UAB SYNOPSIS

VOL. 25, NO. 1, JANUARY 16, 2006

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JCAHO/HEALTH SYSTEM PRIORITY

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UAB IS JCAHO-READY

University Hospital and The Kirklin Clinic® became eligible on January 1 for their first unannounced survey by the Joint Commission on Accreditation of Healthcare Organization (JCAHO).

“It is critical that everyone in our facilities be ready to be questioned by JCAHO surveyors,” says Deborah Grimes, RN, JD, director of JCAHO and Regulatory Compliance.

JCAHO’s new tracer methodology is a major challenge for hospitals nationwide. Organizations that function with “silos” of operation, fragmented services, and little alignment among programs and services are finding it difficult to demonstrate “seamless patient flow and service delivery integration,” Grimes explains.

“Tracer methodology significantly affects the way we prepare for JCAHO surveys. It is crucial that everyone in our facility — from physician leaders to the admissions department — receive training and prepare for questioning from surveyors,” she says. “Health care institutions surveyed in 2005 report that dozens of physicians were observed or questioned during surveys.”

Most intimidating may be the fact that tracer methodology contains “unknowns”: Which patients will be traced? What questions will surveyors ask? Which divisions will be visited?”

Opening “Silos”: The new process

Surveyors will select 8 to 12 patients and use individuals’ records as roadmaps to assess and evaluate the organization’s compliance with selected standards and its systems of providing care and services.

Tracer patients are typically selected from a list of active patients who often have received multiple or complex services. Instead of visiting units and programs, surveyors select a number of charts and then follow each patient’s journey through the system, visiting departments involved in the patient’s care. On each unit, surveyors observe care, review policies and procedures, question staff and (with their permission) the patients themselves. The chart-focused journey is designed to make discontinuities apparent.

The best way to prepare, Grimes says, involves holding mock tracers and focusing on areas surveyors are likely to scrutinize. “We have completed mock tracers in many areas and focused on physician training and information sharing. Comparing an organization’s strategic areas of priority with patient data enables insight into the types of patients surveyors would likely trace. Because every patient is unique and every area of care is different, preparing for tracer surveys can be daunting.”

If problem trends are identified, surveyors issue a Requirement for Improvement. The organization has 45 days from the end of the survey to submit Evidence of Standards Compliance and identify Measures of Success it will use to assess sustained compliance over time. Four months after approval by JCAHO of the Evidence of Standards Compliance, the hospital will submit its Measure of Success to demonstrate a track record.

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UAB Is JCAHO-Ready

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How do surveyors use tracers to assess care and safety?

Surveyors retrace the specific care processes that patients experienced by observing and talking to staff in areas where the individual received care. As surveyors follow the course of a patient’s treatment, they assess the health care organization’s compliance with Joint Commission standards. They conduct this compliance assessment as they review the organization’s systems for delivering safe, quality health care.

What are surveyors looking for?

While conducting tracer activities, a surveyor may identify compliance issues in one or more elements of performance. Surveyors will look for compliance trends that point to potential system-level issues in the organization. The tracer activity also provides several opportunities for surveyors to educate organizational staff and leaders, as well as to share best practices from similar health care organizations.

How many tracers will be completed at each organization?

The number of tracers completed depends on the length of the survey; however, the average 3-day hospital survey with a team of three surveyors typically allows for completion of approximately 11 tracers.

Will surveyors speak to tracer patients?

As in the current survey process, the surveyor may speak to the patient or family member during the tracer activity, as appropriate. As always, the surveyor asks for permission before speaking to a patient. For more information, visit www.jcaho.org.

PATIENT SAFETY

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 honing in on specific patient safety systems at the hospital level. The UAB Health System has shown its dedication to this critical issue by appointing its first director of patient safety, Marcus Montgomery, JD, RN. Montgomery is charged with educational initiatives and encouraging and monitoring compliance with new Health System-wide standards of practice and JCAHO requirements.

“Our goal is to engineer, promote, and maintain an organizational culture of safety,” Montgomery says. “We are doing everything possible to provide the training and resources necessary to minimize the chance of harm to a patient.”

With innovative patient safety cards, Spanish-language brochures, SPP-SCR Web listings, a new University Hospital patient safety alert line, educational offerings, and informational handouts, the Health System and hospital are helping medical staff and patients alike to understand and comply with the 2006 JCAHO National Patient Safety Goals.

“A relatively small thing like a self-imposed ‘time-out’ prior to hanging IV fluids, beginning the infusion of blood products, administering medications, and certainly before any invasive procedure, can provide an invaluable safety net,” says Montgomery.

To inform medical staff of new standards of practice and JCAHO requirements, Montgomery and his University Hospital colleagues also have developed a new Standard and Educational presentation, available on the SPP-SCR Web, called “Universal Protocol: Surgical & Procedural Wrong Site, Wrong Patient: Prevention.”

Based on guidelines authored in 2002 and revised and reissued in September 2005 by Susan Markem, RN, UAB perioperative nursing, and Darcey Ansley, RN, UAB Heart Transplant Intensive Care Unit, for use in the universal identification and verification process for patients undergoing operative or invasive procedures, the guidelines emphasize proper communication between the health care team and the patient/family/legal guardian, and the use of visual markers to decrease the chance of error.

The Health System also recently joined the Leapfrog Group, a consortium of influential institutional health care purchasers that encourages “public reporting of health care quality and outcomes so that consumers and purchasing organizations can make informed health care choices” (www.leapfroggroup.org/for_hospitals).

“Our future relies on patient safety,” says University Hospital COO Michael Waldrum, MD. “These processes will enable us to measure and improve as necessary our quality infrastructure and delivery of care to our patients.”

“Patient safety, quality care, and accountability are the trilogy by which we live,” Montgomery says. “We genuinely care about every one of our patients.”

Based on strengths and areas targeted for improvement, Montgomery and hospital safety officials have synthesized the goals into the following categories:

• Improve Accuracy of Patient Identification

Use at least 2 patient identifiers (at UAB these are the patient’s full name and medical record number) before administering medications or blood products, taking blood samples for clinical testing, or providing other treatments or procedures.
• Eliminate Wrong-Site, Wrong Patient, and/or Wrong Procedure Surgery
  Prior to any surgical or invasive procedure, conduct a verification “time-out” to confirm the patient’s name and medical record number, the procedure, and surgical site. Use a pre-op verification process to confirm appropriate documents are available. Mark the surgical site and involve the patient in the process. All clinical providers MUST document the “time-out” in the patient’s medical record.

• Improve Effectiveness of Communication Among Caregivers
  Write down and read back verbal orders. Use only approved abbreviations, acronyms, and symbols. Improve timeliness of reporting and receipt of patient information. New for 2006: Follow the standardized approach to “hand-off” communications.

• Improve the Safety of Using Medications
  Standardize and limit available drug concentrations. Take actions to identify and prevent errors involving the interchange of look-alike/sound-alike drugs. New for 2006: In perioperative and procedural settings, label all medications, medication containers, and other solutions on and off the sterile field.

• Reduce the Risk of Health Care-Associated Infections
  Comply with Centers for Disease Control and Prevention hand hygiene guidelines. Manage as sentinel events all unanticipated deaths or major permanent loss of function associated with health care-associated infections.

• Accurately & Completely Reconcile Medications Across Continuum of Care
  All new for 2006: Obtain and document a complete list of each patient’s current medication upon admission, communicating these to the next provider.

• Reduce Risk of Patient Harm from Falls
  Implement and routinely evaluate a fall reduction program. Routinely assess patients for fall risk as required by the University Hospital standard.

For a full listing of JCAHO safety goals, see www.jcaho.org.

Patient Safety Resources
Visit the SPP-SCR Web site on UAB computers for details of University Hospital interdisciplinary standards, including: “Surgical and Procedure Wrong Site, Wrong Person Prevention,” and “Preparation for Operative/Invasive Procedures, Surgical Site Identification, and Administration of Sedation Analgesia.”

Patient safety goal cards and a Spanish language version of the UAB patient safety brochure are available from Hospital Support Services, 934-2097

NEW PIN CHEST PAIN ORDERS

Physicians admitting patients with chest pain to University Hospital encountered new Patient Information Network (PIN) nomenclature for triage, diagnosis, and treatment, effective December 13, 2005. Based on the American College of Cardiology (ACC) and American Heart Association’s (AHA) recently updated practice guidelines for “Management of Patients with Acute Myocardial Infarction,” UAB cardiologists have revised the hospital’s “2000-2001 Acute Chest Pain Guidelines.”

To streamline and simplify the process of classifying levels of chest pain, Assistant Professor of Medicine and Director of the UAB Acute Chest Pain Center Silvio Papapietro, MD, and cardiology colleagues have reduced the formerly five levels of chest pain directives to three:

Level 5  ST Segment Elevation Myocardial Infarction (STEMI)
Level 4  Acute Coronary Syndrome, either non-STEMI or unstable angina
Levels 1 to 3  Chest pain of probable cardiac origin

“These recommendations facilitate evaluation and management of University Hospital patients with acute ischemic heart disease,” says Dr. Papapietro, whose clinical interests center on cardiac hemodynamics and percutaneous interventions in coronary and peripheral vascular disease and whose research focuses on the treatment of ischemic disease. “They are not meant to replace the ACC/AHA Guidelines, which offer a comprehensive review of the pathophysiology and treatment of patients with acute myocardial ischemia. It is imperative that anyone involved in these patients’ care be familiar with these guidelines.”


**CHI JOINS GERONTOLOGY AND GERIATRIC MEDICINE**

Richard M. Allman, MD, professor and director of the Division of Gerontology and Geriatric Medicine, the Center for Aging, and the Birmingham/Atlanta Geriatric Research, Education, and Clinical Center (GRECC), announces the appointment of Ru-Chien Chi, MD, as assistant professor. After graduating from the University of California in San Diego, Dr. Chi completed a MD degree at Vanderbilt School of Medicine in Nashville, Tennessee. Following medical school, Dr. Chi’s postgraduate training consisted of an internal medicine
internship and residency and a fellowship in geriatric medicine, all at the University of Washington, in Seattle, as well as a geriatric fellowship at Puget Sound Veterans Affairs Health Care System.

Dr. Chi’s clinical interests center on preventive health. She is seeing patients on an urgent or work-in basis and may be reached at 996-2770.

CHANGE OF ADDRESS

UAB employees are responsible for the accuracy of their official mailing address for UAB Synopsis and other UAB materials. Any address changes must be handled through the new Oracle UAB Self Service Applications. Click on the Oracle icon on your desktop or go to http://www.uab.edu/adminsystems. You will need your Blazer ID and strong password. For problems, call 996-5555 or e-mail AskIT@uab.edu.

Corrections will also need to be made online to the UAB Electronic Phonebook at www.uab.edu/phonebook.

Hospital Smoking POLICY

Robert Cofield, DrPH, University Hospital associate vice president, announces a new smoking policy for the hospital, which can be found on the SPP/SCR Web site on UAB computers. Enforcement began December 19, 2005. Important policy highlights include:

- **No Smoking** is allowed inside University Hospital, at its entrances, or on the curbs.
- There are six designated smoking areas on the University Hospital campus – one for each building.
- Physicians should not grant medical exceptions for patients to smoke within the hospital.
- Physicians and staff should discourage inpatients from smoking while at the hospital.
- Permission cannot be made for pediatric/adolescent patients to smoke.
- All smoking-related trash shall be disposed of in an appropriate trash or cigarette butt receptacle found in the six smoking areas.
- Smoking outside of the designated locations will result in disciplinary action.

Dr. Cofield encourages all members of the Health System community to help enforce the policy.