The Joint Commission

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The Source™

FOR JOINT COMMISSION COMPLIANCE STRATEGIES

Tackling Workplace Violence

THE ROLE OF LEADERSHIP

According to the Bureau of Labor Statistics, 70% of the 16,890 injuries reported in 2016 as due to workplace violence occurred in the health care and social assistance industry. Furthermore, the U.S. Government Accountability Office found that health care workers in hospitals are five times more likely to experience injuries from workplace violence and require days off from work than workers in other private industries.

As awareness of workplace violence in the health care sector increases, some health care leaders have made preventing violence a top priority. When leaders take workplace violence seriously, they send several key messages to their staff, including the following:

Your safety is important. When leaders treat their employees as their most valuable asset, they do everything they can to ensure that they don't get hurt at work.[1] "We can't leave our staff vulnerable in responding to violence," says Lisa DiBlasi Moorehead, EdD, MSN, RN, associate nurse executive, The Joint Commission. "Health care workers need the resources, education, and tools to respond to violence."

And when health care workers feel safe at work, they are better able to ensure the safety of their patients. "How can health care workers focus on the safety of their patients if they feel threatened?" says Suellen Daum, RN, MS, CPPS, CPHQ, patient safety specialist, Office of Quality and Patient Safety, The Joint Commission. "If you don't feel safe at work, you can't concentrate and function."

The culture of safety is important. When leaders create a culture of safety that upholds civility and values learning, they encourage staff to continuously report all types of violence, incivility, bullying, intimidation, threats, and harassment, as well as verbal and physical abuse. "When there is supportive leadership, health care workers feel comfortable reporting all forms of violence, even verbal assault, so that leaders can track the issues," says Lisa H. Wilson, MBA, BSN, RN, CEN, NE-BC, project director, Division of Healthcare Quality Evaluation, The Joint Commission.

Leadership Strategies to Prevent Workplace Violence

The Joint Commission believes leadership plays an important role in preventing workplace violence. As a result, there are several Joint Commission Leadership (LD) standards related to workplace safety (*see* Sidebar 1 for more details).

This article explores key strategies health care leaders can implement to keep workers, patients, and visitors safe from all types of workplace violence:

- Ensure that safe policies are reinforced with action.
- Create a robust reporting culture.
- Recognize the risk for violence within the organization.
- Prepare with constant training and awareness.

- Teach and practice de-escalation techniques.
- Encourage teamwork and team training.

Actions Speak Louder Than Words. Although it is important for health care leaders to *say* that the safety of health care workers and the culture of safety are important, their actions must reinforce their words. "Health care workers need to have enough staff and resources to assess patients carefully and use de-escalation techniques," says Daum. "This resource allocation by leadership is extremely important."

Daum, DiBlasi Moorehead, and Wilson suggest several leadership actions that protect health care workers from workplace violence, including the following:

- Provide adequate staffing, resources, and tools to assess for and mitigate workplace violence. (Examples of innovative resources and tools include a tracking mechanism to flag a patient with a violent history in the electronic medical record; and behavioral emergency response teams that can be called—similar to rapid response teams. For more information, see the "Managing Behavioral Health Issues in Nonbehavioral Settings" article in the August 2017 issue of *The Source*.)
- Educate health care workers to better recognize the signs of potential violence or aggression and then use evidence-based de-escalation techniques to defuse the aggression.
- Frequently focus on workplace violence, such as in daily huddles or employee newsletters, by mentioning certain patients who may be at risk for violence, reviewing recent reports of verbal or physical abuse, and describing or acting out a de-escalation technique.
- Make it easy for staff to report all types of workplace violence, including verbal abuse.
- Investigate all reports of workplace violence and provide feedback to those who submitted a report about what is being done to prevent future violence.
- Debrief following an episode of workplace violence and provide support to those involved in the episode.

Create a Robust Reporting Culture. Leaders must tell and show health care workers that it is imperative to report all violent events that led to harm or could have led to harm. "Reporting is the most important piece," says Wilson. "If you don't have true and transparent reporting, you have no idea how big a problem you have, and that comes back to what kind of leadership do you have."

It is widely accepted that workplace violence is underreported, and leaders may need to combat their own organization-specific barriers to reporting, such as an inadequate or unknown definition of workplace violence, the belief that violence is part of the job, lack of time to report, or a reporting system that is difficult to access or use.[2]

"Before staff can report workplace violence, they have to know what it is," says DiBlasi Moorehead. "We need a clear definition of workplace violence, and it does include verbal abuse. We need reporting systems in place that are not cumbersome and are easy for staff to use. Staff have to trust leaders so that if they report violence, they know there won't be any retribution, the issue will be addressed, and they will get feedback on what was done to correct the issue. If any of those pieces are missing, you will likely not get reports."

The goal is for staff to report all incidences of physical or verbal violence, including bullying, threats, harassment, and incivility. "Workplace violence is not looked upon like zero harm," says Daum. "Bullying or incivility isn't recognized. But do we wait to report it until it escalates to physical harm? How can we capture that information and look at it as a data point instead of letting it escalate until it becomes physical harm?"

When an incidence of workplace violence is reported, leaders must investigate it thoroughly. "Leaders should do a deep dive to investigate the root causes, including whether staff were prepared for the violence, did they respond appropriately, and were they well educated," says DiBlasi Moorehead.

Know the Organization's Risk for Violence. Violence can happen anywhere and anytime—it does not happen only in urban emergency rooms serving certain demographic populations.[3] "The first thing is acknowledging that workplace violence is occurring," says DiBlasi Moorehead. "Sticking your head in the sand and saying it can't happen to us is not beneficial or helpful. We need to do a thorough assessment and vetting of the organization to determine how extensive workplace violence is."

Having a robust reporting culture will allow health care leaders to continually take a pulse of the violence rate within their organization as well as within individual units or departments. But if this reporting culture is in the process of being developed, leaders may consider distributing an electronic survey for staff to complete to determine where problems with potential violence exist. "You can survey all staff—ancillary, physicians, nurses—on how safe they feel in the environment and any risk areas," says Wilson. "This can be used as a starting point to identify the biggest risks and prioritize interventions within the financial constraints of the environment."

James Phillips, MD, from Harvard Medical School and the Department of Emergency Medicine at Beth Israel Deaconess Medical Center in Boston, describes workplace violence in the health care industry as "an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored."[4]

If health care leaders provide health care workers with the support, resources, and training to prevent workplace violence and follow up on all reports of verbal or physical abuse, Phillips may someday describe workplace violence as intolerable, infrequent, and well-reported.

Prepare with Constant Training and Awareness. Leaders must prepare health care workers to be vigilant for potentially violent situations, including how to recognize the risk factors or warning signs of potential violence, de-escalate the aggression, and call for more resources.[5] "Leaders should provide training and assessment tools so staff can evaluate for the potential of violence," says DiBlasi Moorehead. "For example, we know that patients with an altered mental status from whatever cause—dementia, intoxication, or decompensated mental illness—are those most likely to become violent."

There are many other risk factors or warning signs for potentially violent situations in the health care setting (*see* Sidebar 2). "Finding the warning signs for violence really comes down to a thorough assessment that will identify high-risk patients so that staff can have a plan that is proactive rather than reactive," says Wilson.

The Occupational Safety and Health Administration (OSHA) recommends that training to prevent workplace violence should occur at least annually, but high-risk settings may need more frequent training, such as monthly or quarterly. Leaders can access the resources in Sidebar 3 to find other staff training topics related to preventing workplace violence.

Teach, Practice, and Use De-Escalation Techniques. A proactive plan for addressing patients, visitors, or staff who show risk factors or warning signs for violence should include de-escalation techniques, which is the first-line response to potential violence and aggression in health care settings.[6] "There's no gold standard for de-escalation right now," says Daum. "That's why there are so many resources available. Not every de-escalation technique is going to work for every patient, so it's important to know about and use multiple types of de-escalation techniques."

Daum explains that the main purpose of de-escalation techniques is to find a way to connect with patients. "What concerns them most? What are they afraid of?" says Daum. With this information, health care workers can better understand the reasons behind the patient's aggression and can plan how to create a safe, less-threatening environment for the patient. "If staff don't use de-escalation techniques or don't try different types of techniques, then the patient often goes into restraints, and that trust bond is broken with the patient," says Daum. Furthermore, the American Psychiatric Nurses Association (APNA) views coercive measures, including the use of restraints, seclusion, or unwanted intravenous sedation medications, as a last resort to handling violent patients.

When possible, Daum also suggests involving patients in finding the de-escalation technique that works for them when they become agitated. "A lot of patients can tell you what calms them down," says Daum. "You can ask them what they find most helpful when they are upset or what helps them most when they are anxious."

Work as a Team. When there is a potential for violence, health care workers should never work alone.[5] A health care team working with a violent or potentially violent patient needs to work as a cohesive

unit. Oftentimes, the team will pick one person to approach the patient in a nonthreatening way and talk with the patient while the rest of the team stands back in case the situation becomes more violent. "We want to have a unified approach to the patient," says Daum. "Everyone in the room should have the same training so they all can have a shared mental model."

DiBlasi Moorehead adds, "We have to work together and have clear policies and procedures about each person's role and responsibility. The health care worker response is sometimes different from security, so there should be similar training, at least in that initial response."

Team training will likely work best when it occurs face to face rather than remotely or via online training. "The most effective training is training that occurs with the teams that will be responding together, including nurses, physicians, and security, and using simulation training," says DiBlasi Moorehead.

Health care leaders must work hand in hand with health care workers to prevent workplace violence, but it often starts with leaders setting the priority for zero harm due to violence and providing the resources, training, and support to accomplish this goal. While this article described some strategies to prevent workplace violence, leaders can *see* Sidebar 3 for links to resources for an effective workplace violence prevention program within their organization.

References:

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3. The Joint Commission. Physical and verbal violence against health care workers. *Sentinel Event Alert,* Issue 59. Apr 17, 2018. Accessed Mar 26, 2019. https://www.jointcommission.org/sea_issue_59/.
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5. Occupational Safety and Health Administration. *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*. OSHA 3148-06R. 2016. Accessed Mar 26, 2019. https://www.osha.gov/Publications/osha3148.pdf.
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Sidebar 1. Joint Commission Standards Related to Workplace Violence

The Joint Commission has many standards related to preventing workplace violence. This sidebar highlights Leadership (LD) standards, but a more robust list of standards can be found in *Sentinel Event Alert* 59.

- **LD.03.01.01** requires that leaders create and maintain a culture of safety and quality, including enforcing a code of conduct that separates acceptable behavior from disruptive behaviors or behaviors that undermine a culture of safety.
- **LD.03.09.01** requires organizations to have an integrated patient safety program within their performance improvement activities.
- **LD.04.01.01** requires organizations to comply with local, state, and

federal laws, rules and regulations when providing care, treatment, and services. For example, the Occupational Safety and Health Administration (OSHA) is the federal agency that requires employers to maintain a safe working environment for their staff. Specifically, the General Duty Clause, Section 5(a)(1) of the Occupational Safety and Health Act, requires employers to provide a place of employment that is "free from recognized hazards that are causing or likely to cause death or serious physical harm."

Sidebar 2. Risk Factors for Violence in Health Care

The risk for violence in health care settings increases depending on multiple factors, including patient factors, the health care setting, situational factors, and organizational and leadership factors. Examples of these factors follow.

Patient Factors

- Altered mental status associated with dementia, delirium, substance intoxication, or decompensated mental illness
- Feelings of uncertainty, grief, powerlessness, and frustration
- Victims of intimate partner violence who may be followed by an angry spouse or partner
- History of violence or trauma
- Being under the influence of alcohol or other substances
- Verbal abuse

Health Care Settings

- Emergency department
- Labor and delivery or maternal-child inpatient units
- Intensive care units, including adult, pediatric, and neonatal intensive care units
- Community health clinics
- Drug treatment clinics
- Nursing care centers
- Home care organizations

Situational Factors

- Gang activity or high crime rates in the surrounding area
- Long wait times for care
- Late night or early morning hours or weekends
- Patients or family members who receive bad news
- Delayed discharge without frequent communication on expected discharge time
- Overcrowded waiting rooms
- Private citizens who are armed
- Individuals who are in police custody or require a medical clearance after

an arrest by law enforcement
- Providing patient care (lifting, moving, or transporting patients; inserting peripheral intravenous catheters, inserting urinary catheters)

Organizational and Leadership Factors

- Perception by health care providers that violence is tolerated and accepted by leadership and that reporting incidents will not decrease violence
- Inadequate security personnel and clinical staffing, staffing that does not allow for breaks, or staffing that results in health care providers working alone
- Staffing that does not include health care providers and security personnel who are trained to work with patients who are agitated or aggressive and can de-escalate situations
- Lack of training or repeat training for clinical and security staff on de-escalating agitated and aggressive patients
- High worker turnover
- Environmental hazards (such as poor lighting, poor environmental design that blocks vision or escape routes, lack of monitoring by security, inadequate security presence, lack of private areas for distressed patients or visitors, unrestricted public access)
- Lack of emergency communication means (such as staff unable to communicate for help during a violent event or lack of panic buttons, cell phones, or call lights)
- Lack of community mental health care

Adapted from The Joint Commission. *Front Line of Defense: The Role of Nurses in Preventing Sentinel Events,* 3rd ed. Oak Brook, IL: Joint Commission Resources, 2018.

Sidebar 3. Resources for Preventing Workplace Violence

The Joint Commission

- Workplace Violence Prevention Portal
- *Sentinel Event Alert* 59: Physical and Verbal Violence Against Health Care Workers
- Quick Safety Issue 47: De-escalation in Health Care

The Joint Commission Journal on Quality and Patient Safety, February 2019, Volume 45, Issue 2

- "Workplace Violence in Health Care and Agitation Management: Safety for Patients and Health Care Professionals Are Two Sides of the Same Coin"
- "Using a Potentially Aggressive/Violent Patient Huddle to Improve

Health Care Safety"

Occupational Safety and Health Administration (OSHA): Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers

Oregon Association of Hospitals and Health Systems: Workplace Violence Prevention Toolkit TS

NEXT ↓

Workplace Violence in Health Care Settings

The Big Picture

Health care providers in hospitals are **five times more likely to experience injuries** from workplace violence and require days off from work than workers in other private industries (GAO, 2016)

Nearly **75%** of the 25,000 workplace assaults reported annually involved health care and social service settings (OSHA, 2016)

Workplace Violence in Home Care

61% of home care workers report workplace violence each year (Hanson et al., 2015)

Homicide has been found to be the second most common cause of workplace death among home health aides, nursing aides, and psychiatric aides combined (BLS, 2006)

Nurses Report on Workplace Violence

According to the American Nurses Association's HealthyNurse® Health Risk Appraisal survey: (Carpenter, 2017)

- **25%** of nurses have been physically attacked by patients or their visitors
- **48%** of nurses reported experiencing aggression from peers
- **39%** of nurses reported experiencing aggression from authority figures

More than half of emergency department nurses **do not feel safe** from workplace violence and do not feel prepared to handle violent incidents (Strickler, 2013)

Workplace Violence in Nursing Homes

Violence increases when patients are **cognitively impaired**, such as with Alzheimer's disease or dementia (Lachs et al., 2013; Tak et al., 2010)

34% of nursing assistants in nursing care centers reported experiencing physical injuries from resident aggression in the previous year (Tak et al., 2010)

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Tak S, et al. Workplace assaults on nursing assistants in US nursing homes: A multilevel analysis. *Am J Public Health.* 2010 Oct;100(10):1938–1945.

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Managing Patient Flow

A SHARED RESPONSIBILITY

Hospitals face constant pressure to ensure that the care they provide is not only safe and high-quality but also that the flow of patients is sufficiently managed such that it reduces delays that could affect that care and safety. In the Leadership (LD) standards, the patient flow standard—**LD.04.03.11**—states, "The hospital manages the flow of patients throughout the hospital." Element of Performance (EP) 1 of this standard requires the hospital to have processes that support patient flow and that address the following: plans for the care of admitted patients who are in temporary bed locations or in overflow locations, such as the emergency department (ED); and criteria to guide decisions on ambulance diversion. The standard also requires the hospital to measure and set goals for the components of its patient flow process (EP 5), measure and set goals for managing and mitigating the boarding of patients who come through the ED (EP 6), and review measurement results and take action when goals are not met (EP 7). EP 9 requires leaders to communicate with behavioral health care providers if the hospital determines that it has a population at risk for boarding due to behavioral health emergencies.

Standard LD.04.03.11 also recommends that boarding time frames be limited to four hours and that leadership oversight for patient flow include medical staff, the governing body, and senior hospital management, among other key leaders in the hospital. When patient flow is effectively managed, delays in the delivery of care are minimized.

The Emergency Department

Patient flow problems often begin in the ED. As Lisa Wilson, MBA, BSN, RN, CEN, NE-BC, project director, Division of Healthcare Quality Evaluation at The Joint Commission, explains, this is often due to the nature of the service provided by the ED: "The ED's doors are never closed, which can generate surges in patient admissions and put pressure on systems within the hospital. As a result, you have to have the right systems in place to accommodate that." The ED, in a way, can serve as an alarm bell for problems across the whole hospital. "You have inherent systems in the ED, and the ED relies on and feeds into many other parts of the hospital," says Wilson. She adds that an ED with good patient flow is like a team sport where everyone plays their part effectively.

Although the ED is one of the areas most visibly affected by patient flow, it's not the only area where problems can emerge. Problems in other parts of a hospital's system can also be a root cause of problems with patient flow. As Wilson explains, "It used to be that patient flow was seen as an ED problem, but hospital throughput is a shared responsibility. Any delays within the hospital system can have a downstream effect on other departments, including, but not limited to, the ED. A functional symbiotic relationship between all departments, including diagnostic testing, laboratory, transportation, and inpatient discharges, are all essential."

Other Key Areas That Affect Flow

Rising challenges with hospital capacity coupled with an increased number of patients presenting with complex problems all affect patient flow, Wilson notes. "More and more patients are presenting with significant, untreated concomitant health conditions," she says, "because they are not getting recommended preventative care, so when they are admitted, some are extremely ill. This can lengthen stays and require more complex care."

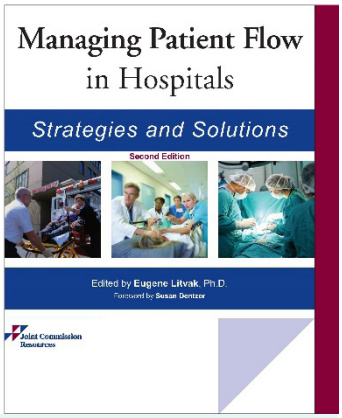
Wilson has also observed a rise in the number of patients presenting with mental health care emergencies who may require admission. In these cases, patient flow is challenged in the ED setting. "For some patients, the most inappropriate place to wait for a bed can be in the emergency setting," Wilson stresses. She recommends that the ED use an interdisciplinary approach to ensure that the environment and staffing are appropriate to care for patients with complex health issues or mental health emergencies, particularly if they have to be boarded because of patient flow issues.

Effective patient flow requires a significant amount of input and coordination from across the hospital, including different staff and disciplines and, most critically, leadership—with whom responsibility for patient flow ultimately resides. This should include all levels of leadership, from the governing body to hospital senior management to leaders in the key departments, including the ED, laboratory, postanesthesia care unit, housekeeping, discharge planning, and radiology. An important oversight responsibility relates to measuring benchmarks and analyzing the data. "A hospital is responsible for measuring patient flow data and tracking the metrics," says Wilson. "This data should be used to identify where the opportunities are and to mitigate what problems may exist. It's critical for leaders to work together and collaborate on this."

Wilson notes that hospitals can use digital tools to support patient flow issues in an ongoing manner. "Using interoperable tools to track patients' movements, which can be tied into the EMR [electronic medical record], can help facilitate improved patient flow across the hospital," she adds.

During an on-site tracer, patient flow often will be looked at along vulnerable points in the process—as a program-specific tracer, the priority will be compliance with the relevant standards and considering vulnerable or at-risk patient populations that may be affected by patient flow. Wilson provides the example of a behavioral health care emergency being surveyed in relation to patient flow: "A surveyor will survey how behavioral health patients are boarded and ensure that appropriate assessments are being done, that resources are being linked up as appropriate, and that the environment is suitable to care for that patient while boarded."

Helpful Resources



Managing Patient Flow in Hospitals: Strategies and Solutions, 2nd edition

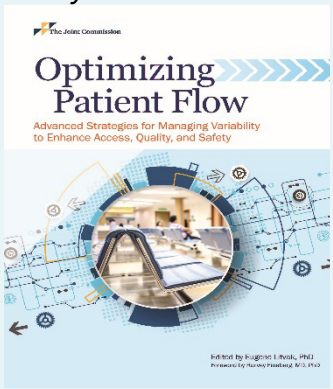
Edited by Eugene Litvak, PhD, world-renowned leader in hospital operations management and redesign, this book provides hospital leaders and professionals with scientifically grounded methods to optimally manage patient flow for effective operations.

This completely revised edition draws on the theory and practice applicable to hospitals, while offering methods and tools that can be adapted to ambulatory health care organizations and others. Among the topics addressed are the following:

- Problems in patient flow management
- Assessing the quantitative impact or patient flow issues on patients and staff
- Assessing, measuring, and evaluating patient flow
- Using quantitative methods to enhance patient flow
- Applying strategies to manage patient flow
- Variability in patient flow
- Sustaining improvements on an ongoing basis

For more information and to order, visit the Joint Commission Resources webstore.

Optimizing Patient Flow: Advanced Strategies for Managing Variability to Enhance Access, Quality, and Safety



Also edited by Eugene Litvak, PhD, this book goes beyond the introductory information provided in Managing Patient Flow for Hospitals to offer innovative techniques for optimizing patient flow and improving operations management to increase quality and safety in hospitals and home care.

In this book, Dr. Litvak teams with CEOs, physicians, and researchers who have compiled their own experiences with patient flow to offer the reader practical advances and specific approaches to patient flow issues in real-world organizations. This book covers the following topics:

- Reducing and managing natural and artificial variability
- Smoothing and optimizing the admissions process and surgical flow
- Capacity planning and queue management strategies
- Assessing the quantitative impact of patient flow issues on patients and staff
- Standardizing patient admission, transfer, and discharge

Click here for more information and to order your copy.

Additional Resources

Patient Flow Resources: Resources to support improving patient flow. https://www.jointcommission.org/accreditation/patient_flow_resources_.aspx

"The 'Patient Flow Standard' and the 4-hour Recommendation": Joint Commission Perspectives article about the patient flow standard, LD.03.04.11. https://www.jointcommission.org/assets/1/18/S1-JCP-06-13.pdf

"Vision in Action" Patient Flow Model: Virginia Commonwealth University Hospital's patient flow model for their emergency department (2017). https://smhs.gwu.edu/urgentmatters/content/vision%C2%A0%C2%A0action%C2%A0patient%C2%A0flow%C2%A0model

Optimizing Patient Flow in the ED: Urgent Matters' Toolkit (2014). https://smhs.gwu.edu/urgentmatters/sites/urgentmatters/files/OptimizingFlowAbingtonMemorialHospital.UMToolkit.pdf

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TRACER Methodology 101

Patient Flow in a Hospital—A Program-Specific Tracer

Scenario

This program-specific tracer was conducted in a 245-bed hospital located in a mid-sized city in the southeastern United States. Earlier, during the on-site survey, the surveyor had noticed that two patients were left boarding in the emergency department (ED) while waiting for an available bed, including one who was waiting for a psychiatric inpatient bed. The surveyor also noted that staff across the hospital reported that there were chronic delays with diagnostic testing. During the tracer, the surveyor met with the ED director, the quality improvement director, a nursing manager who was also the hospital's bed czar, laboratory staff, and the psychiatric department's charge nurse.

Exploring processes to manage patient flow. The surveyor spoke with the quality improvement director to explore the hospital's process to manage patient flow. [1] She also looked at how staff were involved in the patient flow team, what data they collect on patient flow, how the data analysis results are communicated, and how any processes are put in place, particularly regarding improvements in patient flow. [2, 3] The quality improvement director explained that the hospital had been collecting data on patient flow, including information on ED admits, wait times in the ED, and wait times for beds (particularly for mental health patients being admitted). The director explained that an analysis on wait time data indicated an 8% increase in wait times in the ED over the previous year's data. The hospital had seen more patients presenting in the ED, the director explained. The surveyor asked what kinds of improvement efforts the hospital had put in place to address these findings. [4] The surveyor learned that the organization had formed a team to implement a process to reduce patient backflow, especially in relation to boarding and diagnostic testing. The quality improvement director noted that the improvement effort had been introduced several months earlier, when wait times had been 13% higher, partly attributable to staff shortages and the closure of a nearby urgent care center. Wait times were reducing, but the staff shortages remained a challenge.

Upsurge and boarding in the ED. The surveyor asked the ED director how the hospital was addressing the upsurge in patients and related boarding. [5, 6] The ED director stated that hospital leadership had been considering opening an urgent care center to address the gap in services. He added that the hospital had also revisited the staff schedule to better ensure an overlap of mental health nursing staff in the ED.

Bed availability. The bed czar explained that she had been implementing new processes to better track bed availability and to communicate anticipated issues

to key departments in the hospital earlier in the process, particularly in addressing bed availability for mental health patients admitted via the ED. The surveyor asked the quality improvement director and the bed czar what type of training and support they were providing to staff regarding patient flow. [7] The bed czar described how she had been working in conjunction with key hospital leaders to ensure that her new responsibility was clearly communicated to staff, and she indicated that she had been leading in-service training for hospital staff members to help orient them to the new role and communication strategy.

Going forward. The team discussed maintaining efforts to reduce wait times and what kind of data collection and analysis would be included to track reductions. Team members also discussed a new recruitment and staffing initiative for the ED to more efficiently support the care of mental health patients. TS

Sample Questions

The following questions are representative of some questions that could be asked during a tracer. Use them as a starting point to plan your own tracers. Relevant standard: LD.04.03.11.

1. Please describe your process to oversee and manage patient flow in your hospital. Who has oversight and management responsibility? How does this function relate to the rest of the hospital? How is this communicated?
2. What types of data do you collect in relation to patient flow?
3. How are these data analyzed and communicated?
4. What quality improvement activities has the hospital put in place?
5. What kinds of communication processes do you have in place to help the hospital address an upsurge in patients, particularly in the ED? What areas of the hospital are involved in this communication process?
6. What kind of improvement process do you have in place to mitigate boarding issues? Are there any special circumstances you factor in regarding certain patient populations?
7. What orientation, training, and support do you provide to staff in relation to patient flow and the improvement process? How is this documented?

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Top News

A digest of accreditation and health care news

Hospitals Report Major Progress in Combating Hospital-Acquired Infections

HCA Healthcare Reveals Technique to Reduce Bloodstream Infections

Nashville-based hospital system HCA Healthcare found that using an antiseptic infection control technique could be a breakthrough in reducing the rate of health care–associated infections (HAIs) in non-ICU patients with central line catheters and lumbar drains. The ABATE Infection Trial (active bathing to eliminate infection), was funded by the National Institutes of Health and is part of a national strategy to reduce HAIs. The study looked at 330,000 patients at 53 HCA Healthcare hospitals, during a 21-month period, under real-world conditions across hospitals nationwide.

According to the Centers for Disease and Prevention (CDC), 1 in 31 hospital patients has at least one HAI. The trial evaluated the impact of using antiseptic cloths with chlorhexidine soap for daily bathing—and in those patients with methicillin-resistant *Staphylococcus aureus* (MRSA), adding the nasal antibiotic mupirocin—compared to daily bathing with ordinary soap and water. The results, which were recently published in the journal *Lancet*, revealed a substantial benefit to patients with medical devices. It was found that the patient population with central line catheters and lumbar drains saw a 31% decrease in bloodstream infections and a nearly 40% decrease in antibiotic-resistant organisms—particularly MRSA and vancomycin-resistant *Enterococci* (VRE).

Mount Sinai Health System Improves Hand Hygiene

Mount Sinai Hospital System (MSHS) in New York recently reported a 20% improvement in hand hygiene compliance over a three-year period across all staff roles and responsibilities. To date, the health system has collected more than 300,000 observations in each of the 95 units participating in the improvement initiative. The system is using the Joint Commission Center for Transforming Healthcare's Targeted Solutions Tool® (TST®) for Hand Hygiene across seven hospitals as a key part of its strategy to decrease hospital-acquired infections and reduce patient harm.

MSHS cites broad sharing of the improvement plan and resulting data as critical to the overall improvement process and notes that these strides in compliance improvement would not be possible without organizationwide commitment to hand hygiene as the responsibility of all employees—clinical and nonclinical staff. The company uses the data from the TST, analyzes it, and broadly shares it to drive performance improvement. Successes are shared in a number of ways, including the following:

- **Hand Hygiene Dashboard**: An online, password-free dashboard available to all employees via the intranet. The dashboard can be filtered by hospital, unit, and department to allow for specific, actionable data to be widely available.
- **Executive Quality Dashboard**: Hand hygiene is included in the systemwide quality dashboard distributed monthly to all site and health system leadership. The dashboard includes the health system's highest priorities related to safety and quality.
- **Reward and Recognition Programs**: Hospitals provide unit and department awards for highest compliance and most improvement.
- **Grand Rounds, Medical Board, and Other Internal Meetings**: Hand hygiene is a standing agenda item for many meetings.

Campaign Challenges Nurses to Model Healthy Behaviors for a Healthier Nation

In 1993 the American Nurses Association (ANA) designated May 6–12, National Nurses Week to celebrate and elevate nursing professionals. The celebration ends on May 12, the birthday of Florence Nightingale, considered by many to be the founder of modern nursing.

One of the top goals of the ANA is to promote a healthy work environment for nurses, in which their leadership and coworkers work together to protect every nurse and health care worker from injury or illness as well as workplace stress from unmanageable workloads, bullying or violence, working without breaks, and working long hours.

In response to data gathered from nurses between 2013 and 2016, the ANA created the Healthy Nurse, Healthy Nation™ Grand Challenge. This challenge is not just for nurses—the end goal is to improve the overall health of the nation by first improving the health of nurses. In this way, the 4 million registered nurses in the United States can be role models for health for their family members, coworkers, and the patients they care for by making sleep, exercise, healthy eating, safety, and quality of life a priority. In the first year, more than 9,000 nurses joined the Grand Challenge.

When nurses join the Grand Challenge, they take a health assessment survey, which allows the ANA to collect data on the professional and personal health, safety, and wellness risks facing nurses. Nurses pick an area of wellness on which to focus, such as activity, rest, nutrition, safety, or quality of life, and connect with others for support and advice to meet their goal. Finally, nurses are asked to repeat the survey annually to track progress toward mitigating the personal and professional risks facing nurses and all Americans.

May Accreditation Education Events

The Joint Commission's Ambulatory Care Events will be held May 6–10, 2019 in Oakbrook Terrace. The events include the following:

- CMS Basics for Ambulatory Surgical Centers (May 6)
- Ambulatory Care Accreditation Essentials (May 7–8)
- Environment of Care & Life Safety Chapter for Ambulatory Care (May 9–10)

Environment of Care & Infection Prevention and Control: A Partnership will also take place May 16–17 in Oakbrook Terrace. This two-day hospital event will help attendees gain an understanding of how infection preventionists and facilities staff can work together to promote compliance with Joint Commission standards

For details on these events and to register visit the Events page.

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