Learn how a model hospital maximized throughput

The JCAHO's new patient flow standard, LD.3.15, takes effect this month, and JCAHO president Dennis O'Leary is pointing to Boston Medical Center (BMC) as a model system for improving throughput.

In 2003 more than 117,000 patients visited BMC's emergency department (ED), home of the largest 24-hour level I trauma center in New England. The hospital admits more than 27,500 patients annually and employs more than 1,300 nurses.

Even though it's one of the state's busiest hospitals, the 547-bed BMC has successfully overhauled multiple hospital systems to improve throughput and maximize productivity, including a 3%–4% increase in the medical/surgical volume.

"Anybody who comes to me and says, 'I can't do this,' I'm going to send them to [BMC]," Leary told the Boston Globe in a July 8 article.

Eugene Litvak, PhD, professor of healthcare and operations management at Boston University and director of the program for management of variability in healthcare delivery (MVP), worked—INSIDE—Vol. 16  No. 1 January 2005

Survey focuses on nursing shortage, staffing effectiveness, and credentialing

If a candidate for a nursing position walked in the front door to apply, could he or she get an interview that same day?

A surveyor posed this question to the nurse recruitment coordinator during Southern New Hampshire Medical Center's (SNHMC) triennial survey in March 2004. Ensuring that the hospital is responding to the nursing shortage was a major focus for surveyors during the competence assessment process meeting, as were staffing effectiveness and credentialing, says Karen Reed, MS, director of quality management at the Nashua-based hospital.

The recruiter's answer satisfied surveyors—she has granted same-day interviews many times in the past to accommodate nursing candidates. Scheduling a same-day interview would only be problematic if the director were out for the day, says Reed.

"You need to be on your toes with this and go out of your way to bring in [nursing candidates]," she says.
Improving throughput

with John Chessare, MD, chief medical officer at BMC, to secure a grant from the Robert Wood Johnson Foundation, an organization dedicated to improving the health and healthcare of all Americans. With this grant, the team tested Litvak’s theory that flow problems in the ED stem from a lack of available hospital resources, including inpatient beds. To fix the ED’s problem, the hospital must improve its other systems, Litvak told BOJ.

Note: The approach Litvak and Chessare took at BMC is universal, but organizations need to customize how they carry out the changes to meet their individual needs, says Litvak.

Educate staff about changes

In order to revamp various processes, BMC needed support from everyone—beginning with Chief Executive Officer Elaine Ullian. Hospital leadership spurred the change and formed three subgroups to oversee changes in the ED, operating room (OR), and nursing floors.

Staff education was crucial to success. Chessare and the vice president of nursing educated staff about the logic of the new process and the need for participation during the annual competency day, a mandatory eight-hour class for all nurses.

OR problems lead to changes

Litvak and Chessare worked with Keith Lewis, MD, chief of anesthesiology, James Becker, MD, chief of surgery, and Gail Spinale, RN, director of operative services, to transform the OR by carrying out two major changes: eliminating block schedules and separating the flow of urgent and emergent patients from elective cases, which is the result of the MVP’s variability methodology.

Surgeons previously used blocks of time in the OR to schedule elective surgeries. The problem was that surgeons used an average of about half of their block times and the hospital bumped elective cases for urgent and emergent cases. From April through September 2003, the OR performed 157 emergent surgeries between 7 a.m. and 3:30 p.m., bumping or canceling 337 elective cases.

The team’s goals: reduce bumped cases, improve patient and surgeon satisfaction, and increase surgical volume.

Devote space for urgent cases

The team collected and analyzed data, finding that one room accommodated urgent and emergent cases, with only a rare bump of elective cases. After designating a room for those cases, the team abolished block scheduling, opting for an open scheduling model.

The new model
• allows surgeons flexibility in scheduling
• provides equal access for all surgeons
• promotes booking far in advance
• opens free time for other surgeons
• accommodates all cases

Under the new system, the OR conducted 159 emergent surgeries from April to September 2004 between the hours of 7 a.m. and 3:30 p.m., bumping or canceling only three elective cases.

Surgeons were satisfied overall with the process. They found fewer gaps in the OR, greater predictability of their operative day, increased productivity, and no need to provide notice for scheduling time off.

Surgeon buy-in was not difficult, says Chessare. “It’s really a leadership and a trust issue.”

“If it makes your lives worse, we’ll reverse it,” Chessare told surgical leaders. With nothing to lose, leaders accepted the change and found they had everything to gain.

Pull in ED patients

The inpatient team tackled several projects of its own to smooth out flow, such as creating a “pull system” to admit ED patients.

Typically, ED nurses push patients up to units, says
Janet Gorman, bed facilitator at BMC. However, communication was often unclear and disorganized, with phone calls back and forth between the departments. The pull system shifts the power to the inpatient unit nurses. They can pull patients from the ED as soon as they have an opening and plan for the patients accordingly. “ED nurses love it when it works,” says Gorman. “It makes them feel like part of the hospital.”

Clean up the housekeeping system
Previously, BMC was unaware of how long it took to prepare a room for a new patient. Chessare and his colleagues collected data about bed turnaround times and were aghast to find that the process took 90 minutes on average.

The housekeeping supervisor knocked 30 minutes off the process time by integrating admissions and housekeeping in one computer system. As soon as a patient is discharged, the computer automatically notifies the department to deploy a housekeeper. The system shows that the room is in the process of being cleaned until the housekeeper reports that the task is complete.

Taking out the human element has saved time, says Gorman. Previously, a secretary was responsible for calling housekeeping after the discharge of a patient; however, if the secretary had other priorities, he or she might set aside the call to housekeeping.

Smooth discharge times
BMC is testing a new project: discharging patients when they are able to leave, rather than sending them home in batches in the late afternoon and early evening. Many patients wait in bed until family members can pick them up at the end of the work day or until prescriptions are filled.

The hospital is making cab vouchers available to all inpatient units; this way, a patient who can go safely home alone does not need to wait for a family member, says Gorman.

BMC is also providing early lunches for these patients because nurses are sometimes reluctant to send a patient home without another warm meal. Now patients can eat their meals at their convenience, instead of having to wait until the official lunch time.

BMC is also developing a program with the outpatient pharmacy to make prescriptions available for these patients.

Buy-in to this process was slightly more difficult than the other changes BMC has made, says Gorman. Having patients leave early made nurses uneasy, but once they saw that patients were happy and could leave safely, they appreciated the outcome. If patients do not want to leave early, they are not forced to, she says.

Play zone in the ED
The ED—which treats about 300 patients daily—cut the overall patient throughput time from 4.5 hours to 3.75 hours and the waiting time for a bed from 60 minutes to 40 minutes, which also boosted patient satisfaction survey scores. “That’s because we improved the waiting time, the single biggest dissatisfier for patients,” says Chessare.

One major change in the ED is the switch from assigning nurses to individual patients to assigning nurses to a zone. Before this new system, depending on where their patients were placed, nurses wasted time walking back and forth between patients and tracking down the appropriate physicians.

Now nurses are assigned to three or four contiguous beds and are partnered with one or two residents and a physician. This way, they work as a team, says Chessare. Nurses are thrilled with the new system, which creates a less chaotic and more efficient environment.

“In general, when systems become reliable, staff become happier,” he says.

Additional ED improvements include reducing
- the time from bed placement to physician examination from 30 to 20 minutes
- the time from clean bed assignment to arrival of new admits from 110 to 95 minutes
Frontline staff were the key to making the many changes that Boston Medical Center took on as part of its initiative to improve patient flow. Convincing nurses to embrace the changes in the emergency department (ED) boiled down to using one method—rapid-cycle testing, says Linda Fisher, BSN, nurse manager in the ED. Under this methodology, the ED tested an idea for two or three days and decided at the end of the testing period whether it was a success, didn't work, or worked but needed adjustments and additional trials.

**Encourage staff feedback**

The ED tested 50 changes in 50 weeks, with some changes happening simultaneously. The changes that became permanent endured several trials so staff could tweak and perfect them. Staff embraced the rapid-cycle testing because they were so involved in it, says Fisher. The ED often tested the ideas of frontline staff and depended on staff feedback to determine how well a process worked.

For example, when the ED trialed the switch from assigning nurses to individual patients to assigning nurses to a geographic zone, only a few nurses initially tested the idea. They supplied feedback to Fisher and the idea was modified and tested again, this time by more nurses. Before bringing it to the whole ED, all staff trialed zone nursing in four-hour increments so the change happened gradually.

When nurses discovered issues or potential problems with a system such as zone nursing, they were encouraged to bring them forward to management. For example, if ED patients ended up in the hallway, management needed to decide which nurse would take on those patients.

**Keep everyone in the loop**

Busy ED nurses cannot always get away from their work to attend meetings about the progress of each project, says Fisher. For this reason she uses various methods to keep everyone up-to-date on the changes, including putting memos in mailboxes and grabbing available staff to meet with her briefly, sometimes in a one-on-one or one-on-three format. In addition, all project data collected are posted on a bulletin board next to the break room so staff can see their progress.

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**Get into the gab**

How well are you keeping in touch with your peers in the field? Have you asked standards questions? Are you testing ideas? Did you know that BOJ offers a free e-mail group to subscribers only? It only takes a moment to join, and the benefits are many—advice, sample forms and tools, and the peace of mind of knowing you’re not alone.

The following is taken from a recent string on BOJ-Talk. See what you’ve been missing, and then send an e-mail to **owner-boj_talk@hcpro.com** to join:

**Post:** I’ve been asked to find out what other hospitals are doing to comply with MM.2.20 element of performance 3 (medications are secured in accordance with hospital policy and law regulation so that unauthorized persons cannot gain access to them).

**Reply:** We use the Pyxis machines for all of our medications. It’s like an ATM machine for medications.

**Reply:** The biggest issue we have had with this one is bedside medications such as inhalers. We decided to keep all of them in the med cart. We have Pyxis for all meds including all IVs with admixtures/electrolytes or other additives. Radiology keeps contrast under lock and key as well.

**Reply:** We are in the process of locking them all. We are into the second day of a CMS survey. All have to be locked, no exception. Do not accept that medications are under observation.
Survey monitor  < p. 1

Make sure staffing effectiveness plans are complete
Standard HR.1.30 states that hospitals must assess staffing effectiveness by using data on clinical and service screening indicators and human resource screening indicators. “We had 90% of what [the surveyor] was looking for,” says Reed.

The hospital’s plan did not include follow-up actions taken as a result of the data analysis—the one thing the surveyor said was missing. SNHMC has since updated the plan to include benchmarking, Reed says, although it is not a standards requirement.

The surveyor liked that the hospital presented data in graphs and tables, which is a standards requirement.

Make measures as specific as possible
The hospital spent time creating the appropriate measures for behavioral health and birthing to ensure that data analysis is specific to staff in these units, according to Reed, although it is not a standards requirement. For example, the birthing unit does not have many patient falls, so its measures were different than those of other units.

In addition, the plan includes the initiatives and actions the hospital will take as a result of the study, says Reed. SNHMC’s studies showed that staffing was not related to falls or to other areas the hospital examined.

Reed and her team had predicted that per diem staff would document taking fewer comfort measures, such as rocking or supplying pacifiers, for newborns than would employed staff. “This turned out not to be the case and was the only surprising result,” she says. Whatever the findings, it’s important to document the results and your action plan.

Allow for flexibility with recredentialing
SNHMC has experienced difficulty in the past when trying to recredential its medical staff on time, says Reed. In 2004, it solved its problem by scheduling reappointments two or three months early.

Although some physicians don’t make it in for their credentialing meeting until 30 days before deadline, they’re no longer lagging 30 days behind deadline, and they can now work out any problems within those two or three months, says Reed. “Surveyors checked to make sure that staff had gone through this process on time,” she says.

Involve staff every step of the way
“What made us successful was that our staff were really prepared,” says Reed. Conducting mock tracers boosted staff members’ confidence to answer surveyor questions.

“They felt comfortable and knew how to give surveyors the information they were looking for,” she says.

During the survey, the team of staff who escorted the surveyors met each day while the surveyors took a lunch break. They pooled the information they gathered so far that day and highlighted the most important results in an e-mail to all employees. For example, e-mails might include information about areas surveyors had visited that day and questions they asked staff and patients.

“It was very motivating for staff to be involved,” says Reed.

Questions? Comments? Ideas?

Contact Managing Editor Amy Anthony

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Tips to get staff ready for the big day

It’s only natural to be nervous before your JCAHO survey. To combat her and her staff’s anxiety, Sandy Gee, CPHQ, quality improvement director at Valley Regional Hospital in Claremont, NH, created a tip sheet prior to her hospital’s September survey. It highlights how staff should conduct themselves and gives tips on how they should answer a surveyor’s questions. She distributed a copy to about 200 hospital staff members.

Valley Regional’s tip sheet reminds staff to do the following:

✔ **Conduct a last-minute readiness assessment.**
  Do a quick sweep of your unit before the survey. Ask each other questions to prepare for the real survey. Share your findings with each other. The more you do this, the more comfortable you will be during the survey.

✔ **Review records closely.** Remember that surveyors will conduct open-chart reviews during their visit, and encourage staff to document completely and legibly and to use only acceptable abbreviations.

✔ **Have documents ready.** Organize policies and minutes from committee meetings, the quality improvement program, and staff meetings. Give surveyors only the documents they request.

✔ **Exhibit displays.** Surveyors look for visuals such as quality improvement storyboards, patient safety posters, and patient rights list. Don’t forget the “Welcome JCAHO!” banners. If they see visuals, they are less likely to ask questions. Look at your bulletin boards to see what’s posted.

✔ **Be on time.** The survey team has a tight schedule and cannot wait for people to assemble. Plan to be at work early before surveyors arrive.

✔ **Dress the part.** Remember good hygiene. Wear clean clothing and your picture identification. Shine your shoes.

✔ **Be positive.** For example, answer questions with, “Yes, we do that. Let me tell you about our approach.” You may know your shortcomings, but focus on how you meet the standards. This is not the time to vent or complain.

✔ **Remember the three-second rule.** Try to answer the surveyor’s question within three seconds. If you don’t know the answer, here are three responses:
  • Ask the surveyor to repeat the question
  • Ask for clarification if you don’t understand the question
  • Redirect the question to someone who can answer it

✔ **Answer only the question asked.** Approach surveyor questioning as if you’re in a courtroom. Do not elaborate or provide extraneous details about a process or procedure unless the surveyor asks. The surveyor will ask a follow-up question if he or she needs to know more.

✔ **Participate.** Help each other respond to questions. If you are in a group interview and the surveyor directs a question to you but you’re unsure of the answer, it’s okay to deflect the question.

✔ **Listen to surveyors.** If the surveyor goes into teaching mode, listen patiently and thank him or her for the information. Surveyors can have interesting solutions to complex issues that plague hospitals.

✔ **Prepare to answer questions multiple times or not at all.** Repeat visits by surveyors may be stressful for staff and managers. Be constantly ready and remain calm and friendly while maintaining daily operational and patient activities.

✔ **Focus on the excellent service or care you provide.** The surveyors will observe staff. Don’t worry about performing for surveyors. Concentrate on the tasks you do every day (e.g., washing your hands, dressing a wound, identifying patients before administering medications, responding to clinical alarm responses, reading back orders).

✔ **Buy a little time if there’s a problem.** Explain to the surveyor that you will look into the matter and gather information. Try to get the information to him or her in a timely fashion.
PPR measures of success questions answered

Editor’s note: During the JCAHO’s November 18 teleconference for accredited organizations to discuss the accreditation process, several participants asked questions about the periodic performance review (PPR) and measures of success (MOS). BOJ knows many of you may have similar questions, so we thought we’d report the answers given by speakers Chuck Mowll, JCAHO executive vice president for business development, government, and external relations, and Linda Murphy-Knoll, vice president for JCAHO accreditation service operations. The JCAHO occasionally offers these free teleconferences; replays are available on its Web site.

Q: What do you do if a standard requires an MOS, but you’re in compliance? For example, we haven’t had any issue in our hospital with patient rights, so how would we do an MOS?
A: You don’t need to do an MOS for every element of performance (EP), but only if you have an issue with that EP and you find yourself out of compliance.

Q: Does this apply even if the EP has an M beside it?
A: In that case, do an MOS only if it’s required and only if you’re noncompliant. If you are compliant, you don’t need to do it.

Q: We’ve completed our PPR and we’re getting ready for survey, but how will the information on our MOS be used for the standards that we had some issues with during the on-site survey?
A: On-site surveyors will ask you how your MOS ended up, and you can simply show them that number. They won’t really have your plan in their hands, so just give them your average for the time that you did your MOS.

Q: Will they know what our target goal was that was in our PPR, or is that left up to them in discussion?
A: Tell the surveyor what your target was and your target will at least meet what the standard requires.

Q: So we need to brief them on what our plan of action was, where we are with that, and what our MOS is?
A: All you really have to do is give them the MOS and tell them what your goal was. They’ll understand if you met or did not meet your goal. And they’ll be looking at that as they go around with the tracer methodology.

January accreditation calendar

Events and items of note for January 2005

1 National Patient Safety Goals take effect (see cutout on p. 12), as well as LD.3.15, the new patient flow standard (see story on p. 1)
10 JCAHO optional field review questionnaire about proposed 2006 Medication Management standards changes due today (www.jcabo.org)
11 HCPro audioconference on advanced strategies to overcome compliance barriers to the National Patient Safety Goals (877/727-1728)
24 HCPro audioconference on IM standards (877/727-1728)
27–28 Joint Commission Resources Accreditation Essentials program on the periodic performance review and tracer methodology in Glen Allen, VA (804/965-1223)
28 HCPro audioconference on strategies, tips, and tools for medication reconciliation (877/727-1728)

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What CMS’ privileging guidelines mean to hospitals

A hospital’s medical staff must individually evaluate all practitioners and determine that they have the qualifications and demonstrated competencies to perform all of the specific privileges granted, according to a November 12 letter from the Centers for Medicare & Medicaid Services (CMS) to its state survey agency directors.

Hospitals that have a solid core privileging system in place—one that ensures that the medical staff leadership independently assesses the current competence of each individual practitioner—will comply with CMS regulations, says Carol Cairns, CPMSM, CMSC, a senior consultant with The Greeley Company in Marblehead, MA, a division of HCPro Inc., which publishes BOJ.

To meet federal regulations, hospitals need to have a well-defined, criteria-based clinical privileging system that considers an individual’s education, training, experience, and current competence when recommending, granting, and continuing privileges at reappointment, Cairns says.

CMS released the guidance to clarify for hospitals what surveyors expect. CMS and JCAHO officials held discussions last summer after some hospitals complained of conflicting messages about acceptable privileging practices.

So just what is CMS’ position? A hospital’s medical staff bylaws must state the duties and scope of privileges that the facility can grant to each category of practitioner, such as medical doctors, doctors of osteopathy, nurse practitioners, physician assistants, podiatrists, etc. “The individual practitioner’s ability to perform each task/activity/privilege must be assessed and not assumed,” CMS said.

Reappointment on privileges requested is also noted in the standard MS.4.20, EP 7, which requires reappraisal to address professional performance, including clinical and technical skills, says Rashid.

“How does the organization know the individual is competent to perform all privileges requested, especially when that privilege is not exercised during the entire two-year appointment period, which is frequently the case?” he asks.

“I suspect JCAHO will handle this by amending both EP 3 and 7 to align with CMS requirements,” Rashid predicts.
Tips, trends, and tidbits

JCAHO invites comment on 2006 medication management standards changes

Proposed revisions to the JCAHO’s medication management (MM) standards are out for field review until January 10.

The proposed changes include new or revised elements of performance to medication:

- Storage (MM.2.20)
- Order review (MM.4.10)
- Preparation (MM.4.20)
- Access after pharmacy hours (MM.4.50)
- Management system evaluation (MM.8.10)

“[The proposed MM changes] are designed to sharpen their focus on medication management safety issues,” stated JCAHO President Dennis O’Leary, MD, in a press release coinciding with the December 3 posting of the changes.

Visit the JCAHO’s Web site, www.jcaho.org, to read the complete text of the proposed changes and to submit feedback via an online questionnaire.

PPR extranet access to be unlimited
The JCAHO plans to allow hospitals unlimited access to periodic performance review (PPR) extranet sites beginning mid-January.

Chuck Mowll, JCAHO executive vice president for business development, government, and external relations, announced during a November 18 JCAHO teleconference call that all organizations will have access to PPR on a continual basis beginning January 18.

The JCAHO decided to allow full access because of hospital concerns and to encourage organizations to use the PPR as a management tool.

Mowll said the JCAHO had to rework its information technology systems to accommodate the continuous access.

Since January 1, 2004, more than 4,000 organizations have accessed the PPR online tool.

Don’t let the November CAMH update get buried
Mail can easily pile up during the holidays, but if it’s the November update to the Comprehensive Accreditation Manual for Hospitals (CAMH) that’s buried, here’s a look at what you missed:

- A new chapter on the 2005 National Patient Safety Goals (NPSG) that addresses the purpose of the goals, each goal’s requirements, and the Universal Protocol
- A revised chapter on sentinel events for 2005 that outlines the goals of a sentinel event policy, the standards relating to sentinel events, and sections on reviewable sentinel events, the JCAHO’s sentinel events database, and procedures for implementing sentinel events policy
- A crosswalk between the 2004 and 2005 infection control chapter standards
- Standards and scoring changes and information for the environment of care, human resources, information management, medical staff, and nursing chapters
- A revised and updated glossary for 2005

Also, in the cover letter that came with the CAMH update, the JCAHO mentions a few things to expect in 2005, most notably 2006 NPSGs. A calendar in The Source, a Joint Commission Resources publication, indicates the goals will come in July for a January 1, 2006, implementation. If 2004 was any indication, expect a field review of proposed goals sometime in the spring.

The November update was the last for 2004. The 2005 standards took effect January 1, and the JCAHO will make the next CAMH update available in February.
Briefings on JCAHO 2004 index

Editor’s note: Here is a listing of all the stories that appeared in BOJ in 2004. If you missed an issue, you may contact HCPro customer service to order a copy (877/727-1728).

Challenging standards
JCAHO standard of the month—MM.2.20—safely securing medications. Dec., p. 10.
Prevent prohibited abbreviations from creeping into your records. Nov., p. 7.
Put PC.13.20 to sleep: How to address the preanesthetic/presedation assessment. Aug., p. 10.
Twelve tips for three of the JCAHO’s most challenging standards. July, p. 1.

Environment of care
Check these fire-safety concerns from 2004 surveys. May, p. 7.
Clearly identify who is in charge of your EC plans. April, p. 9.

Failure mode and effects analysis

Infection control
Create a committee to tackle the JCAHO’s IC standards. Aug., p. 9.

Leadership
Forge medical staff collaboration. Feb., p. 11.

Miscellaneous
Accreditation alternatives: Why some hospitals leave the JCAHO and where they’re going. March, p. 10.
Check with your state for telemedicine licensing questions. Jan., p. 1.

National Patient Safety Goals
Learn what the experts have to say about complying with the new 2005 National Patient Safety Goals. Sept., p. 8.
Heads up: Unapproved abbreviations lurk in more clinical documents than just medication orders, April, p. 5.
The JCAHO’s proposed National Patient Safety Goals make for improvement, but not without a hefty price tag. June, p. 9.

Performance measures

Periodic performance review (PPR)
A tale of two hospitals: How to decide which PPR option is right for you. Dec., p. 1.
How to figure out which PPR option is best for you. May, p. 10.

Quick tips
Clean up messy handwriting. Nov., p. 4.
Don’t go overboard when revising policies on securing medications. Feb., p. 12.
Four quick ways to help staff comply with the preanesthesia/presedation standard. Aug., p. 12.
How to address standard RI.2.60. Sept., p. 12.
How to isolate a fire safety violation. Oct., p. 12.
How to manage sample drugs. Dec., p. 12.
Tackle the new IC standards through a broader approach. Jan., p. 12.
What you need to know about category C scoring guidelines. May, p. 12.

Survey process
Ask the expert: What the JCAHO’s clarifications to the scoring guidelines mean to you. June, p. 11.
Get ready to discuss your hospital’s systems during your next survey. Feb., p. 4.
How one hospital improved interdisciplinary patient care. April, p. 1.
Keeping your cool: Top three survey survival pointers. May, p. 6.
Survey hot spots: Five problem areas and how to avoid them. Dec., p. 1.
Your building tour will focus solely on the Life Safety Code®. May, p. 4.

Survey tracker/survey monitor
February survey offers better snapshot on patient care. April, p. 1.
The JCAHO scrutinizes how a Texas hospital handled unacceptable drug abbreviations. Feb., p. 6.
Learn what got JCAHO surveyors all fired up in one hospital’s emergency management department. Oct., p. 7.
Multiple-service hospitals must communicate among departments. May, p. 1.
Surveyors quiz staff at length on how they care for patients. March, p. 1.
The top five concepts I learned during my February survey. June, p. 1.
What should you do if you find yourself face to face with a difficult surveyor who is causing problems? Nov., p. 10.
What the JCAHO’s unannounced survey process is really like. Sept., p. 1.

Tools: Sample policies and forms
Interdisciplinary plan of care. April, p. 6.
Medical abbreviations and symbols policy. Feb., p. 9.
Mock survey planning tool. March, p. 4.
Monthly summary report of tracer activities. Feb., p. 5.
Nutritional assessment form. Aug., p. 3.
Premoderate sedation assessment record. Aug., p. 11.
Telemedicine policy. Jan., p. 5.

Tracer methodology
Use mock tracer methodology exercises to improve services. Feb., p. 1.

Training
Hospitals spend the most on patient safety goals compliance in 2004. June, p. 8.
How to foster team training: Honor fellow staff members’ feedback. May, p. 1.

Universal Protocol
Build double-checks into your preop procedures. March, p. 7.
Six processes you must have in place to comply with the JCAHO’s Universal Protocol. July, p. 7.
2005 National Patient Safety Goals

As of January 1, you must comply with the following:

**Improve accuracy of patient identification**
- Use at least two patient identifiers when administering medications, blood products/samples, etc.

**Improve communication**
- Verify verbal/phone orders by reading back the order and critical test results
- Standardize a list of abbreviations not to be used
- Improve timeliness of reporting critical test results/values

**Improve safety of medications**
- Remove concentrated electrolytes
- Standardize the number of drug concentrations
- Identify look-alike, sound-alike drugs

**Improve infusion pump safety**
- Make sure all general-use and patient-controlled analgesia intravenous infusion pumps have free-flow protection

**Reduce the risk of healthcare-acquired infections**
- Comply with Centers for Disease Control and Prevention hand-hygiene guidelines
- Manage deaths caused by healthcare-acquired infections as sentinel events

**Medication reconciliation**
- Document all patient medications at admission
- Give lists of patient medications to each provider

**Reduce patient falls**
- Assess patients’ fall histories and medication risks

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**Briefings on JCAHO Editorial Advisory Board**

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