the public using statistics that have little meaning, and that do not reflect the true oversight of America’s hospitals through Medicare’s public-private sector partnership with the Joint Commission,” he wrote in a letter included with the report.

**Note:** This not the first time that the JCAHO has come under fire. The Department of Health and Human Services Office of Inspector General also concluded in a 1999 investigation that JCAHO surveyors failed to identify patterns of deficient care.
Medicare Conditions of Participation

Below are the mandatory Conditions of Participation (COP) that all Medicare-reimbursed hospitals must meet—and which all JCAHO surveys must confirm. The COPs highlighted in red are areas that JCAHO surveyors haven’t examined closely enough, according to Congress’ Government Accountability Office:

Compliance with federal, state, and local laws: Hospitals must comply with applicable federal laws on patient health and safety and state and local laws on hospital and personnel licensing.

Discharge planning: Hospitals must have a discharge planning process applicable to all patients. Policies and procedures must be in writing.

Food and dietetic services: Qualified personnel must organize, direct, and staff dietary services.

Governing body: A hospital must have a legally responsible governing body or persons charged with the responsibilities of a governing body.

Infection control: A hospital’s sanitary environment must avoid sources and transmission of infections and communicable diseases. It must have an active program to prevent, control, and investigate infections and communicable diseases.

Laboratory services: Hospitals must maintain or have adequate laboratory services available.

Medical record services: Hospitals must have a medical record service that has administrative responsibility for medical records.

Medical staff: Hospitals must have an organized medical staff that abides by bylaws approved by the governing body and that is responsible for the quality of patient medical care.

Nursing services: An organized nursing service must provide 24-hour nursing services that are supervised or performed by registered nurses.

Organ, tissue, and eye procurement: The hospital must have and carry out written protocols on procurement and have adequate organ transplant policies.

Patients’ rights: A hospital must protect and promote patients’ rights.

Pharmaceutical services: The hospital must have pharmaceutical services that meet patient needs.

Physical environment: Hospital construction, layout, and maintenance must ensure patient safety and provide diagnostic and treatment facilities and special hospital services appropriate to community needs.

Quality assessment and performance improvement (PI): A hospital must have an effective, hospitalwide quality/PI program aimed at increasing patient safety.

Radiologic services: The hospital must maintain or have available diagnostic radiologic services. Therapeutic services provided must meet professionally approved standards for safety and personnel qualifications.

Utilization review: The hospital must establish a utilization review plan to review the services it provides to Medicare and Medicaid patients.

**Required reading**

**Five books every patient safety officer should read**

Still pining for those back-to-school days? If you yearn to don a backpack and head for the nearest all-night café to mingle with the college crowd, consider stuffing one of these tasty morsels, recommended by your peers, into your bag.

- *The Challenger Launch Decision: Risky Technology, Culture, and Deviance at NASA*, by Diane Vaughan, MA, PhD (University of Chicago Press, 1997). “This might seem an unlikely must-read, but it doesn’t take long to see your own experience as you read this remarkable study. It seems to be the definitive root-cause analysis,” says Betty Ann Wilkins, RN, MS, director of risk management for Inova Health System in Falls Church, VA.


- *Escape the Fire: Designs for the Future of Health Care*, by Donald Berwick, MD, MPP (Jossey-Bass, 2003). This collection of speeches “echoes the theme that our healthcare system needs drastic change and a whole new design,” says Patricia Gilroy, MSN, MBA, clinical patient safety coordinator for Alfred I. duPont Hospital for Children in Wilmington, DE. “Don Berwick outlines new designs and practical tools for change.”


Let these recent survey examples help you identify focus areas for your mock tracer surveys in preparation for your next JCAHO visit:

**X High-alert medications:** Surveyors were impressed with how Renaissance Behavioral Health System ensures the safety of high-alert medications (National Patient Safety Goal #3).

Facilities in the Jacksonville, FL–based system store medications in a locked room that is well-lit, quiet, and organized to make sure that nurses can concentrate when working with the high risk medications, says **Leah Guthrie, BA, RN, LHCRM**, director of quality improvement/risk management at Renaissance.

Staff label high-risk medications appropriately and are careful to store look-alike/sound-alike drugs apart from one another. Only one staff person per shift holds keys to the room for security reasons.

Prior to administering drugs, a nurse asks patients their names and verifies the information against their identification bands.

“Our population doesn’t like to keep the ID bands on for some reason, but when they come to the medication window, they need to have the band on,” she says.

**Head’s up:** The 2005 National Patient Safety Goals will require you to take proactive measures to prevent look-alike/sound-alike drug errors.

**X Emergency drills:** Surveyors studied how Renaissance staff prepare and assist patients during emergency situations. Staff at the beginning of each shift are assigned sole responsibility for one disabled or restrained patient in the event of an emergency. Managers check regularly to ensure that staff comply with this policy and further monitor their compliance during monthly fire drills.

**X Patient ID:** Tulare (CA) District Healthcare Systems received a recommendation for improvement for using room numbers and 911 as identifiers for critical patients who have not been officially registered into the hospital system, such as those brought in by ambulance.

**Solution:** The ED now uses a special green-colored band that displays a temporary number that nursing staff can use until the patient is registered, says **Julie Gresham, RN**, JCAHO coordinator. Staff identify all other patients by their names and dates of birth.

**X Biohazard safety:** Tulare also received a recommendation for improvement for not using a biohazard bag to transport blood from the lab to a nursing unit. The blood was kept in a blood-unit bag when carried between the two buildings, says Gresham.

**Solution:** The hospital now requires staff to place the blood-unit bag in a biohazard bag during transportation.

**Editor’s note:** Want to share your patient safety survey adventures with your peers? Tell us about your recent survey! Contact Managing Editor Wendy Johnson at wjohnson@hcpro.com or 781/639-1872, Ext. 3207.
Survey monitor

How to disagree with a surveyor’s finding

If you disagree with a surveyor’s finding, call the JCAHO immediately to contest it, advises one California accreditation coordinator who didn’t want to wait for the JCAHO’s formal appeals process.

A surveyor cited Tulare (CA) District Healthcare Systems with a recommendation for improvement during its April survey after noticing that ED employees did not identify a patient before administering medications, says Julie Gresham, RN, JCAHO coordinator.

As you know, National Patient Safety Goal #1 requires clinicians to use at least two patient identifiers when administering medications or blood products. The hospital questioned whether the surveyor’s interpretation of the goal was too narrow when applied to a critical care patient in the ED.

Head’s up: On January 1, 2005, the JCAHO’s patient identification requirements will expand to include “other specimens for clinical testing” and “other treatments or procedures.”

At Tulare, staff apply a patient-identification band and register patients within five minutes of their arrival. The surveyor noticed that staff did not do this for at least one patient who presented to the ED in need of urgent care, and that staff administered medications before properly identifying the patient because time was critical, says Gresham. “You’re talking about a patient who was not breathing,” she says.

Despite the emergency situation, the surveyor stood firm that the facility must comply with the patient safety goal. “She was very cut and dry,” Gresham says.

State your case
Gresham contacted her JCAHO account representative immediately after the survey to state her objections to the surveyor’s finding. She argued that such a narrow interpretation of the goal could jeopardize patient safety during emergency situations. Her persistence paid off: The JCAHO removed this recommendation for improvement, says Gresham. She advises others who object to a surveyor’s findings to call the JCAHO immediately and provide clear explanations about what went wrong. “We didn’t wait to do a written response,” she says.

Surveyors asked these 11 questions

Below are questions that surveyors asked during recent surveys in California, Massachusetts, and Florida. Consider using them during your next mock tracer survey:

1. How do you educate staff about your prohibited abbreviations list?
2. Do you conduct root-cause analyses?
3. Describe the process for obtaining medicines. How do patients access medications?
4. How are sample medications controlled and accounted for?
5. Do you ever encounter problems obtaining informed consent for medications?
6. Do you check visitors for infection? How?
7. Have you ever had to use Cardiopulmonary Resuscitation?
8. Do staff report infections?
9. Do staff receive annual immunizations? How do you keep track of who has been immunized?
10. How do you comply with the National Patient Safety Goals?
11. How do departments share information?
**Speak up**

How one hospital designed a patient-friendly brochure

The quality improvement (QI) director at Fairlawn Rehabilitation Hospital expected staff resistance when she began designing a “Speak Up” brochure to encourage patients to remind staff about the hospital’s handwashing and patient identification policies.

**Reminder:** The JCAHO will continue to clamp down on your infection control and patient identification practices next year because both of these areas will remain key components of its 2005 National Patient Safety Goals.

Fairlawn’s QI director, Patricia Garvey, MSN, RN, wondered whether staff would balk at the idea of patients reminding them to wash their hands and check their ID bracelets. However, the opposite occurred.

Staff at the Worcester, MA–based facility not only embraced the brochure, but they asked Garvey to include other important information, such as why the hospital tests alarms and conducts frequent fire drills. Staff wanted patients to understand the reasons for occasional noise on the unit.

The resulting three-fold brochure, developed by Garvey and the hospital’s media relations specialist, reminds patients to ask questions about their medications, speak up about handwashing, make sure staff verify their identity, and voice any concerns they may have.

The brochure also includes photographs of staff and patients to make it appealing and is written at an eighth-grade reading level so it’s easy to understand, says Garvey.

In addition, the brochure is printed in green and black—colors that are consistent with other patient-safety materials. Garvey wants to print all of Fairlawn’s patient-safety materials in these colors so that they are easy to distinguish from the rest of the information that patients receive in their admission packets.

**Asking patients for feedback**

On July 1, Fairlawn’s admissions team added the brochure to its admissions packets. Garvey and her staff will learn what patients think of the brochures at the end of September when Fairlawn conducts its next patient-satisfaction survey.

Garvey has received positive feedback from at least one patient who questioned staff when he didn’t see them wash their hands upon entering his room. When staff informed him that they use the Sani-Gel dispensers located just outside his room, the patient was satisfied. In fact, he began instructing his family members to use the gel dispensers as well, says Garvey.

The patient told Garvey that the brochure made him feel safer by inviting him to watch and participate in the events going on around him.

**Improving quality and pleasing the JCAHO**

Encouraging patients to become more involved in their care enhances the quality of care they receive and promotes a culture of safety. In addition, patients feel more confident about the care they receive if they are aware of the measures that staff take to ensure their safety, says Garvey.

For example, Garvey instructs staff to explain to patients why they must repeatedly verify a patient’s identity. This explanation helps patients feel more comfortable with the process and helps staff build a better relationship with them.

It also pleases the JCAHO. The accreditor launched its “Speak Up” program in March 2002 as a way to reduce medical errors by encouraging patients to become more proactive.

**Result:** Hospitals now provide Speak Up materials in patient rooms and in admission packets and sponsor Speak Up public service announcements on local radio stations.
Medical students and junior medical staff can teach physicians a thing or two when it comes to hand-washing. They’re far more likely to wash their hands than their older, more experienced role models. However, they’re less likely to wash up once they see that senior medical staff don’t do so, according to new research on physicians’ attitudes and practices.

Researchers from the University of Geneva Hospital, an acute care facility in Switzerland, observed 163 physicians’ hand-hygiene practices and counted the number of times they should have washed their hands with soap and water or an alcohol-based hand gel v. the number of times they actually did.

Results: Overall, physicians cleaned their hands only 57% of the 887 times they should have, while medical students did so 79% of the time.

The compliance rate varied dramatically depending on specialty. Internists displayed the best practices by washing their hands a whopping 87% of the time. Anesthesiologists fared the worst washing only 23% of the time.

Researchers also found that

- surgeons were among the least likely to wash their hands. They did so only 36% of the time.
- pediatricians were among the most likely to wash up and did so 83% of the time.
- female physicians washed their hands 67% of the time while their male counterparts washed their hands 53% of the time.


Physicians were more likely to wash when they knew someone was observing them (61%) than when they were unobserved (44%).

The researchers considered physicians in compliance if they washed their hand/removed their gloves

- before and after having contact with a patient
- between contact with a dirty and clean site on the same patient
- before and after providing intravenous or arterial care
- before and after providing urinary, respiratory, or wound care
- after contact with biological body fluid

A simple safety precaution that physicians don’t want to follow

Evidence-based literature has repeatedly shown that the simple act of handwashing can reduce the spread of healthcare-acquired infections (HAI).

However, most of the physicians (67%) who responded to a written questionnaire included in the study perceived handwashing as a difficult task—even though most of them (85%) were aware that they could expose patients to cross-transmission of bacteria if they didn’t wash up.

“Although the hand-hygiene procedure is simple, its application by healthcare workers is a complex phenomenon that is not easily explained or changed,” wrote lead researcher Didier Pittet, MD, MS.

Kristie Geil, MSN, CPHQ, manager of quality and medical staff services for CGH Medical Center in Sterling, IL, agrees that handwashing is a universal problem among physicians. She attributes noncompliance to several factors, including time pressures and misperceptions.

“I think there’s a knowledge deficit,” she says, explaining that some physicians may think it’s unnecessary to wash their hands after visiting...
patients whom they don’t touch.

“But in reality, there are always [germs] in the room,” she says. “Sometimes I think physicians just don’t understand the epidemiology.”

Reminder: The JCAHO’s National Patient Safety Goals for 2004 and 2005 require accredited hospitals to reduce the risk of HAIs by complying with the Centers for Disease Control and Prevention’s (CDC) hand-hygiene guidelines.

Pittet found that several factors influence a physician’s conscious—or unconscious—decision to skip the important step of handwashing. They include

• **role modeling:** Junior medical staff and students were more likely to abandon their hand washing habits when they saw that senior staff don’t bother to wash.

Role models can play a pivotal role in changing behavior, Pittet notes, adding that “strategies to promote hand hygiene should include attempts to reinforce the importance of the role model.”

• **workload:** Physicians were less likely to wash up when they were the busiest.

• **accessibility:** Not surprisingly, physicians were less likely to disinfect their hands if a sink or an alcohol-based hand gel was not easily accessible.

In a previously published study, Pittet showed how his hospital improved its overall handwashing compliance rate from 48% in 1994 to 66% in 1997 by taking such actions as making antiseptic hand rubs available at the bedside. During that time, the facility also experienced a decrease in its HAI rate according to the December 23, 2000, *Lancet*. □