Conflict management yields positive results that include effective decision making, staff satisfaction, and a positive work environment. Negative results due to conflicts have the potential to threaten patient safety and quality of care.

Conflict that is not managed appropriately can have negative consequences, including ineffective decision making, a negative work environment, and patient and staff dissatisfaction. Such conflict also has the potential to threaten health care safety and quality.

Avoiding conflict or hoping it will just go away can result in unresolved issues that can exacerbate over time. This “do nothing” approach can lead to an escalation of an issue; sometimes to a point where conflict resolution is much more difficult. In these scenarios, when people do decide to confront their differences, they may default to a debate about who’s right and who’s wrong, or haggling over small concessions. This, at best, can lead to suboptimal resolutions or compromises and, at worst, to complete deadlock.

(Continued on page 2)
Conflict can occur anywhere in any organization—between staff members, leadership groups, and professional disciplines. It can pit one leadership group against another, or one professional discipline against another. Any conflict in a hospital can potentially impact patient care, but conflict among leadership groups can be particularly serious, as it can affect an entire organization and the safety and quality of the care provided by that organization.

Complying with the Leadership Standard—Conflict Management
Effective January 1, 2009, The Joint Commission’s new Leadership Standard LD.2.40* requires hospitals to manage conflict between leadership groups to protect the quality and safety of care. The standard requires the leaders of the organized medical staff, the governing body, and senior managers to work as a team to develop ongoing processes for managing conflict among leadership groups, and it requires a hospital’s governing body to approve these processes.

Managing conflict does not necessarily mean resolving it. The goal of Standard LD.2.40 is not to resolve all conflict or prevent future conflict, but to create an expectation that hospitals will develop and implement a process to manage conflict so that it does not adversely affect patient safety or quality of care. At a minimum, the standard requires a hospital’s conflict management process to include the following steps:

1. Meet with involved parties as early as possible to identify the conflict.
2. Gather information regarding the conflict.
3. Work with the parties to manage and, when possible, resolve the conflict.
4. Protect the safety and quality of care.

The following sections illustrate some important factors your hospital should keep in mind when creating and implementing a conflict management process.

Training People in Conflict Management
When managing a conflict, it is important to have a designated individual or individuals skilled in managing conflict available to help with the process. This allows your hospital to manage a conflict quickly—many times without seeking assistance from anyone outside your organization. These skilled individuals can also help your hospital manage or avoid future conflicts. You can draw from administration, nursing, or physician leaders, as well as individuals from the human resources department, to serve in this capacity. Individuals who take on this role should be adequately trained in conflict management.

Within each specific conflict, a different individual may need to serve as a mediator for the process. The ability to mediate a conflict requires knowledge of the issues and credibility with the parties in conflict. Authority and title alone do not qualify an individual to act as a mediator. For this reason, consider having several individuals within your hospital trained to effectively mediate and manage conflicts.

Your hospital may want to train all leaders in conflict management so it becomes part of the day-to-day work processes. Conflict management skills can be taught in a variety of ways, including in-services, off-site training sessions, and role playing. You may want to bring in a trainer from outside the organization to conduct a conflict management seminar for all leadership. Or, individuals from your hospital’s human resources department may receive training on conflict management and use a “train-the-trainer” approach to train leadership.

Involving Multiple Perspectives in Designing the Process
There are many ways your hospital can develop a conflict management process. One way is to look at existing polices regarding conflict management and see how these policies could be adapted to include a process for resolving conflict among leadership groups. Your hospital may want to consider convening a multidisciplinary work group to create a new conflict management process or modify the existing process. Members

* Standard LD.2.40 is applicable to the following programs: critical access hospitals and hospitals.

The Joint Commission: The Source
Senior Editor: Iliese J. Chatman
Project Manager: Andrew Bernotas
Manager, Publications: Paul Reis
Executive Director, Publications: Catherine Chopp Hinckley
Vice President, Learning: Charles Macfarlane, F.A.C.H.E.
Contributing Writers: Kathleen Vega

Subscription Information: The Joint Commission: The Source™ (ISSN:1542-8672) is published monthly by Joint Commission Resources, One Renaissance Boulevard, Oakbrook Terrace, IL 60181; 630/792-5000.
Send address corrections to: The Joint Commission: The Source™, Superior Fulfillment, 131 West First Street, Duluth, MN 55802-2065
Annual subscription rates for 2007: United States—$299 for both print and online, $249 for online only; Mexico/Canada—$350 for both print and online, $299 for online only; all other countries—$389 for both print and online, $249 for online only; online site license—Contact Superior Fulfillment, 800/746-6578, for pricing. Back issues are $25 each (postage paid). Direct all other inquiries to Superior Fulfillment, 800/746-6578.
Editorial Policy: Reference to a name, an organization, a product, or a service in The Joint Commission: The Source™ should not be construed as an endorsement by Joint Commission Resources, nor is failure to include a name, an organization, a product, or a service to be construed as disapproval.
© 2007 by The Joint Commission. No part of this publication may be reproduced or transmitted in any form or by any means without written permission.
of this group may include administrative leaders, human resources professionals, physicians, and nurses.

Identifying System Issues
Most conflict is a symptom of a bigger problem. Consequently, it is important that your hospital keep system issues in mind when resolving conflicts between leadership groups. For example, a disagreement between surgeons and anesthesiologists may be a result of communication issues, scheduling issues, or staff shortages. To determine the underlying root(s) of a conflict, it is important to adequately define the conflict and its components. Questions to ask when defining the conflict include: Why is the conflict occurring? Is this conflict related to system problems such as inadequate resources, lack of training, or organizational culture? How can any deeper issues be resolved to help address the root(s) of the conflict?

Ensuring Consistency
Whenever there is a conflict between leadership groups, the conflict management process should be implemented consistently. Further conflict can arise if different situations are addressed differently. As previously mentioned, conflict management should be an integral part of the way your hospital conducts business. If the conflict management process is used only during specific instances, it will likely wither away when initial managerial enthusiasm wanes.

Measuring Success
It is important to go back after the conflict management process has been used to see if it was effective in managing the conflict. If not, your hospital may need to consider revising the process. Depending on the nature of the conflict, measures of success will vary. For example, if a conflict is between nursing and physician leaders, looking at employee turnover rates, number of grievances, or staff satisfaction surveys may be helpful in determining whether the conflict has been resolved.

Fostering Open Communication
One way to effectively manage conflict is to prevent it from happening in the first place. Although some conflict is inevitable, some can be easily avoided if groups within your hospital talk with each other. Senior leadership must be open to discussion, cooperation, and effective communication, and foster an environment in which communication and collaboration not only thrive, but are expected. If efforts to improve communication within your hospital take place at the same time that the conflict management process is being implemented, you can work toward preventing conflicts and effectively addressing those that do occur.

Conflict is an inevitable part of human interaction. However, if your hospital creates and consistently implements a process for managing conflict and incorporates that process into the day-to-day operations of the hospital, it can achieve a more collaborative environment in which new and existing ideas can thrive, and the best possible care for patients can result. The Source

References

Elements of Performance for LD.2.40
1. Senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups.
2. The governing body approves the process.
3. The organization implements the process when a conflict arises that, if not managed, could adversely affect patient safety or quality of care.
4. Individuals who help the organization implement the process, whether from inside or outside the organization, are skilled in conflict management.

At a minimum, the conflict management process includes the following (EPs 5–8):
5. Meeting with the involved parties as early as possible to identify the conflict
6. Gathering information regarding the conflict
7. Working with the parties to manage and, when possible, resolve the conflict
8. Protecting the safety and quality of care
An Interview with Dr. Mark Chassin, Next President of The Joint Commission

As announced in the September 2007 issue of The Joint Commission Perspectives®, Mark R. Chassin, M.D., M.P.P., M.P.H., has been appointed to lead The Joint Commission as its next president, succeeding Dr. Dennis S. O’Leary, M.D. Dr. Chassin’s appointment is effective January 1, 2008. Dr. Chassin is the Edmond A. Guggenheim Professor of Health Policy and Chairman of the Department of Health Policy at Mount Sinai School of Medicine, New York, and Executive Vice President for Excellence in Patient Care at The Mount Sinai Medical Center.

What follows is an insightful question-and-answer session with Dr. Chassin. Dr. Chassin shares his thoughts with Joint Commission–accredited organizations and other interested stakeholders as he prepares for his new position.

Q  Why did you choose to accept the position of president of The Joint Commission?
A  I wasn’t looking for a job. I’ve been very enthusiastic and content in my work at Mount Sinai. A lot of job opportunities do come across my desk, but this was one of the very few that I took seriously. It is undeniable that The Joint Commission is the most prominent quality and safety organization in American health care, from the standpoint of importance and level of influence. Also, this opportunity came at the right time, for quality and safety have never been higher on the agenda of all stakeholders. I believe we are poised to make major and substantial improvements in health care, and I want to be a part of that national effort.

Q  What do you see as some of the major opportunities and challenges facing The Joint Commission and you as president?
A  The biggest challenge and opportunity are to build on the momentum of demands for major improvements to bring about real and durable change that improves health outcomes for patients. It is a challenge to get beyond measurement and measures to help accredited organizations make the substantial and quantifiable improvements that we all—not just The Joint Commission—want to see. Accreditation is vital to improvement, but it is not sufficient by itself. I would like to go beyond measurement and accreditation to facilitate that kind of improvement in quality and safety in accredited organizations.

Q  How has your career up to now prepared you for this position?
A  I’ve been fortunate to have been able to play a variety of different roles, and all have been important in contributing to how I approach quality. I practiced emergency medicine for 12 years, and that was in real practice, not just supervising residents, in medium to medium-large community hospitals. I’ve been a state and federal regulator, I am a researcher, and, more recently, I took on the additional responsibility of overseeing all the quality, safety, and risk management activity of a very large hospital.

Q  Quality measurement has been a particular interest of yours. As health commissioner in New York, you led some pioneering work in measuring performance using risk-adjusted outcomes. Do you see The Joint Commission developing new metrics for quality and safety?
A  The short answer is “yes.” We need more and better measures of quality, ones that address a wider spectrum of health care. In that development process, however, we must never lose sight of the absolute necessity to be as sure as we can that improvement on those measures will translate directly into improved outcomes for patients. Now, with respect to New York, we started with clinically and scientifically sound measurement, but we didn’t stop with measurement. We took the data on risk-adjusted mortality following coronary artery bypass surgery to the hospitals. But the part that I am most proud of is that we helped the hospitals figure out which clinical and administrative processes they needed to improve in order to achieve better outcomes. And when they improved those processes, outcomes did in fact get better.

Q  Through its standards, National Patient Safety Goals, white papers, and other activities, The Joint Commission has taken a leadership role in spearheading efforts to improve safety and quality. Do you plan to continue on this path, and are there any new areas on which you would like to focus?

Mark R. Chassin, M.D., M.P.P., M.P.H.
A Well, I’m still learning about the organization and would not claim to be an expert on Joint Commission standards and procedures. It’s too early for me to be able to recommend any changes. But I do believe that the innovations in standards and accreditation surveys that Dennis O’Leary has introduced, particularly in the last five or six years, are really responsible for The Joint Commission’s leadership position in quality and safety. However, I would like to emphasize the need to understand the specific needs of accredited organizations as they initiate improvements and to then respond with high-quality products and services from The Joint Commission and Joint Commission Resources. I want us to take part in the process of creating, in a careful and rigorous way, the necessary tools and metrics and then disseminating them to organizations. We should be able to provide organizations with generalizable lessons so that they save time and resources from developing tools on their own and move more rapidly toward improvement. For example, if you want to reduce the frequency of long delays in getting laboratory tests back to clinicians, what specific causes of that problem have other hospitals, similar to yours, found when they tackled that problem? How exactly did they successfully manage the underlying causes of the problem? How do you embed improvements into routine work so that they are sustained once the specific team that invented them has disbanded—we’ve done some work in this area at Mount Sinai.

Q Concern has been voiced that organizations are often asked to take on quality and safety interventions for which there may not be the evidence of effectiveness, as there might be for clinical or drug interventions. Where do you come down on the issue of the evidence?

A A careful consideration of available evidence is vital to developing sound targets for quality improvement. We must have a high level of confidence that the actions that we are asking organizations to take improve patient outcomes. We will be careful to focus on the actions, then, that have the greatest effect on outcomes, and that have a beneficial long-term impact on organizations. We must also be mindful of the “opportunity costs” in undertaking a given improvement activity, for it takes the organization’s resources away from other improvement activities in which it might otherwise be engaged. There is a need to “prune this garden” to ensure that scarce resources are deployed in the most beneficial interventions.

Q How can The Joint Commission help providers address the proposed CMS rules about not paying for preventable adverse events?

A I plan on exploring the Centers for Medicare & Medicaid Services (CMS) rules in greater detail. I would then involve the provider community in helping define The Joint Commission’s role in determining how to address them. I hope that CMS would be open to discussion about how to best achieve its quality and safety goals. Usually, it is very difficult to develop financial incentives for quality based on the administrative data available to Medicare. They are often a blunt instrument, and relying on them alone can produce unintended consequences.

Q What key messages do you have for Joint Commission–accredited health care organizations that read this newsletter?

A First and foremost, I want to continue with the kind of innovations that The Joint Commission has made to even further increase the value of Joint Commission–accreditation and other programs, and I look forward to working with—and learning from—accredited organizations to achieve this goal. Second, as I have indicated, I also want to go beyond measurement and accreditation to help accredited organizations achieve real and major improvements in quality and safety. The Source
One More Time—Understanding Staff Competency

From the Editor: Joint Commission Resources’ Practice Leaders represent a caliber of excellence in consultative services by offering the best knowledge-based real-world solutions to health care organizations that are seeking innovative and practical advice. Look for future articles in The Source that offer the Practice Leader’s know-how insight and advice from the perspective of using the best compliance tools and strategies for your organizational needs.

Hardly a week goes by that someone doesn’t ask me a question about staff competency. Understanding staff competency is critical to a successful Joint Commission accreditation survey. Accreditation is fundamentally a risk reduction activity, and the underlying patient safety principle for staff competency is the notion that a hospital cannot provide a safe, reliable, and appropriate environment if its staff members are not competent.

Many people have written articles, papers, and books about competency. So with all this information, knowledge, and historical data, what prompts the continued questions? Consider the following: (a) Assessing staff competency can be viewed as this vague, subjective, interrogation of staff members; furthermore, these staff members may have worked for decades at the organization, view themselves as competent, and silently question management’s competence at defining their competence; (b) many organizations have made competency assessment complex and arduous, which prevents effective implementation; (c) some organizations try a “one size fits all” campus methodology in which the medical staff and allied health professionals, for example, receive the same infection control competency test as the front desk receptionists; (d) when the competency process is established, it is held “untouchable” despite organizational experience, technology enhancements, or external forces; and (e) human resources (HR) keeps the personnel files, and a manager needs to get the file from HR to determine if someone is current on their competencies. If any of these examples (there are many more) caught your eye or caused you to smile, you understand why staff competency continues to be so problematic.

Since its inception, The Joint Commission’s Sentinel Event Database has listed two items as the top two factors in contributing to sentinel events: communication and orientation and training. Clearly, having a competent workforce is paramount to a significant reduction of these events.

Competency Foundation

Three words appear very often (more than 1,000 times) in the Joint Commission standards. They are plan (planned), system (systematic), and risk. These words give clear evidence that competency must be a planned and systematic process based upon risk assessments. Planning ensures that key concepts such as confidentiality, infection control, and safety are covered prior to ever touching a patient. Additional issues can be covered during the employee’s first introduction to the unit (no matter how long he or she has been at the organization), and periodic reevaluation of the effectiveness of the knowledge, education, and training is planned. Systematic measures ensure that responsibilities are done consistently and shortcuts are not taken, the employee completes the required process, and ongoing review occurs in accordance with basic design concepts of performance improvement and/or law and regulation. Risk (in the context of competency) means lowering the risk of patient, staff, or visitor injuries through competency program design and staff training. A credible risk assessment is required to determine what is or is not relevant. Imagine for a moment that you are boarding a plane that has already arrived late and needs to depart. The pilot announces that normal procedures for checking the plane will be abandoned because everything seemed to be working fine when the plane arrived, so they must still be okay to depart. “I have my own checklist that I use,” states the pilot. As passengers, we would immediately take notice that the usual planned and systematic processes designed to lower risk in the airline industry had been avoided. Feelings of concern would be immediate, and we would probably report it to the Federal Aviation Administration. Do we do this in health
care? Is competency truly unit and population based? Are our competency processes designed to lower risk or “just get it done” so that something is in the file for inspection?

**Competency Mortar**

*Competency* is defined in many ways. The basic tenet is that everyone who comes into contact with the patient care environment (no matter how remote) is properly qualified and skilled to function under the varied circumstances of the patient care world. This means that they have three essential components in their mortar that span across five support columns. The mortar is made up something like the picture in Figure 1.

**Competency Bricks**

Considering the above, the process can be tied together with bricks containing tasks (the activities and procedures involved to support the physician’s privileges or individual’s job); results or output (the staff member’s ability to produce the desired results); knowledge (the information the staff member needs to meet job performance expectations in the given “real world” situation); skills across the three domains of the mortar; attitude (the approach, orientation, motivation, commitment, and energy to performing the job; the human factors of self-image, customer service, and insight the employee may bring to the position); and licensure, registration, or certification to function within the scope of practice.

**Risk**

Finally, we must consider risk such as the following:
- What is the process I am evaluating?
- What are the risk points?
- What are we doing to mitigate the risk points?

The correlation to risk assessment is that every time we change a process we change all the risk points.

**Standards Compliance**

For example, Standard HR.3.10* (“Staff competence to perform job responsibilities is assessed, demonstrated, and maintained”) may seem rather vague, but given the elements of performance (EPs), we can see the direction that the Joint Commission is expecting. Furthermore, we can apply some key principles to this process.

**Conclusion**

Staff competency depends on leadership. Quality leadership requires a thorough assessment of the competency domains cited above. Next month I will discuss this HR standard in more detail by describing how a planned, systematic, and risk-related process can be applied to EP 1, “population served,” (see page 8).

---

*Standard HR.3.10 applies to the following programs: ambulatory care, behavioral health care, critical access hospitals, home care, hospitals, laboratories, long term care, and office-based surgery.*

---

Figure 1. Essential Components to Competency

![Diagram of Competency Mortar](http://www.jcrinc.com/). Competency can be considered an intersection of the following three ingredients:

- **Psychomotor** — The ability to physically perform the task. For example, passing a nasogastric tube or starting an IV requires fine and gross motor skills such as dexterity, physical feedback to resistance, and physical positioning of the patient.
- **Critical Thinking** — The ability, even in the face of a provider’s order, to stop or start a process. For example, not allowing the wrong medication to be administered due to the patient’s condition.
- **Communication** — The ability to communicate clearly and concisely document what you are doing so that other members of the healthcare team can perform their jobs.

Source: Joint Commission Resources, Oakbrook Terrace, IL.
### Elements of Performance for HR.3.10

1. The competence assessment process for staff is based on the population served.
   - **Advice:** Consider for each population served (or “scope of service”) how the three circles (see Figure 1, page 7) are identified.

2. The competence assessment process for staff is based on the defined competencies to be required.
   - **Advice:** Given laws and regulations, and the tasks, results, knowledge, skills, and attitude an employee needs, what privileges and nursing processes do we intend to provide?

3. The competence assessment process for staff is based on the defined competencies to be assessed during orientation.
   - **Advice:** What are the risk points prior to patient care that need to be considered prior to seeing a patient, and how will staff be exposed to a patient care process that covers all of the population we wish to support?

4. The competence assessment process for staff is based on the defined competencies that need to be assessed and reassessed on an ongoing basis, based on techniques, procedures, technology, equipment, or skills needed to provide care, treatment, and services.
   - **Advice:** You may wish to support a ventilated patient, but perhaps patients are admitted sporadically, and some time may be needed by the staff member to be on shift when this actually occurs.

5. The assessment process for staff is based on a defined time frame for how often competence assessments are performed for each person, minimally, once in the three-year accreditation cycle and in accordance with law and regulation.
   - **Advice:** First, consider those competencies mandated by law. Then consider a planned and systematic approach to risk. A procedure performed once a month is more risky than a procedure performed once a day. Infrequent performance is a risk point.

6. The competence assessment process for staff is based on the assessment methods (appropriate to determine the skill being assessed).
   - **Advice:** How will you measure the psychomotor, critical thinking, and communication skills?

7. The competence assessment process for staff is based on the use of qualified individuals to assess competence. **Note:** When there is no qualified individual in the organization who performs comparable care, treatment, and services, the organization may utilize qualified staff from other organizations to assist with the assessment of competence OR consult the appropriate professional organization guidelines with respect to expectations for competence and use these guidelines to assess competence.
   - **Advice:** Just because someone has worked for 20 years, or is a supervisor/manager does not make him or her competent. How do you tie the risk of the procedure back to a knowledge source?

8. The organization assesses and documents staff’s ability to carry out assigned responsibilities safely, competently, and in a timely manner upon completion of orientation.
   - **Advice:** Beyond the HR file, how will the direct supervisor know that education and training has been transferred to the employee knowledge has been retained to lower the risk?

9. The organization assesses staff according to its competence assessment process.
   - **Advice:** Planned and systematic—as noted above, with the exception of law and regulation, the more often an employee performs a process the less reassessment that needs to occur. The exception is if a process changes. In this case, change all the risk points and start over.

10. When improvement activities lead to a determination that a person with performance problems is unable or unwilling to improve, the organization takes appropriate action (which may include modifying the person’s job assignment).
    - **Advice:** Don’t be afraid to reestablish competency on the spot. Sentinel events occur when we “assume” that a staff member knows the process.
Prevention of pressure ulcers is a basic nursing function sometimes lost in the health care maze. The National Pressure Ulcer Advisory Panel (NPUAP) reviewed studies published between 1990 and 2000 and found that pressure ulcer incidence rates in acute care settings were as high as 38%. The cost of care for pressure ulcers has been reported to be as high at $15,760 per case.

In 2000 Saint Francis Medical Center became involved in the Nurses Improving Care to the HealthSystems Elders (NICHE) program. A geriatric nurse clinician (GNC) was added to the hospital staff in 1999 who became responsible for this geriatric initiative. The GNC was a member of the Nursing Quality/Safety Committee where information regarding pressure ulcers was analyzed quarterly. The statistical data provided evidence of the need to do a Geriatric Institution Assessment Profile (GIAP). This tool is part of the NICHE program, developed by the Hartford Institute for Geriatric Nursing at New York University College of Nursing. The NICHE initiative supported and promoted the GIAP and assessment of some basic care issues. The tool was designed to survey nurse attitudes and knowledge regarding care of the elderly, knowledge of best practices, and perceived institutional barriers to best practices for geriatric care.

The GIAP results related to pressure ulcers reported that the nurses were confident about their ability to care for and/or prevent pressure ulcers; however, staff lacked the necessary knowledge to care for patients with pressure ulcers. The knowledge score was low at 4.03 out of 10. The professional attitude about pressure ulcers was just above average at 5.68%. Although the staff reported a desire to provide appropriate care to patients at risk for pressure ulcers, there was a knowledge deficit. This presented a dilemma: How do you teach staff about pressure ulcers and pressure ulcer prevention when they already think they know all they need to know? Saint Francis needed nurse buy-in, and this was achieved through the use of Six Sigma.

**Process Approaches to Care**

In 2002 Saint Francis Medical Center adopted Six Sigma methodology and a five-phase problem solving process: (1) define, (2) measure, (3) analyze, (4) improve, and (5) control (DMAIC). In the first wave of projects was pressure ulcer prevention. The goal was to decrease the number of hospital-acquired pressure ulcers by 50% in the first six months. The team included a nurse in main surgery, a nurse from the surgical unit, the GNC, the wound/ostomy therapist, a certified nurse assistant, and two interested nurse staff members. When the team first met, the hospital-acquired pressure ulcer rate was 9.4%. It was estimated that at the current rate of patients acquiring pressure ulcers, the cost to care for these patients during one year would be $4,877,000. If the hospital could reduce the rate of hospital-acquired pressure ulcers by 50% to 4.7%, there would be a reduction in cost of $2,438,000 (see Figure 1, page 10).

**Organization Facts:** Saint Francis Medical Center is a Magnet Award winner and is also a 710-bed teaching hospital. Affiliated with the University of Illinois College of Medicine located in Peoria, Illinois, the hospital is a tertiary referral center and a Level I Trauma Center, and operates a Life Flight Program, an adult hospital, The Children’s Hospital of Illinois, and the Saint Francis Heart Hospital. Saint Francis Medical Center is part of a comprehensive network of seven health care facilities, 17 affiliates, OSF Medical Group, two colleges of nursing, and OSF Home Care, consisting of home health, hospice, private home care, home infusion pharmacy, home medical equipment, and Health Watch services.

**Project Purpose:** To reduce the number of hospital-acquired pressure ulcers by 50% to 4.7%, and to reduce the cost associated with the care of patients with pressure ulcers by $2,438,000.

**Outcomes:** Improved patient safety, reduction of complications due to hospital-acquired pressure ulcers, reduction in cost by more than $3,000,000 annually, and continued control rate over time. Pressure ulcer rate is currently at 2%—four years after the project began.
Spotlight on Success: OSF Saint Francis Prevents Pressure Ulcers: Best-Practice Notes from the Hartford Institute for Geriatric Nursing
Continued from page 9

The Try This Series of the Best Practices in Nursing Care to Older Adults and the NPUAP recommend using a validated reliable tool for pressure ulcer prediction. The hospital was currently using the Braden Scale, but had to go a few steps further with the new initiative. The steps include the following:

- Reeducation and ongoing education of all nursing staff about pressure ulcer prevention and skin care
- Skin assessments on admission, daily, and on transfer to another unit
- Standardized interventions that include skin breakdown prevention protocols; turn Q 2 hours (nursing is reminded audibly via overhead music and pagers); patient and family education about pressure ulcer prevention; moisture management for incontinent patients that includes dry flow pads, moisture barriers, and pre-moistened disposable barrier wipes
- S.O.S. signs on the doors of patients at risk
- Accountability from the nurse manager and the unit council who were responsible for collecting and reviewing pressure ulcer data
- Reporting data quarterly to administration
- Quarterly prevalence and incidence studies

Quick Wins
The team evaluated a number of pressure relief beds and ordered 140 static air mattresses for the six pilot units of the study. In a five-month period there was a savings of $100,000 in rental costs for pressure relief beds. The patients on the pilot units were placed in beds that provided pressure relief. Pressure ulcer incidences decreased by 4%; an immediate decrease of 11% was shown on the pilot units.

Quality improvement initiatives in the past did not contain key element-defined roles for ongoing sustained gains. A skin team was developed with an S.O.S. champion for each unit who became the resource for skin care on their unit. These champions assisted in unit data collection, data entry, and skin reports. The S.O.S. champion worked with the process owners on their individual units to ensure that the process was in control. The S.O.S. champion held team meetings each month and quarterly meetings for data collection.

Education
Training sessions took place with one-on-one training for every staff member. This was a time-consuming process, but administration recognized that a sustained change required this effort up front.

The Six Sigma team for pressure ulcer prevention has dispersed; however, this initiative could not be allowed to end. One of the wound/ostomy nurses became the global process owner for this initiative. This nurse and the S.O.S. team meets monthly to assess quarterly prevalence and incidence studies. The team analyzes organizationwide data, and assists units that need more guidance or clarification. The owners of the process are the nursing units, the unit councils on the units, and the nurse manager. The process has sustained long-term results.

Source: Saint Francis Medical Center, Peoria, IL. Used with permission.

Figure 1.
Hospital-Acquired Pressure Ulcer Rates 2001–2007

The pink line denotes the hospital’s goal for pressure ulcers. The dark navy line represents results of the quarterly studies.

Source: Saint Francis Medical Center, Peoria, IL. Used with permission.

Check the daily and weekly moisture management records; patient and family education about pressure ulcer prevention; turn Q 2 hours (nursing is reminded audibly via overhead music and pagers).
Communications Checklist

Teaching staff how to communicate is important, but organizations can go one step further by using a comprehensive communication strategy or various tools that not only reduce the possibility of a sentinel event, but also provide a teamwork pattern to every avenue where communication skills can be used. From conflict management to assessing staff competency, how many of these tools does your organization use?

<table>
<thead>
<tr>
<th>I. Written Materials</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Memos</td>
<td>Books</td>
<td>Postcards</td>
</tr>
<tr>
<td>Newsletters</td>
<td>Magazines</td>
<td>Posters</td>
</tr>
<tr>
<td>Direct mail</td>
<td>Surveys</td>
<td>Advertisements</td>
</tr>
<tr>
<td>Letterhead</td>
<td>Instructions</td>
<td>Catalogs</td>
</tr>
<tr>
<td>Business cards</td>
<td>Handbooks</td>
<td>Slogans</td>
</tr>
<tr>
<td>Brochures/pamphlets</td>
<td>Financial reports</td>
<td>Contracts</td>
</tr>
<tr>
<td>Fliers</td>
<td>Annual reports</td>
<td>Performance agreements</td>
</tr>
<tr>
<td>Booklets</td>
<td>Pie charts and graphs</td>
<td>Paper style/color</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Meetings, Etc.</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>One-on-one</td>
<td>Lunch meetings</td>
<td>Focus groups</td>
</tr>
<tr>
<td>Group discussions</td>
<td>Dinner meetings</td>
<td>Grievance systems</td>
</tr>
<tr>
<td>Team meetings</td>
<td>Speeches</td>
<td>Open door policies</td>
</tr>
<tr>
<td>The grapevine</td>
<td>Seminars</td>
<td>Teleconferencing</td>
</tr>
<tr>
<td>Breakfast meetings</td>
<td>Conferences</td>
<td>Videoconferencing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Individual</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dress</td>
<td>Body language</td>
<td>Smell</td>
</tr>
<tr>
<td>Intonation</td>
<td>Eye contact</td>
<td>Facial expressions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV. Telephone</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice mail systems</td>
<td>Pagers</td>
<td>900 numbers</td>
</tr>
<tr>
<td>Interactive voice response systems</td>
<td>800 numbers</td>
<td>Telemarketing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>V. Computers &amp; Technology</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E-mail</td>
<td>Screensaver</td>
<td>Web sites/Internet</td>
</tr>
<tr>
<td>CD-ROM</td>
<td>Multimedia</td>
<td>Intranet</td>
</tr>
<tr>
<td>Geographical information systems (GIS)</td>
<td>Global positioning system (GPS)</td>
<td>Internet message boards</td>
</tr>
<tr>
<td>Push technologies</td>
<td>Virtual simulations</td>
<td>Internet video cams</td>
</tr>
<tr>
<td></td>
<td>E-zines</td>
<td>Contact management program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VI. Facilities</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Design/layout</td>
<td>Colors</td>
<td>Access</td>
</tr>
<tr>
<td>Lighting</td>
<td>Art</td>
<td>Flexibility</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VII. Miscellaneous</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cassettes</td>
<td>Fax-on-demand</td>
<td>Symbols</td>
</tr>
<tr>
<td>Videos</td>
<td>Suggestion systems</td>
<td>Trademarks</td>
</tr>
<tr>
<td>Awards</td>
<td>Bulletin boards</td>
<td>Service marks</td>
</tr>
<tr>
<td>Bonuses</td>
<td>Bus benches</td>
<td>Giveaways</td>
</tr>
<tr>
<td>Media articles</td>
<td>Billboards</td>
<td>Community activities</td>
</tr>
<tr>
<td>Public relations</td>
<td>Sales force</td>
<td>Aroma</td>
</tr>
<tr>
<td>Closed-circuit TV</td>
<td>Satellite transmission</td>
<td>Stories/fables</td>
</tr>
</tbody>
</table>

Source: The Joint Commission, Oakbrook Terrace, IL.
New!
Medication Use: A Systems Approach to Reducing Errors,
Second Edition

Written by nationally recognized experts, this new edition helps organizations evaluate and improve their medication use systems by providing guidance on using a systems approach to medication use. This systems approach includes defining and preventing medication errors; measuring and monitoring the medication use system; and incorporating physicians, nurses, pharmacists, caregivers, and patients into the medication use system.

Special features of this new book include the following:
- Completely updated material reflecting advancements and research in preventing medication errors
- Profiles of a systems approach to reducing medication errors
- Details on how to measure and monitor the performance of your medication use system
- Recommended methods of evaluating and improving medication use systems
- Case studies on how organizations have successfully measured and improved their medication use systems

Order Code: MU200SJ
Price: $75.00

For more information please visit our Web site at http://www.jcrinc.com/ or call our toll-free Customer Service Center at 877/223-6866.

Our Customer Service Center is open from 8 A.M. to 8 P.M. eastern standard time, Monday through Friday.