

# Rural Healthcare *Quality* Network

RHQN Quality Newsletter, May 2008

## Introductions

We are very pleased to announce the hiring of a new, full time, Rural Healthcare Quality Network Executive Assistant. Amy Voros, who was working for us through a temporary employment agency, was hired on April 16. She is working 25-30 hours per week and will begin working full time June 1<sup>st</sup>. Amy comes to us from Harborview where she worked in UW Medical School clinical education. Some of you may have already had an opportunity to interact with Amy as she is scheduling Dr. Bloom's hospital visits.

Amy is responsible for preparation and distribution of newsletters, arrangements for conference calls and web seminars, support for the Executive Director and peer review physicians, and coordination of services between the RHQN and WSHA Patient Safety.

If Amy can be of assistance to you, please feel free to contact her at 206 216-2550 or [amyv@wsha.org](mailto:amyv@wsha.org).

## Highlights from the DOH Survey Preparedness Conference Call

On May 8 our conference call on DOH Survey Preparedness was held. Nineteen hospitals and forty three individuals participated in a round table discussion of common DOH citations, the citation rationales with WAC references, and ways to avoid citations. We focused on both clinical and environment of care issues. As a result of the conference all participants requested copies of commonly used environment of care checklists and survey forms. If you did not receive your copies please send an email to [randyb@wsha.org](mailto:randyb@wsha.org). Below is an excerpt from the conference.

### *“Growing Expectations for the CEO in Infection Control and Quality”*

Hospital Administrators are being held to a greater level of accountability in Department of Health surveys regarding infection control and quality. In the past, administrators were able to turn to their hospitals expert to answer questions. The Department of Health, as they survey, are watching for leadership. The hospital administrator's demonstration of leadership in this area plays a crucial role for a favorable outcome of a survey process. Various regulatory agencies assess and survey hospitals to ensure that appropriate methods are being followed and the quality of health care delivery is high. Specific to infection control and quality, it is important that every hospital have a policy and program in place and that it is followed appropriately.

It is the CEO's responsibility to ensure that the plans and programs that are in place are working and giving expected results. CEOs should ensure that infection control practitioners have adequate resources to successfully implement parts of the program. CEOs are responsible to inform the Board about the results from the Quality program that is in place in their hospital.

- CEOs and department managers should be able to answer questions around programs, plans, processes, actions, and results in their hospital. They need to work in conjunction with the Infection Control Practitioner and Quality Leaders. The CEO needs to know the big picture and the results.
- Leadership is responsible to ensure that the plans are working (e.g. they should know what their VAP rate). Quality and infection control results should go to the Board from the quality program.
- Citations at the leadership level have been given in WA State.

Regulatory agencies are very interested in seeing results after an action plan is instituted with data to support the results. It is important for a CEO to create a culture where the hospital handles not just incidents but looks for trends and institutes steps to resolve the whole picture. CEOs are expected to be able to answer questions around programs and know the plans, actions, and results. A CEO is expected to know the "big picture" of all quality related issues, steps taken to resolve them, and the results. E.g. It is important for an administrator to know the ventilator associated pneumonia rate or days since last central line infection in their hospital. Citations at the leadership level have been given in WA State hospitals due to inappropriate follow through on plans and programs.

### *RHQN Commentary - The Patient/Customer's Perspective on Quality*

*"The patient's perception of quality at the bedside"*

Last month we talked about the fact that all customers/patients to our hospitals/clinics come to us 'pre-stressed.' Because they are pre-stressed, our customers/patients don't remember where they parked their car, how they got into the building or where they are supposed to go. They are convinced that there are no good reasons for coming to the hospital or clinic.

Most healthcare customers/patients do not have background in healthcare that would allow them to determine healthcare quality based on the technical and/or professional skills that we use. Our customers wouldn't know a good x-ray from a bad x-ray, a good clinical diet from a bad clinical diet or accurate lab chemistry data from inaccurate lab chemistry data. So, our customers/patients measure quality based on what they do know. Our customers know high quality versus low quality guest relations skills. They know a friendly face, a warm greeting, an empathetic voice, and a desire to help when they need it.

If the customer gets admitted and becomes our patient they place themselves a system that does not just stress them, it scares them. So, what do our customers expect as quality indicators while they are a patient? The patient expects that if they need help

they will receive it *now*, not 20, 30 or 40 minutes from now. They expect a cheerful face, a positive attitude and an empathetic voice. Because patients don't have the knowledge to accurately evaluate the technical or professional level of care received, they fixate on the environment of care in which they are placed. Patients want a room that is clean, (no dust, clean bathroom floors, clean windows), they want a room that is warm when it should be warm, dark when they want it dark, quiet when they need to rest, and calming to the eye. One of the biggest patient satisfaction issues is the degree to which the unit is quiet. Patients frequently mention this on satisfaction surveys.

Another issue patients quickly pick up on is the degree to which staff work as a team. In this respect the housekeeper is as much a part of the 'team' as the nursing staff, lab personnel or therapists. Quite often the patient is more like to confide in the housekeeper than the nurse. Patient satisfaction surveys quickly point out where there is not a strong team spirit.

Many times it is not what nursing staff say to a patient which makes or breaks and opportunity to provide quality from the patient's point of view, its how it's said. Press-Ganey, one of the nation's leading patient satisfaction survey providers, offers assistance in this area. Scripting of how to ask questions and provide information to a patient can make a world of difference on patient satisfaction scores. This is especially evident ion outpatient surgery units/centers. Satisfaction scores in these areas are so high that a facility with a ninety four percent satisfaction score is in the lower twentieth percentile in the nation. Very careful and thoughtful wording of scripts for care providers has a huge impact on the scores.

Healthcare providers and patients evaluate quality on the basis of two differing sets of criteria. Yet, for the healthcare provider we must know both definitions and deliver quality under both sets of criteria. It isn't easy, but then nothing in healthcare is.

*Next month, "Scripting as a means of increasing patient satisfaction scores"*

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If you have ideas, comments, questions or concerns about the patient's perceptions of quality care, contact Randy Benson, Executive Director, RHQN, at [randyb@wsha.org](mailto:randyb@wsha.org).