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AHC Media

Are hospitals safer now?

TJC data may show yes, but OIG isn't sure

When you talk to officials at The Joint Commission (TJC) about the annual sentinel event reports released in July, they are quick to tell you that the data represent just a portion of sentinel events in the country, because reporting them to the organization is voluntary. But it's hard not to draw conclusions. Look at some of the rarer events reported, such as discharging an infant to the wrong family — it hasn't happened since 2010, when there was a single case. Or ventilator deaths, which went from 39 reported events two years ago to just one thus far this year.

Even those that are most common among the reports, such as wrong site/wrong person/wrong procedure errors, have declined precipitously, from 846 in 2010 to an annualized rate of about 120 this year.

While the bulk of sentinel events have been self-reported for as long as TJC has created these reports, the percentage has increased from just below 64% in 2004 to 72% in the first quarter of this year. That increase partly explains the climb in the number of events reported in the data: 740 five years ago, 810 in 2010 and 1,243 last year. The annualized rate for 2012, based on the 225 events reported in the first quarter of this year, looks to be around 900.

Still, don't read into the rates, says **Gerard Castro**, MPH, project director for patient safety initiatives at TJC. "This is all voluntary data, and is just a small portion of what's going on out there," he says. "This is just the proverbial tip of the iceberg, and I don't think we can draw any conclusions about the frequency of events."

OIG report on adverse events

Indeed, the HHS Office of Inspector General (OIG) found that of all the adverse events in U.S. hospitals, just 12% meet reporting requirements for states — just half of which require adverse event reporting — and only 1% of events are reported. If those numbers are used to extrapolate from TJC data, then the 900 events that might be the total reported to the commission this year may really be more like 90,000.

The OIG report looked at a sample of 780 Medicare patients in 2008, and found that 13.5% had an adverse event happen to them, and 13.5% experienced temporary harm. Of the incidents that the OIG discovered,

it found 32 that should have been reported to states but were not; only one of those was actually reported to the hospital itself. The rest, the report notes, may not have even been recognized by staff as being adverse events, even though six were associated with patient death, and others required serious medical intervention.

That proves what Castro says about the need to take the data part of the report with a grain of salt. But he notes that it still provides insight into the kinds of events reported and the emphasis that hospitals are putting on certain areas to address them. For example, if they are working on reducing medication errors — down from 345 in 2010 to 44 in 2011 and 45 in the first quarter of this year — then there might be more attention paid to that kind of event, and thus more reporting.

That there are a lot of reports on retained foreign objects may be due to the increased complexity of medical devices, Castro says. "It might be a guide wire associated with a catheter, rather than a medical instrument," he says.

No uniform solutions found

That increasing complexity — throughout the entire healthcare industry — means that there are more things that can go wrong, says **Paul Schyve**, MD, senior advisor for healthcare improvement at TJC.

"The kinds of retained objects we see reports of now didn't exist a few years ago," he says. "And we see issues related to electronic health records now that we didn't see before. There are a lot of safety advantages related to them for patients — avoiding the perils of misreading someone's handwriting, providing information on drug-drug interactions — but as we have introduced them, more and more people identify risks that occur because of them." Take the example of computerized physician order entry. If someone programs in a mistake about a standing order for a particular drug in a particular class of patients, you can end up providing a wrong dose not just for a single patient, but for dozens.

Alerts that pop up in the electronic records may become less alarming and more pestering, leading people to become immune to them, Schyve says. "Then they won't pay attention to them, and a significant risk might be ignored." What happens when a system goes down and there is no back up? These issues weren't even considered to be risk factors for sentinel events before, but they are now. "Changes in technology that can be good for patients can also change where the risk is."

What Schyve says you can tell from the data is that no uniform solutions have been found to the things that happen most often to harm

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Editor: Lisa Hubbell

Executive Editor: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).

Associate Managing Editor: Jill Drachenberg, (404) 262-5508 (jill.drachenberg@ahcmedia.com).

Editorial Questions

For questions or comments, call Russ Underwood at (404) 262-5521.

patients. And that gives quality managers a list of things they can look at to see what they have in place and what might need to be addressed. "This won't tell you what to do, but it will tell you what to pay attention to," Schyve says.

He adds that many organizations have tried valiantly to solve these issues and made amazing progress — the kind of progress that leads them to share their solutions with their peers. But the results can't always be replicated. The first few years of the reports, the root cause analyses showed that one of the main issues resulting in a sentinel event was imperfect communication. "So we told everyone to pay more attention," says Schyve. But if it was that simple, then the problems would have all been solved in all situations. It doesn't work like that, though. Every situation is different; the problem may be communication between nurses and doctors in one hospital, and between nurses changing shift at another. What works in one hospital may not make any difference in another.

There are some commonalities, though, and you can see those in the data collected on root cause analyses for sentinel events. Certain items turn up again and again in a variety of sentinel event situations.

Schyve says you should determine the causes that relate to your events, and then craft solutions that work for you. Your peers may have great ideas to share — and that's a great resource to tap — but don't just ask them about what worked, because it might not work for you. Also, find out what didn't pan out. You might get some other good ideas.

Using sentinel event data

One resource that Schyve says is underutilized is the Center for Transforming Healthcare, which was created just for the purpose of helping hospitals determine the causes of their problems and specific solutions that fit their needs.

Take the case of hand hygiene, he says. The center had eight hospitals pilot a project. Together, their hand hygiene rate averaged an abysmal 48%. No hospitals had the same pattern. No single cause was the same in every single hospital (although seven did share at least one cause). In a handoff project, Schyve says that only one of more than 20 causes appeared in every hospital involved. "We have used that project to develop a tool for organizations to use that steps them through how to make an accurate diagnosis of causes and then find solutions related to those causes in a database we have."

Whatever the issue, the improvement rates by those who have used the tool have been impressive, he says. The hand hygiene group improved hand-washing to 82% in just eight months.

The reason so few have made use of the center and its tools, Schyve thinks, is that you can get access only through the accreditation coordinator at your hospital. "People don't know about this because it isn't filtering down from that office to others. The coordinator can help other appropriate people gain access and use the tools."

The website for the center, along with some publicly available information on the hygiene and handoffs projects, as well as one on wrong-site surgery, is www.centerfortransforminghealthcare.org/tst.aspx.

The sentinel event data and associated root cause analysis information are something that quality and safety staff should look at and use. Even if TJC doesn't want to make any overarching comments about what the data mean, they are useful, Schyve says. "If you have a particular kind of event that happens — or even if you are just doing a prospective analysis of a kind of event, you can look at the causes related to them and use that as a starting place for your investigation."

And Castro notes that the root cause analysis data are more scientifically reliable, since they're a sample of the reports TJC receives, not an imperfect self-reported sample of what exists.

So use the report, Schyve concludes. If you see a spike in the number of a particular kind of sentinel event, you might use that as an impetus to look at your own systems and procedures around it. TJC itself can use an increase as rationale for putting new emphasis on a topic. "If it's at the top of your mind, you naturally pay more attention and put it higher on the list of priorities."

The Joint Commission reports are available online at www.jointcommission.org/assets/1/18/General_information_1995-1Q2012.pdf for the general information and http://www.jointcommission.org/assets/1/18/Root_Causes_by_Event_Type_2004-1Q2012.pdf for root causes. The OIG report can be found at oig.hhs.gov/oei/reports/oei-06-09-00092.pdf.

For more information on this story, contact Paul Schyve, MD, senior adviser for healthcare improvement, and Gerard Castro, MPH, Project Director, Patient Safety Initiatives, The Joint Commission, Oakbrook Terrace, IL. Email: pschyve@jointcommission.org and gcastro@jointcommission.org. ■

Facility cuts falls 88% and med errors 30%

Butler County Health Care Center (BCHCC) in David City, NE, is small — it has 25 beds serving a rural community of 2,500 — but the administrators think big. Using a program that enhances teamwork, the hospital has reduced patient falls by 88% and medication errors that reach the patient by 30%.

The improvements came as a result of the free Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) program offered by the Agency for Healthcare Research and Quality (AHRQ), which improves communication teamwork.

The effort began as BCHCC was working on a project to reduce medication errors, explains CEO **Don Naiberk**. "We had had a couple of medication errors that, although they didn't result in harm to the patient, were significant and could have caused harm," Naiberk says. "We really felt like we needed to do something different."

By studying error reports and the results of root cause analyses, the organization learned that poor communication was the most frequent cause of mistakes. The organization's staff needed to find a way to work as a team, not as independent healthcare providers. TeamSTEPPS training was identified as a way to help BCHCC staff overcome communication barriers and improve workplace culture. With that goal in mind, Naiberk and two other hospital leaders — a registered nurse from the outpatient department and the new director of patient safety — took the master training course offered by AHRQ in 2008.

BCHCC began implementing TeamSTEPPS incrementally. The Surgery Department was among the first, and two TeamSTEPPS tools were introduced there: CUS ("I'm **C**oncerned, **U**ncomfortable, this is a **S**afety issue") and the two-challenge rule, which requires assertively voicing a concern at least twice to make sure it is heard. The Magic Wand exercise — in which participants are asked what they would improve in their department if they had a magic wand — was used in the first meeting to help identify safety problems that were rooted in exchanges with other departments and staff members.

After a few sessions, it was evident that a global approach was needed to improve patient safety, Naiberk says.

Training began with supervisors and managers. During a supervisor retreat, TeamSTEPPS fundamentals were taught in a four-hour session. After evaluating this phase of the training, the TeamSTEPPS team realized that more support for TeamSTEPPS was required, so five more master trainers were added, including a member of the medical staff. To increase its effectiveness, training became more interactive, and class size was limited to 14 participants.

A series of two training sessions, each lasting one-half day, for all employees was scheduled during a four-week period to intensify the training and results. Training was held off site to minimize distractions and lend a sense of priority to the sessions. Finally, training groups were implemented across departmental lines.

All 117 employees at BCHCC have received TeamSTEPPS Fundamentals training, and the hospital regularly offers refresher courses and training for new employees, Naiberk says. There have been numerous improvements as a result, he says. The most prominent improvements were reducing medication errors that reach the patient by 30% and patient falls by 88%, both the result of using TeamSTEPPS tools to identify problems and improve communication, he says.

"The program leads you to identify the underlying issues in any target problem. TeamSTEPPS doesn't by itself solve your patient safety problem, but it gives you the tools to work together and identify those root causes better," Naiberk says. "Staff communicate better, and there don't seem to be the conflicts that we used to have. They're given tools to deal with conflict and avoid having things escalate to the point that administration has to intervene."

(For the schedule and other information on TeamSTEPPS, go to http://teamstepps.ahrq.gov.) ■

SC hospitals taking on mislabeled specimens

'You have to do it out loud'

What do you do when something you desperately want to fix just won't be fixed? For one quality improvement manager in a South Carolina academic medical center, the problem was mislabeled lab specimens that didn't get any less common over 18 months, despite policy changes and even red rules that would leave staff open to discipline for failing to abide by them. Nothing worked. She talked about this with her peers at a meeting about creating a just culture. Listening was **Lorri Gibbons**, RN, CPHQ, vice president for quality improvement and patient safety at the South Carolina Hospital Association.

"She talked about how the staff said the emergency room was just too busy a place to get better than a certain level," Gibbons recalls. The conference included sessions with David Marx, sometimes talked about as the godfather of just culture and CEO of Dallas-based Outcome Enginuity (www.outcome-eng.com).

He said that the number of labeling errors in the South Carolina teaching hospital could move by 90% in 90 days, and it could be sustained at that level. He offered to come to South Carolina and— along with Gibbons and the South Carolina Hospital Association — work with this quality manager.

For a week, Gibbons says, he observed, pulled in ED and lab staff, asked for input. They did probability risk assessments to figure out where the gap was, where the key would fit that would unlock the mystery of continually mislabeled specimens.

Staff-driven

Everyone involved in collecting specimens was invested in the project, she says, which helped the final program to be seen as staff-driven, not department-driven. If it was just nursing, why would lab personnel feel engaged? And if it was lab-driven, then why would nurses listen? "We didn't care what department you worked in, we just wanted to make sure that everyone involved was there."

It came down to one simple thing, Gibbons says. "You do everything you are supposed to do — you walk in, you say your name, you check the name and date of birth of the patient, you draw the specimen, and you put the label on it — and then you read aloud the last three digits of the medical record number on the vial of blood and match that out loud to the last three digits of the record on the patient's identification band. The critical piece is to say that, to match that out loud. If you do that, you will drastically reduce unlabeled or mislabeled labs."

There is no cost. There are no extra staff. There really isn't any training to do. But Gibbons says it works because you can't read those numbers out loud and be on autopilot.

"Think of the times you have gone somewhere and don't realize how you got there," she says. "Or how many times you think you're reading something, but you don't recall what it says. Part of what we do in assessing a risk is to identify what act can reduce the risk of error. Saying something in your mind isn't the same as reading something out loud. You want to do something consciously."

Program expanded to 10 hospitals

Often nurses will look at a patient they've seen a half dozen times before and figure they know the record number, they've said it in their head a million times, Gibbons says. "But the one time you don't really check it, that's the time you miss the error. You have to do it out loud."

The out loud part of the project helps to make other people part of the accountability system — patients and other staff expect to hear someone collecting a specimen match the two sets of numbers out loud. Another part of the project was for staff to report when they discovered errors in the labels.

This started out as a small project — just a single hospital in a system. But it expanded quickly to 10 pilot hospitals, and if it's sustained for a year, Marx says he'll take it national. All the hospitals barring one have seen their rates of mislabeling drop — one went up in July, and there is a team already investigating what went wrong there, Gibbons says. The drop, by the way, was the anticipated 90% or more in the facilities participating.

Some of the hospitals are expanding to other kinds of samples, such as urine, or in departments like radiology, and Gibbons says she's

getting calls from around the country to ask about the program. *(The toolkit is available for download from http://www.thefinalcheck.org/.)*

At The Regional Medical Center in Orangeburg, SC, the program was piloted on the unit with the highest rate of mistakes in labeling — the emergency department. But the program seemed so promising, they rolled it out to other units while still participating in data collection for the hospital association pilot program.

Convincing stakeholders

Phlebotomists ask patients to state their name and date of birth, and check it with the patient's arm band. After blood is collected, they are labeled with preprinted labels. Once those labels are put on the tubes, the phlebotomists read the last three digits of the medical record arm band and the specimen labels. They have to match. Sometimes patients ask why, and the program is explained.

Gary Ferguson, BSMT, MHA, the director of pathology and laboratory medicine at the center, says that he was interested in the program for a couple of reasons.

The first was the low cost and impact to procedures already in place. Nothing much had to change. Second was how shallow the learning curve is for the program. Indeed, the hardest thing was "convincing the stakeholders that there was a potential for significant patient harm whenever a mislabeling event occurred."

The success in the pilot probably helps convince new units: from a baseline of 3.5 mislabeled samples per month to just 2 after 30 days, 1 after 60 and down to nothing after 90 days. The next units to get the program are intensive care and coronary care. And Ferguson thinks it will go very smoothly.

"I believe we will have their full support and appreciation that this will make their jobs a little easier," he says.

For more information on this topic, contact:

• *Lorri Gibbons, RN, CPHQ, Vice President for Quality Improvement and Patient Safety, South Carolina Hospital Association, Columbia, SC. Telephone: (803) 796-3080.*

• *Gary Ferguson, BSMT, MHA, Director, Department of Pathology and Laboratory Medicine, The Regional Medical Center, Orangeburg, SC. Email: gcferguson@regmed.com.* ■

How a hospital brought VAP rates to zero

It used easily adaptable tools and steps

No one would argue that ventilators are life-saving tools for many critically ill patients. But like so much in healthcare, too much of a good thing can be bad. Getting patients off of them is vital in the effort to reduce rates of ventilator-associated pneumonia (VAP), one of the hospital-acquired infections that are the increasing focus of national regulators and payers.

That makes what Mercy Hospital in Buffalo, NY, did all the more impressive: Using easily adaptable tools and steps that led to the reduction in the use of sedation and the amount used with patients, the hospital was able to bring down VAP rates in the intensive care unit to nothing, and keep them there for an extended period of time.

Hospital infections have been on the hospital's radar for a long time, says **Linda Horton,** vice president for clinical innovations and outcomes at the facility. "The focus came out of the Institute for Healthcare Improvement's (IHI) Million Lives campaign, and we were really energized by looking at the concept of using bundles." Partnering with the Hospital Association of New York State (HANYS), the hospital began studying the tools available and the processes in place.

Increasingly, they were seeing literature that talked about getting to zero, having no events, Horton says. "We wanted to think about that and go in that direction, even though we know that in our industry, there will always be patients who try that idea."

They started by implementing the IHI's VAP prevention bundle, which calls for five steps:

• elevate the head of the bed — they raise it to 30 degrees;

• give the patient daily sedation vacations and determine if extubation is possible — these are scheduled daily;

• peptic ulcer disease prophylaxis;

• deep vein thrombosis prophylaxis;

• daily oral care with chlorhexidine — this is done every four hours.

Each of these elements alone is associated with decreased risk of VAP. More in-depth information on the bundle is available

at www.ihi.org/knowledge/Pages/Changes/ImplementtheVentilatorBundle.aspx.

Respiratory therapists, nurses, and physicians all participated, "taking a dynamic look" at what was in place and what was added, Horton says. The goal was to do every element every time. There was also team rounding, with infection control, respiratory therapists, and nurses who were encouraged to interact with each other and not merely make a report at the bedside.

"We got some positive traction out of that," she says. "Nurses got better bedside tools and things like oral care resources. They tested different products and we got their input on whether something worked better." Being the cheapest product wasn't a guarantee they would use it; being the best was.

They worked on issues such as how to transport patients for MRIs or other tests and how to splint chests so that patients can better clear their lungs and oral secretions so that they can remain extubated. The latter topic drew on the expertise of people outside the ICU: nurses from cardiology.

All of the team members worked together to identify patients who met the criteria for the project. "I think a lot of the improvement stems from the team approach we took," says **Patricia Jones**, RN, MS, CIC, director, infection prevention and control for the Catholic Healthcare System, of which Mercy Hospital is part. "You can't just go to one discipline and win. You have to have physicians on board, and nurses and therapists. You have to look at each element of the bundle, and it has to be a focused team approach."

Checklists and tools

The team created and continues to use a checklist, as well as a ventilator order sheet. Team members use specific tools related to the use of propofol, and educate appropriate team members on how to interpret Motor Activity Assessment Scale (MAAS) scores.

If something doesn't go right, Horton says they are quick to look at every element of the program: the process, the people, and the tools and resources alike.

If something isn't getting done, why not? If it's related to oral hygiene, is there a lack of oral care kits? Was a patient off the floor and missed a scheduled sedation vacation? One incident involved a therapist who was on vacation. The replacement person didn't document the work on the checklist appropriately. "The work was done, but not documented," she notes. That means they need to do a better job of training of people who don't work regularly with these patients.

Every vent patient's chart is reviewed weekly, she says, and every checklist from every day is evaluated and recorded. There is a dashboard on the unit that shows the unit's performance on implementing the bundle, patient outcome, vent days, and various process steps. If there was a VAP case, infection control would be called in to look at what might have gone wrong and what could be done differently.

If something shows up as a miss on the dashboard, nurse managers investigate, although those cases are fewer over time, Horton notes. Now the team is looking at more complex cases, such as end-of-life patients who have some additional risks, to see if there are things that can be changed or tweaked to ensure the same infection rate successes.

"We are looking to see if there is some other way we can manage those cases," says Horton. "Maybe the pulmonologist can be brought in in a more timely way."

There is always something to learn, she continues. "We had a patient once who had cardiac surgery. He did very well and was extubated in a timely way. But he ended up with more pulmonary and oral secretions and had a really tough time coughing and rebreathing. We had to reintubate him. The challenge was to determine if we did it too early and whether we could learn something. It wasn't too early, because he was stable. But he couldn't manage the secretions because of his sternal wound, even with pain management."

What they needed was a way to better support the wound and a way to train the patient before surgery on how to do what needs to be done. Using a pillow as a brace wasn't working. But a flat-backed stuffed bear, stiff but soft, does. Now, all patients who are having chest surgery have one of those at the bedside, ideally preoperatively if possible, so they can learn to use the bears before they need them.

Looking just at propofol use that extended for more than three days, Mercy recorded a reduction of 77.2% in days on the drug, and 82.2% reduction in the doses dispensed. VAP rates?

They've been at zero for more than 18 months now.

Keep teaching

The project was a wild success, but Horton says there are things she would do differently if she started over, including looking at the propofol use in particular earlier than they did. She thinks you should work very hard to get the tubes out of patients as early as possible, and by weaning them off propofol — perhaps using a smaller dose — you can achieve that goal. "I wish we had created a protocol for a sedation vacation earlier," she notes.

If you want to get to zero, you can, she says. Start by tracking your vent days, your sedation use, and your VAP rates. Put up a dashboard so that everyone can see your progress and celebrate the successes. "You have to be patient and persevere. It isn't something you can take your eye off ever. You will have fewer and fewer infections as you get better, but you have to be vigilant. You may not be as hardwired into the daily practice as you think, and you will always have new staff you need to keep teaching."

For more information on this topic, contact Patricia Jones, RN, MS, CIC Director Infection Prevention and Control, and Linda L. Horton RN, MSN, CPHQ, VP Clinical Innovation, Mercy Hospital of Buffalo (NY). Telephone: (716) 828-2066. ■

Hospitals honored by Quest prize for quality

Leadership involvement key to all winners

Maybe in today's jaded world, $75,000 doesn't seem like a lot of money to win. But along with that little financial windfall won by University Hospital Case Medical Center in Cleveland in July, came a prestigious title: Winner of the American Hospital Association McKesson Quest for Quality award.

It's kind of unsettling being held up above so many other great facilities, particularly when the finalists all have so much in common, says **William Annable**, MD, chief quality officer at the hospital. At a panel discussion with the three finalists, he said he was struck by how often they do the same things as each other, despite differences of geography or size or patient type.

Among the projects that the Cleveland facility was hailed for implementing was an innovative transparent reporting system for events that allows for facilitywide study, leadership review, and prioritizing of event attention. They also have one of the most unique resident training programs in the country, which requires new doctors to spend a rotation studying quality and then create a yearlong quality improvement project to see from concept through implementation and review.

Other elements mentioned included a surgical safety checklist, which started off with a mandatory meeting for education that left the ORs vacant barring for emergent needs; implementation of checklists to reduce infections; focus on the time it takes to do several key tasks, such as admitting or discharging a patient, or getting a particular lab result; and accessible information for employees regarding how they are doing on key measurements.

"I think the most important thing about us is that our board is tremendously involved in quality and safety issues," Annable says. Patient representatives sit on the board committee for quality; they participate in "lessons learned" sessions related to adverse events.

The resident education in quality is something else in which Annable expresses deep pride. "Most doctors are supposed to learn about quality through osmosis or something," he says. "What we do is highly unusual, but I think it is vital to their future functioning as physicians."

Annual safety education for surgeons — that continues to shut the operating theaters for a morning — includes speakers and topics that engage people who might otherwise think they have nothing more to learn.

And what they learn isn't considered proprietary, Annable says. "People in medicine have often hidden things about their quality programs, but quality is for sharing." He is on line daily with other members of the University Health Consortium, either sharing ideas, asking questions of other members regarding what they are doing in a particular area, or brainstorming to help someone else solve a problem.

But most of what they do at the Cleveland hospital isn't much different from what other fine facilities are doing, says Annable. While they want to reach zero — or 100, depending on the

metric — for everything they do, the last few points are often hard to achieve. One of the questions on the application for the award asks about something they have seen the least progress on. "For us it is timeliness on just about everything. Whether it's transfers, the surgical schedule, or discharges, we really struggle." They use the "Time Is…" phrase a lot to engage staff — time is muscle, time is brain. And they have started working toward the finish line before the patient knows something has started. Discharge planning now starts on admission, or before if it is a planned visit.

The hospital and the other seven facilities in the University Hospital system are working to achieve new goals in new ways that continue to underline the ways in which it is different from its peers. For instance, they wanted to decrease healthcare-acquired infections by 5-10%. So far, it's down by half, in part because they are rewarding staff for achieving a decrease in those infection rates. That may not sound so unique, but in Cleveland it's not just doctors who share in rewards for good performance. "Incentive goals are kind of unique here because we reward down to the nursing level, and it is really helping."

North Carolina wins, too

To the southeast, University of North Carolina Hospital in Chapel Hill is also proud after being named runner up to the AHA-McKesson Quest for Quality award. The facility took home $12,500, according to **Larry Mandelkehr**, MBA, CPHQ, the director of performance improvement at the facility.

"I can't say I was surprised," he says. "I think we found we were where we thought we were, and that we deserved the level of award we received." He sees success in many of the facility's endeavors, and also room for improvement. "There is always something we can do to improve, and the nice thing about this is that after the site visit, they give you great feedback on areas where you can work harder. They give you ideas for things where you are challenged."

One area that needs work, he says, is spread — applying success in one area to a different clinical environment or a different patient population. "Our coordination needs work. We have multiple improvement groups, and we meet and work together well, but not as well as we could."

What does work in a stellar fashion, says Mandelkehr, is the model for interdisciplinary leadership they have at the facility. "We use triads that are co-led by a physician service leader based on a clinical area like orthopedics or pediatrics, a nurse manager, and a case manager. Those people drive the improvements within that particular group of patients, even down to documentation and coding issues, as well as patient experience and mortality and all the other things QI projects traditionally involve."

Patient experience data shows they are excellent on that front, too, in Chapel Hill. "We have seen real improvement in our HCAHPS scores, and are the highest in our area." That effort, called Carolina Cares, was spearheaded by the department of nursing and the dean of the school of nursing. It is a multi-pronged program that involves developing a caring connection; service recovering rounding; and words and ways to communicate. It was rolled out first among inpatient units, and has since been the basis of an education program for all employees in the healthcare system. It's currently being expanded to diagnostic and outpatient areas, as well.

The award specifically noted the leadership connection to quality in the hospital, and Mandelkehr says it has been spearheaded by the chief operating officer, the chief of staff, and the vice president for operational effectiveness. "We have strong physician leadership here, and that includes around quality improvement," he says. "But we make it a point to identify the right people to take a leadership role in specific projects. They are supported with coaches, the data is provided for them, and if we reach out to someone and it isn't a good fit, we are willing to find someone else to take over, rather than stick with what we have." They don't rely solely on division chiefs or chairs, but will engage physicians who are interested from a research perspective or on a personal level if that's the right person for the job.

Having a top-down quality emphasis has made it easier to engage physicians in quality improvement programs, he continues. It doesn't hurt, either, that the current chief operating officer was the chief of staff for a decade and had the reins of quality improvement among physicians that entire time.

Just having access to the other winners has proved an impetus to make some quality changes at the hospital, says Mandelkehr. "We have talked about the quality education program they

have in Cleveland," he says. "We have a performance improvement project requirement in our pediatrics department, with a large educational session and expo after. But it isn't everywhere. So we're expanding it, and every resident in the preventive medicine program will have to do a quality improvement project."

Indeed, the best way to improve is to see what others are doing. The quality scorecards that University Hospital Case Medical Center uses in nearly every area of operation is another thing that Mandelkehr is looking closely at. Another finalist, Lincoln Medical and Mental Health Center in the Bronx — which also took home $12,500 — has a great community outreach and collaboration program. "I've talked to them about that, and also about the issues we have with spreading what we do in one area to another. This is a great chance for us to collaborate."

The AHA also gave out two awards in July to hospital associations for quality work. The Michigan Health and Hospital Association and the South Carolina Hospital Association were awarded the Dick Davidson Quality Milestone Award.

The AHA praised the Michigan association for several programs, including one that seeks to reduce left-without-being-seen rates in emergency rooms. The program saw a decline in such cases of 16.5%. Other quality programs related to reducing harm to perinatal patients and improving Apgar scores in newborns. Participating hospitals reduced elective inductions by 40% and elective Cesarean sections by nearly half.

South Carolina's hospital group has several noted programs, including a partnership with the American Heart Association to reduce treatment times for heart attack patients by more than a third over five years; a safe surgery program involving the World Health Organization Surgical Safety Checklist; and a project that helped reduce central line-associated bloodstream infections by two-thirds over two years.

For more information on this topic, contact:

- *William Annable, MD, Chief Quality Officer, University Hospital Case Medical Center, Cleveland, OH. Email: william.annable@uhhospitals.org*
- *Larry Mandelkehr, MBA, CPHQ, Director of Performance Improvement, University of North Carolina Hospitals, Chapel Hill, NC. Email: lmandel@unch.unc.edu* ■

Are you flu-shot ready?

TJC rules on staff vaccines in effect now

By 2020, all accredited hospitals are supposed to achieve a 90% success rate for flu vaccinations among staff. And while that might seem like a long time from now, some organizations are already having a tough time convincing staff to roll up their sleeves for a shot. The notion of mandating these vaccines sits ill with some people on principle, regardless of the scientific studies that show it's vital to patient safety.

According to the requirements that went into effect in July, accredited organizations must do the following:

1. Establish a flu vaccination program.
2. Educate staff and independent licensed practitioners about the vaccine, non-vaccine control and prevention measures; and diagnosis, transmission and impact of flu.
3. Provide vaccines at places and times that are accessible to staff.
4. Have a plan for improving vaccination rates.
5. Set incremental goals to reach 90% by 2020.
6. Have a description of how you determine vaccination rates.
7. Evaluate reasons given for refusing vaccines at least once a year.
8. Improve rates of vaccination annually towards your goal.
9. Provide rate data to stakeholders.

The plan is already under way at MedStar Health, which serves the Baltimore/Washington, DC, area, says **Lynne Karanfil**, RN, MA, CIC, the corporate director for infection prevention at the Columbia, MD-based organization.

It began as a patient safety initiative in 2006, she says. It included a vaccination declination process, but they still managed to significantly increase vaccination rates from what she calls an "unacceptable" level of 54% among healthcare workers. "We conducted a review of the literature, which indicated evidence to enact a mandatory program. A proposal was developed to move to a mandatory vaccination program, which was presented to our executive leadership, who decided to mandate influenza vaccinations to protect our patients. A multidisciplinary committee was formed to develop an implementation plan and influenza vaccination policy."

Three summers ago, they adopted the mandatory program, requiring all associates, physicians,

other credentialed medical staff, volunteers, contracted staff, and vendors to be vaccinated for influenza unless they had a medical contraindication or religious exemption, says Karanfil. "Failure to comply with the policy would result in disciplinary action for associates, up to and including termination."

They were one of the first systems in the country that mandated vaccinations by both associates/staff and physicians. Without both, an element of improving patient safety would be missing. Key to the success of the plan, though, was education and communication designed to change the minds of people who weren't sure it was a good idea.

"Anyone who has concerns about the mandate can discuss their concerns with occupational health, an infection preventionist, or their manager," she says. "There is also an online education program that addresses concerns."

A database tracks vaccinations through the occupational health department. Reports are sent on to managers to help them track compliance. Vendors are tracked through a different database. They provide free vaccinations during scheduled sessions to make the vaccines convenient.

All of this was done before the rule by TJC related to flu vaccines was final. But now that

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com/. *Hospital Peer Review's* executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute. ■

COMING IN FUTURE MONTHS

- Accreditation field reports
- Improving throughput
- The best in discharge planning
- Tips and tools for implementing and improving quality initiatives in your facility

CNE QUESTIONS

1. According to TJC, sentinel event data is useful for
   a. telling you what events happen more than others
   b. seeing how you compare to national totals
   c. giving you a list of potential problems to consider
   d. defining the root causes of sentinel events

2. Final Check safety program works because
   a. You pay better attention when you say things out loud
   b. You check two different sources for the right number
   c. Phlebotomists check the number before they print the label
   d. Alarms sound if you have an incorrect number

3. Mercy hospital elevates vent patients' beds to what level?
   a. 33%
   b. by a third
   c. 25%
   d. 30%

4. Residents at a Cleveland hospital learn about quality improvement through:
   a. a project and end of year exposition of all of their results
   b. osmosis
   c. a morning session that includes closing the OR except for emergencies
   d. a month-long rotation and associated improvement project

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

others will be creating programs to address the requirement, Karanfil says that there are ways to improve the odds of success. First and foremost are education and communication. "The communication plan included the development of comprehensive education material for associates and physicians to help dispel myths and misconceptions about flu," she says. "Additionally, by requiring anyone who entered a MedStar entity to be vaccinated — with the exception of visitors and patients — we helped to ensure the safety of our patients, our first and highest priority."

Strong leadership was another factor, and she recommends having a physician leader champion the program to help alleviate concerns among the doctors in your facility.

More information on improving staff vaccination rates is available on The Joint Commission's requirement at http://www.jointcommission.org/assets/1/18/Strategies_-__Improving_Health_Care_Personnel_Influenza_Vaccination_Rates.pdf

For more information on this story, contact Lynne Karanfil, RN, MA, CIC, Corporate Director, Infection Prevention, MedStar Health, Columbia, MD. lynne.v.karanfil@medstar.net. ■

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■