FEBRUARY 2007
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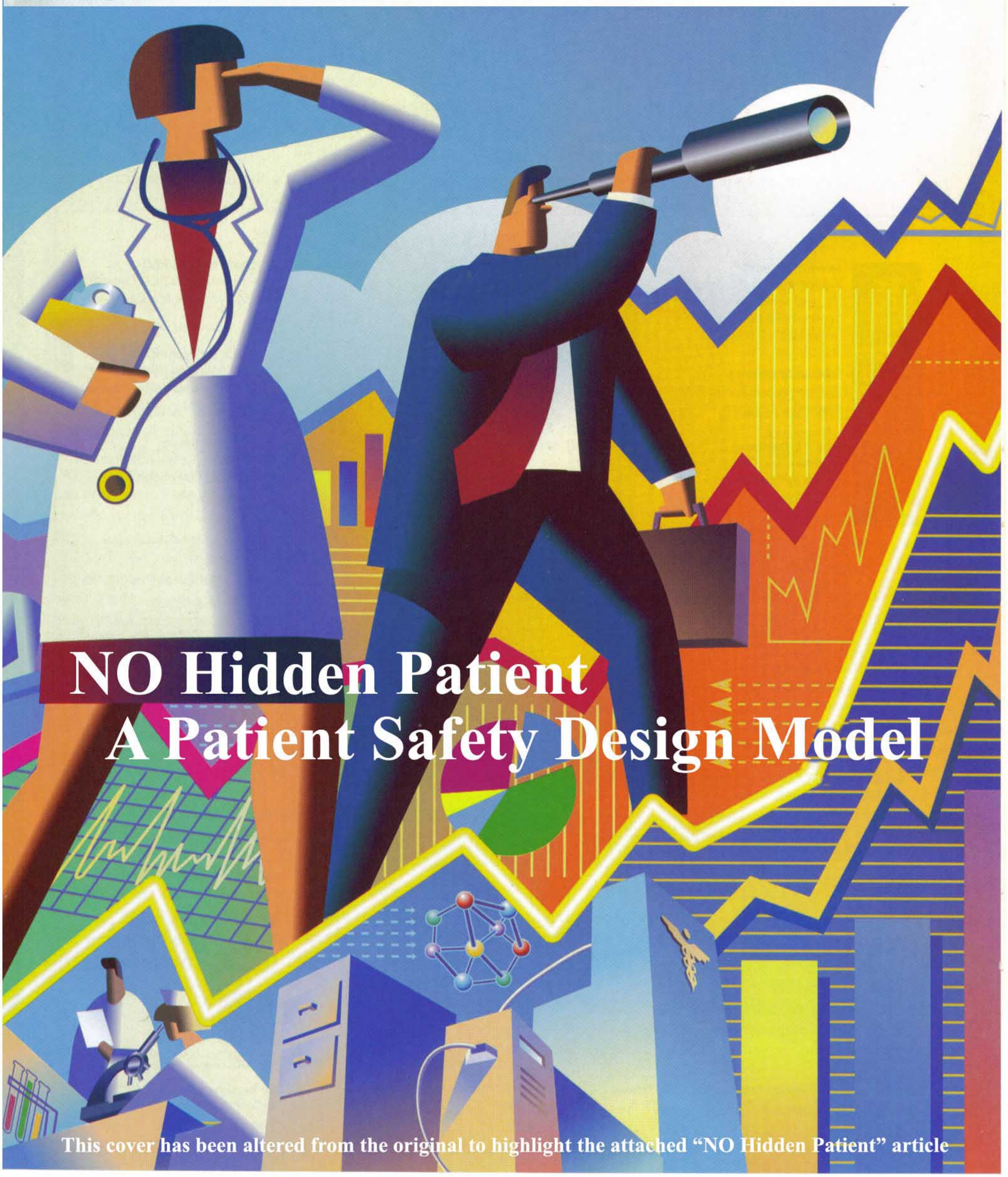
Trustee®

VOL.60 NO.2



NO Hidden Patient
A Patient Safety Design Model

This cover has been altered from the original to highlight the attached "NO Hidden Patient" article

DESIGN

No Hidden Patient: A Safety Design Model

By Jeff Hardy

The national spotlight is now shining on the unacceptably high number of hospital deaths caused by clinical and other patient safety errors. The actual numbers range from the Institute of Medicine's 2001 account of 98,000 deaths per year to Healthgrades' 195,000 deaths in each of the years 2000, 2001 and 2002 due to potentially preventable medical errors. Then there's a well-documented hunch by the Agency for Healthcare Research and Quality that we may have lost an additional 490,000 patients between 2001 and 2004 due to our failure to improve patient safety.

Our hospitals may be winning awards for their stunning architectural designs, their "green" environments and for being peaceful and uplifting for their patients. However, whenever there is a formal complaint, state Department of Health Services agencies register claim reports, documenting patient falls and slips, food and liquid asphyxiation, and tracheotomy tube accidents among many other causes of avoidable patient deaths or harm. Clinical and patient safety error statistics include deaths from adverse drug reactions, hospital-acquired infections, and surgical procedure errors.

Embedded within these statistics, however, are the patient deaths, injuries or mistreatment resulting from the hospital's design—for example, patient rooms that obscure the patient from nurses' clear sight.

Equally difficult to quantify is the threat to patient safety when the nurses' station is either hidden from any area in the patient care unit or is designed like a hotel reception desk that faces only one direction. In such designs, clinical nursing staff may be distracted by one task and be unaware that a needed physician has come and gone. Short of calling the physician at his or her home or office, the nurse will not have an opportunity to tell the doctor that, for example, the decubitus ulcers on a patient's legs have been getting worse by the hour.

The solution to these problems is the "No Hidden Patient" hospital design (author's term) for all emergency, outpatient and inpatient care centers. Anywhere there is a patient in a bed, on a gurney or in a service recliner, the "No Hidden Patient" rules apply. These rules dictate three criteria that should never be compromised for any reason:

1. All patients will be visible at all times by clinical staff.

All patient rooms should be clustered close together, similar to an intensive care unit, where nurses have optimum visibility of patients, and patients can easily see nurses, which allays their fears and anxieties. There are no long corridors, and staff can see the entire floor from any position. Corners, where patient rooms are customarily located and "hide" patients, are instead used as stairwells and for equipment storage, private conference areas and so on.

2. All patient rooms and holding areas are designed for immediate access to patients by the clinical staff.

Each patient room is close to a clinical nurses' worktable—i.e., a dining-room-style central worktable—so nurses can reach patient rooms quickly.

The average age of clinical nursing staff is 42, and many have foot, knee and hip pain as well as joint problems. The elimination of hotel-style patient care units with long corridors drastically reduces the amount of walking nurses must do. Also, in this design, the supply center is located on the floor so staff do not have to leave the unit for supplies.

3. All medical, clinical and professional staff will be able to communicate formally and informally among themselves without threatening their ability to observe every patient for whom they are responsible, risk confidentiality, or increase the sound level.

The nurses' worktable that has been tested in Glendale (Calif.) Memorial Hospital's intensive care and critical care units for the last 10 years gives staff the feeling of a home environment, according to Valli Washburn, R.N., director of intensive and emergency care, and designer of the workstation. She notes that, "promoting communication is the best patient safety factor there is." In addition, she says the decrease in nurses' stress levels and their pleasure in working in the intensive care and critical care units has attracted clinical nursing staff, who are "virtually lined up" to work in the nurse-friendly units.

The "No Hidden Patient" hospital design model is striking a chord with physicians, too, because of its impact on improving patient safety and reducing medical malpractice claims. Larry Bedard, M.D., a member of Team Health Emergency Physicians and a physician delegate to the California Medical Association (CMA) in Sacramento, has submitted a resolution for endorsement this year by CMA's 33,000 physician members that recommends all new health care facilities in the state be designed according to the "No Hidden Patient" model.

What is the board's role in facility design? When the need for a new hospital or a new unit, renovation, or addition to the existing hospital is first discussed, the trustee's role is to be the

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ombudsman for patients and to advocate for thoughtful planning of design elements that promote the highest level of patient safety.

Before building projects get under way, three important steps should be taken:

1. Predevelopment. At this stage, the board, key executive staff, a planning facilitator and selected experts should obtain demographic, market area and direct competition data that will be used to identify services, systems and operations criteria by which the facility or facilities will operate and be designed. Facility tours, best-practices review, town hall meetings and brainstorming discussions all take place during this period.

At the completion of phase one, the hospital should produce a "bare lot" analysis—the document that identifies, in general terms, how a new facility or facilities will fulfill community needs.

2. Preplanning. During this phase, the board, key executive staff, a development facilitator and as-needed experts should create a model of the services and systems, as well as the organizational and operations criteria for the new facility's design and operation. System, subsystem and component criteria for clinical delivery, clerical and operations support should be written in policy statements, such as the three "No Hidden Patient" policy statements above.

After this stage, the hospital should produce an overall operations model—a document that details specific service, system, facility, and human resources criteria that will be used during all subsequent phases of planning.

3. Planning. At this stage, key stakeholders make sure the process that architects will use during their charge conforms to the overall development process dictated by the hospital.

The document produced at this point—process guidelines—specifies how each step in the planning process will occur and identifies timelines, milestones, and steps that should be taken to enhance the likelihood of success.

Patients are dying unnecessarily in American hospitals every day due to what may appear as small design flaws. Hospital trustees need to ensure that their facilities are designed for maximum patient safety, maximum attention to an older nursing workforce and maximum communication among all medical, clinical and executive staff. **T**

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