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May 2014: Vol. 39, No. 5
Pages 49-60

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Financial Disclosure:
Editor Lisa Hubbell, Executive Editor Russ Underwood, Associate Managing Editor Jill Drachenberg, and nurse planner Paula Swain report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

AHC Media

When it comes to healthcare quality, should titles matter?

A push to make quality everyone's business

A few years back, staff suggestion boxes were a big thing. It was as if there was a burgeoning realization that people who didn't have big titles might sometimes have a good idea on how to make things better. Some organizations even gave prizes away to the little people who came up with the best big ideas for saving money or time.

The idea has evolved. It seems that the powers that be understand that the people who do the actual work usually have the best ideas of what is wrong with processes and often how to fix them, and they are increasingly seeking their advice and input in quality improvement.

At Cleveland Clinic, **J. Michael Henderson**, MD, FASC, the chief quality officer, says he came to his job seven years ago wanting to turn things "upside down" by making sure every department or institute had the tools and infrastructure it needs to implement ideas that come from the front line, and an overarching quality and patient safety institute to handle all the reporting, infection prevention issues, and environmental health and safety. Staff are free to change things to serve patients quickly and innovatively, he says.

Guido Bergomi, BS, the senior director of the quality and patient safety institute, says that the new structure has enabled people to work together across functions and disciplines in a way they didn't before. For example, they are developing several new care pathways, and anyone who is involved in the process of care, whether a nurse or orderly or dietician, can comment and participate in the writing and review of that care path. During the pilot phase of any pathway, Bergomi continues, those same people are encouraged to speak up about what works and what doesn't.

There are no egos among the highly educated or shrinking violets among those who make hourly wages, he says.

Unforeseen benefits

Henderson says there are some unforeseen benefits that come from this cross-discipline work. Practices change quickly. In an orthopedic pathway that was created, they saw transfusion rates plummet as physicians

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and nurses saw what others were doing. "The culture of working together around the patient, rather than just doing things as we always had took over," Henderson says.

By putting the focus on who is involved in a process and figuring out how it should run in an ideal situation, Bergomi says the focus becomes the patient. Hierarchical issues such as titles or nurses versus doctors disappear, or at least recede. "The focus is on the outcomes we want to achieve, like reducing readmissions or infections or falls. If you talk to a team about surgical-site infection rates, and to a surgeon about fixing it, the docs know that nurses, technicians, the equipment entering and exiting the room matters. Smart people know that. And since most people want to do a good job, it becomes about the work, and the goal you want to achieve," he says.

Henderson says that one way you get titles to make less difference and create cross-functional trust is to get the right stakeholders involved from the start. "You get a nurse or physician or other key project manager to facilitate, and people who are involved in the process to complement that," he says.

Simple, measurable, attainable

Bergomi adds that you need to make the goals simple, measurable, attainable. They need to be shared by all participants, fit the mission of the organization, and be about more than just Medicare reimbursement rates. Money alone won't resonate, he says.

Limit their number, too. "You can't have 400 goals in an organization," Bergomi says. "We have a lot of hospitals around the country and the world, but have a small number of enterprisewide goals, maybe a dozen of them."

Don't let participants sit quietly, Bergomi says. "Ask questions to encourage participation."

If you are worried that departments that you haven't involved before might not be willing or capable of participating, think again. Bergomi says a recent insulin project needed input from food service, and they were thrilled at being involved. As more organizations create a culture where the well-being of the patient is paramount, giving every department a chance to participate in ways to improve patient care is something they will welcome. "If the activities have meaning, like improving patient care, they are engaged," Bergomi says. "We have done a lot of work here so that everyone in the organization from surgeon to housekeeper has participated in half-day meetings to discuss our culture. How we treat patients, and each other, whether we work in finance or as engineers, matters. It helped us create an even field."

Hospital Peer Review® (ISSN# 0149-2632) is published monthly by AHC Media LLC, One Atlanta Plaza, 950 East Paces Ferry Road NE, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Website: www.ahcmedia.com. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Peer Review®, P.O. Box 550669, Atlanta, GA 30355.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for Hospital Peer Review® is hospital-based quality professionals and accreditation specialists/coordinators.

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Editorial Questions

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Down in Phoenix, the Banner Good Samaritan Medical Center Emergency Department found a way to translate removing hierarchies into better patient satisfaction scores. In that case, the department was struggling with low scores, says **Moneesh Bhow**, MD, FACEP, the medical director for the department. "We wanted to look at the patient comments and see where we were falling down."

New voices

But it wasn't as simple as finding a single thing wrong, or even a few things to put on a to-do list, Bhow says. Many of the items boiled down to poor communication. "Even if we attributed every negative score to one of five categories, half of them were in communication," he says. In many cases, if a nurse had spoken up to a doctor, a problem could have been averted. "Why weren't the nurses speaking up to the doctors? Was it a culture thing? Do we blow the nurses off or make them somehow uncomfortable?"

They knew that nurses spend more time than physicians with patients, and the more that the nurse tells the physicians, the better care the patient gets, and the more cohesive the group looks. Bhow wondered whether there was too much hierarchy and blinkered work going on. "With computers and instant messages, we don't have to talk to each other," he says. "The electronic world means we gain stuff, but we lose stuff, too."

The goal became to have doctors and nurses talk more and to break down the idea that one of them was more important than the other, Bhow says. "The old school idea that you stand up if the doctor walks into the room? No way. We wanted to empower the nurses to speak up, to say what they think, to say why. In my own practice, I know that the nurse knows more about the patient and what he or she wants, his or her goals, than I do."

The lesson would be that everyone can give anyone a suggestion, regardless of their place on the pay scale, he says. "And if the suggestion isn't useful, you don't have to be rude or shut them down."

Not everyone is comfortable speaking up, though, and not everyone feels he or she has a voice, Bhow says. Similarly, not everyone is ready to hear all those new voices. So Bhow and his team identified the people they thought had challenges.

For them, they talked not about patient experience numbers, but about how better communication with patients reduces the risk profile of the patient, or improves outcomes, or increases repeat business. "We look for the intrinsic motivation of the person. We ask them what their goal is." Chances are, improved communication between physician and nurse can positively affect that goal.

Happiness

While the initial goal was to improve patient satisfaction, Bhow says that is just one component. "Don't focus on that. Focus on your happiness instead. Our motto is that a happy provider means a happy patient. One of the unintended consequences of this is that people are much happier coming to work. Our retention rate for nurses has improved, and they are more involved. When you have engagement like that, the patient benefits, too. There is a greater chance that the nurse will pick up something she might otherwise have missed."

Having an environment where you feel like a member of a team, rather than like someone being given orders from above did far more at Good Samaritan than Bhow anticipated. He still hasn't seen patient satisfaction scores hit 100%, although there has been ample positive progress.

"When we take our eye off the ball, it slips or we plateau," he says. "We have to keep our focus on all the time. But the culture is changing. The really cool thing is that people are feeling a lot freer to speak up about other ideas, too."

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Public quality reporting: a plea for consistency

AAMC sets out guiding principles

Every few months, another big headline is splashed across the mainstream media, touting the top 100 hospitals, or the best cancer doctors, or your city's number-one neurologist. But what is missing from these stories is the fact that often, a facility or physician can rank in different places on different lists — fabulous on one, middling on another.

Why? Because they don't use the same metrics or data sets. Even when they do, the outcomes may still differ.

One famous study in *Health Affairs* in 2008 compared five websites that reported local hospital rankings of five diagnoses.[1] "The sites assessed different measures of structure, process, and outcomes and did not use consistent patient definitions or reporting periods," the report noted. "Consequently, they failed to agree on hospital rankings within any diagnosis, even when using the same metric (such as mortality). In their current state, rating services appear likely to confuse, rather than inform, consumers."

Using the data

Certainly what is out there isn't being used, or at least isn't being used to change minds. One study, released online in March, found that the Centers for Medicare & Medicaid Services' (CMS) own comparative data on Hospital Compare didn't have robust enough data to show enough difference to sway consumers' opinion of hospitals.[2]

And a Cochrane review of multiple public quality reporting programs in 2011 found no evidence that these programs changed consumer behavior, improved care, or changed provider behavior[3] — all three things which proponents of these programs say they think would be key benefits of giving the public access to key quality metrics.

It is not that the wider healthcare community doesn't think that transparency is a good idea, says **Jennifer Faerberg**, MHSA, the director of clinical transformation at the Association of American Medical Colleges (AAMC). The issue is whether what is out there is valid, and whether it meets the needs of the public by educating them, or whether it just makes things more muddled by presenting incomplete, irrelevant, or incorrect information.

"There has been a lot of variability and confusion across different reports," she says. As a result, members were concerned, so the AAMC pulled together an expert panel to come up with a framework by which the public and providers and even hospital board members can evaluate the various report cards, lists, and grading sites out there.

They came up with three domain areas — the purpose of the report, the transparency of the process by which the data were compiled, and the validity of the measures used. Under each of those domains is a list of qualities to be met.

Start with the purpose of the report. If it is supposed to be about patient safety, then all of the metrics used should relate closely to patient safety or be an accepted proxy. If a measure is something just tangentially linked to patient safety and not supported by evidence, then the measure selection is not supporting the stated purpose, Faerberg says. The purpose of the report should shine through in every metric chosen.

In the measure area, the AAMC principles state that all measures should be endorsed by the National Quality Forum (NQF) or an equally respected body. "This allows for rigorous review of the measure and methodology," she says. "Without that, you can't be sure that it is an appropriate measure for quality. If a site is using NQF-endorsed measures, it says something. If it isn't, that is a red flag that says this measure may not be a good indicator of quality of care."

The importance of transparency

Transparency is also important. An organization providing a list of the best hospitals should be willing to share the documentation of how they came up with their scores, Faerberg notes. Being able to replicate scores is vital to scientific validity. If you want the physicians — scientists all — to trust what you say about them, you have to be willing to let your data stand the test of scientific rigor.

Risk adjustment falls under the transparency and validity domain. "What is in place now is pretty minimal for what is available for

outcomes-based measures," she says. "The NQF has a report out for comment now that includes changes to guidelines on risk adjustment that will include socio-demographic factors. Getting a robust and transparent risk adjustment is critical because each patient is unique, with their own set of characteristics."

"These principles represent the ideal," she says. "No one is there yet. But healthcare is very complex, and to distill it down to a letter grade or numeric rating is very difficult. It doesn't present a full picture and by its very nature must limit the information it can convey. This tool can help users to evaluate what they are seeing on those sites."

Engagement

In addition, Faerberg says she hopes it will lead to engagement with those who create the lists and reports. Some have already been in contact with the AAMC and have expressed a willingness to make changes along the lines suggested by the expert panel — something she finds very gratifying.

"We support the idea of transparency," Faerberg says. "The issue we have had is that there is no standardization. We want to be sure that sites are using the valid and tested metrics, so that you won't have a situation where you look on one site and you're wonderful and another and you're terrible."

Every question answered seems to spawn two new ones. What Faerberg does know is that the destination is somewhere far down the road. And she thinks there will be other changes in the next few years. Some of them will be spurred by the AAMC Guiding Principles.

"I feel encouraged that some of the reporters of this information are willing to engage with stakeholders, including providers," she says. "I don't know what a report will look like in five years. But there is a willingness by some to get us all to a better place."

For more information on this topic, contact Jennifer Faerberg, MHSA, Director of Clinical Transformation, Association of American Medical Colleges, Washington, DC. Email: jfaerberg@aamc.org.

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Why QI plus IP is more than alphabet soup

Working closely is more important than ever

It seems impossible when she recalls it, but **Kathleen Kohut**, MSN, CIC, CNOR, director of infection prevention at Cone Health System in Winston-Salem, NC, tells a story of an infection prevention department that was left out of the discussion of meeting infection prevention standards for an upcoming Joint Commission survey. The hospital administrator figured the quality department, which handled survey matters, could handle all survey matters, regardless of which department the particular standards related to.

It is the kind of separate-silo thinking that has kept infection prevention departments and quality improvement departments from working together in many organizations. But in a time when reducing hospital-acquired infections has taken on an important role in terms of reimbursement and public awareness, that time is over, and she says if you don't have a working relationship with each other, the time to forge one is now.

Understanding each other's jobs

Start by understanding each other's job, she says. There's a lot over overlap and intersect. Identify the commonalities. Pair up your quality and infection prevention staff, or just limit it to managers. Schedule a couple of lunch dates. On the first, bring your job descriptions. Look for the commonalities and differences.

Over the second lunch, go over the Joint

Commission infection prevention standards and the required infection control plan. Discuss where you see problems and opportunities for improvement, she says. Where do you have questions and need help? What expertise does your counterpart department have that you could use? Where do they need your help?

Once you have gotten to know each other, follow each other around for a couple of hours, Kohut suggests. IP is "a piece of the quality puzzle," so being familiar with that department's world can only assist you. And knowing what you do can help the infection control department know who to reach out to when they have a problem that is beyond their grasp.

While most people in healthcare know that their world is all about change, Kohut says you might run into some people who are less than flexible and who don't want to share information or resources. For those individuals, your best bet is to come at them with data and a program to articulate. Show them why it is in their interest, how you can help them and bring value to what they do. Be respectful of their time and be efficient, she says.

Similar goals

If quality and infection prevention aren't joined at the hip yet, they will be soon, says **Kelley Boston**, MPH, CIC, a member of the communications committee of the Association of Professionals in Infection Control and Epidemiology (APIC) and a regional manager at the Houston-based consultancy Infection Control and Management Associates.

"The two departments have the same goals: patient safety, safe effective patient care, and cost containment," Boston says. "We do have slightly different ways of looking at things, though — a broad view in quality improvement, and a narrow view in infection control." For example, QI wants to improve things in general throughout the hospital to reduce the chance of hospital-acquired infections. Infection control, however, wants to find a way to mitigate infection when it occurs or prevent it in specific circumstances.

Boston says when you meet up with your counterparts, be clear about your agenda and priorities. "If you have specific things you are working on and want to achieve, be transparent. Be clear about what you need from the other person and what they can do for you. Infection control has a wealth of knowledge and skill on the science side that you might not have."

And what can you provide in return? Implementation skills. "We can partner together and really make an impact on patient care by using each other's strengths," says Boston.

Like Kohut, Boston thinks you and your infection prevention counterpart should spend time in each other's departments. "It is not a bad thing to walk in each other's shoes," she says. "You will see us in the future looking for more quality skills. We want, and need, to develop them. That would be an opportunity for us to do so."

Facilitating discussion

Quality is also good at facilitating discussions between departments to help create a good improvement project, says Boston. That is another skill that many infection department managers lack and could use some tutelage in. They might swap it for some training in technology that you don't have, or introductions to front-line staff, with whom most infection prevention professionals have a great working relationship.

If you need a last good reason to make nice with your infection prevention coworkers, consider these two examples from Boston's past. "One organization I worked with had a direct reporting relationship between infection prevention and the quality director," she says. The director was constantly pulling the infection staff off the floor to essentially count infections, rather than using them to make meaningful changes. When the infection prevention staff brought this up to the quality director, they were brushed off. The staff became so demoralized they left as a whole, with all their knowledge and expertise.

Compare that to another organization Boston worked with. Initially, there were some lingering communications problems between the two departments. But they instituted a weekly meeting at which they discussed areas where the two departments could work together or merely support each other. They started to partner on projects, and eventually, their collaboration inspired others to likewise work outside their silos.

"The work you each do matters to all of you

equally now," says Boston. "The goal is the same, right? It is the patients."

For more information on this topic, contact:

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CDC updates hospital infection data

1 in 25 patients gets sick while trying to get better

If it seems as if your hospital takes two steps forward and one back when trying to conquer healthcare-associated infection rates, you aren't alone. According to two reports released by the Centers for Disease Control and Prevention (CDC) in late March, things are getting better in some ways, but one in 25 patients are still going into the hospital and getting sick there.

The first study, published in the *New England Journal of Medicine*, used 2011 data from 183 U.S. hospitals to estimate the burden of a wide range of infections in hospital patients.[1]

That year, there were some 721,800 infections in 648,000 hospital patients. About 75,000 patients with healthcare-associated infections died during their hospitalizations. The most common of those infections were pneumonia (22%), surgical-site infections (22%), gastrointestinal infections (17%), urinary tract infections (13%), and bloodstream infections (10%).

The most common germs causing healthcare-associated infections were *C. difficile* (12%), *Staphylococcus aureus*, including MRSA (11%), *Klebsiella* (10%), *E. coli* (9%), *Enterococcus* (9%), and *Pseudomonas* (7%). *Klebsiella* and *E. coli* are members of the *Enterobacteriaceae* bacteria family, which has become increasingly resistant to last-resort antibiotics known as carbapenems.

The second report, National and State Healthcare-associated Infection Progress Report, has some of the more positive news, including:

• a 44% decrease in central line-associated bloodstream infections between 2008 and 2012;

• a 20% decrease in infections related to the 10 surgical procedures tracked in the report between 2008 and 2012;

• a 4% decrease in hospital-onset MRSA between 2011 and 2012;

• a 2% decrease in hospital-onset *C. difficile* infections between 2011 and 2012.

That said, there was a 3% increase in catheter-associated urinary tract infections between 2009 and 2012, and no state managed to perform better than the national standardized infection ratio (the measure used by the report) on all four infection types.

Sixteen states performed better than the nation on two infections, including two states performing better on three infections. In addition, 16 states performed worse than the nation on two infections, with seven states performing worse on at least three infections.

The data on which the CDC based its release of information in March can be found at http://www.cdc.gov/HAI/pdfs/progress-report/hai-progress-report.pdf for the progress report on healthcare acquired infections, and http://www.nejm.org/doi/full/10.1056/NEJMoa1306801#t=articleTop for the 10-state survey.

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CDC updates surgical site infection guidelines

APIC: Lack of guidance could affect pt safety

The Centers for Disease Control and Prevention has updated guidelines for preventing surgical-site infections, focusing on some difficult issues in an exhaustive and largely futile attempt to find conclusive data on various practices. As a result, "no

recommendation" is a recurrent theme in the document, which was the work of the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC).

While that may be a completely accurate reflection of the dearth of data on many infection control issues, as a practical matter it leaves the infection preventionist with little to work with in trying to improve patient safety.

Comments from APIC

In comments submitted to the CDC, the Association for Professionals in Infection Control and Epidemiology (APIC) made similar points and requested a "plan of action" to provide practical guidance over a wider range of infection control issues.

"Our main concern is that the methodology used to create the document has resulted in significantly fewer practice recommendations than were in the 1999 SSI Guidelines," APIC stated. "… Although we understand the importance of scientific rigor and the need to develop a springboard for future research needs, we are faced with the concern that the application of these guidelines by healthcare professionals has the potential to lead to great confusion on topics for which there are limited or absent recommendations."

Another concern is the body of evidence that was excluded from the document due to an exclusive reliance on systematic reviews and randomized controlled trials, APIC noted.

"This approach does not provide practical guidance to healthcare providers at the bedside, which may then result in lack of standardization and regression to less safe practices and, potentially, in poor outcomes for patients," APIC warned. "… Due to limitations in scope, we fear that many professionals will misunderstand the statement 'No recommendations' and revert back to traditional or unstudied practices."

In addition, APIC questioned the inclusion of clinical practice guidelines from various surgical societies and specialties as a supplement to the guidelines. "[T]he information has the potential to confuse readers as many sections are now in conflict with recommendations made in this document. If this section is to be included, reasoning as to the differences, i.e. the differing review methodologies and influence of regulatory and governing bodies on evidence building, needs to be included." ■

Only a 50% adherence rate to infection control in ICUs

Researchers find more policy than practice

Hospital intensive care units (ICUs) in the U.S. report a high level of infection prevention policies in place, but the numbers fall off sharply when actual adherence to the interventions are factored in, researchers report. While that implies that some ICU patients are more protected on paper than in actual practice, the lead author of the study says the vast majority of healthcare workers are trying to "do the right thing" in a very challenging environment.

"I think we're doing well with getting the policies in place, but we still have work to do to make sure the clinicians at the bedside can and do follow the policies," says **Pat Stone**, PhD, FAAN, director of the Center for Health Policy at Columbia University School of Nursing. "We need to support them so they can comply every time. I'm not saying there are bad clinicians out there. It's not easy to do the right thing all of the time."

Stone and colleagues at Columbia collaborated with the Centers for Disease Control and Prevention to conduct a nationwide survey of 1,534 ICUs at 975 hospitals.[1] The survey inquired about the implementation of 16 recommended infection prevention measures at point-of-care, and clinician adherence to these policies for the prevention of central line-associated bloodstream infections (CLABSIs), ventilator-associated pneumonia (VAP), and catheter-associated urinary tract infections (CAUTIs). The three healthcare-associated infections (HAIs) are among the most commonly acquired by ICU patients.

According to the survey, hospitals have more policies in place to prevent CLABSIs and VAP, than CAUTIs. The presence of infection control policies to prevent CLABSIs ranged from 87% to 97% depending on the measure being counted. The presence of policies for VAP ranged from 69% to 91%. The well-established use of a checklist for CLABSI insertion practices was reported by the vast majority of hospitals (92%). Uptake was less for a ventilator bundle checklist, as 74% of the ICUs reported having the policies in place. Of particular concern, only 27% to 68% of the ICUs reported having poli-

cies in place for prevention of CAUTIs.

"CAUTIs are the most common healthcare infection, but the policies don't have the uptake yet like for CLABSIs," Stone says. "We still have work to do there and then the adherence [for CAUTIs] is worse. Rightly so, we have seen a lot of attention from the infection control departments and the federal government on CLABSIs, but we have to put that emphasis in other places."

Indeed, in survey results for adherence, only 6% to 27% of the ICUs reported compliance with practices to prevent CAUTIs. Adherence numbers are better for the other two infections, but still show a considerable gap between policies and adherence. Adherence to prevention policies ranged from 37% to 71% for CLABSIs, while VAP adherence was reported by the ICUs at 45% to 55%.

Stone and colleagues noted in the paper that "Establishing policies does not ensure clinician adherence at the bedside. Previous studies have found that an extremely high rate of clinician adherence to infection prevention policies is needed to lead to a decrease in healthcare-associated infections. Unfortunately, the hospitals that monitored clinician adherence reported relatively low rates of adherence."

However, it should be noted that the survey did not ask how adherence was measured and so a variety of common infection control breakdowns could be considered as lack of adherence.

"We didn't ask how you measure it, but the last time you measured it what was it?" she says. "One thing about infection prevention is that these are data people, and they know their data. [Lack of adherence] could be hand-washing lapses, breaks in sterile technique, all different sorts of things."

The electronic survey was sent to infection prevention departments through the CDC's National Healthcare Safety Network (NHSN). The department director was asked to fill it out, reporting policies specific to the ICUs and then their assessment of adherence to them.

"The CLABSI policies are pretty much getting out there and we know that the rates have been going down, but still the adherence [for all three HAIs] was about 50%," Stone says. "We need to focus on how we can help the clinicians, both the nurses and doctors and decrease these infections. There is a whole science in human engineering to try to make the right thing the easiest thing to do."

The lack of adherence is multifactorial, but could include education and insufficient support for infection preventionists to work with bedside clinicians, she says.

"It is important to ensure that [infection control] is something on everybody's mind all of the time," Stone says. "We know when the top administrators and everybody in the C suite are on board it trickles down. It takes leadership to change the culture at the bedside."

The survey was part of the larger Prevention of Nosocomial Infections and Cost Effectiveness Refined (P-NICER) study, which is funded through the National Institute of Nursing Research. Several more studies are forthcoming from the same project, she says.

"This is the largest survey of infection control departments, and eventually the data will be linked with infection rates," Stone says. "We have four [other] papers under review right now."

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How hot is too hot for patients?

ECRI reaffirms warmer temp max at 130F

A decade ago, ECRI investigated a series of incidents in which patients were burned — sometimes severely — by blankets that were warmed to a high temperature and placed on body parts that either temporarily or permanently lacked sensation. At the time, there wasn't even a discussion of what should be a maximum temperature for blanket warming cabinets.

The institute, based in Plymouth Meeting, PA, initially came up with a recommendation that warming cabinets not be set higher than 110 degrees Fahrenheit, explains **Chris Lavanchy**, the organization's health devices

engineering director. This allowed for uses that included rolling and folding blankets, which stored heat longer. It was in these kinds of instances that some of the previous injuries occurred.

Those initial recommendations, announced in 2005, were questioned by many clinicians, who felt the temperature wasn't warm enough. The warmers might be far from the bedside and lose significant heat during transport from the cabinets, Lavanchy notes, or they were used spread out, not rolled up, which meant the heat dissipated quickly.

In 2009, ECRI updated the recommendations to a maximum of 130F, and there it has stood, adopted and approved of by many organizations, including the Association of periOperative Registered Nurses (AORN).

"When we first investigated this, we had several investigations of burns, including some blistering ones," Lavanchy says. "Since we made our recommendations, and even after the change in 2009 to 130 degrees, we haven't heard since of blanket burns. That doesn't mean it isn't occurring, but it means it probably isn't widespread."

What of the reasons that nurses and doctors give for wanting higher temperatures — that their patients still complain of cold, that a blanket at 130 degrees can't hold heat for long enough to make a difference or loses heat before it gets to the patient? There are other fixes, he says. Move the warming cabinet close to the patients, he says. And remember that what feels warm to an active nurse may be different to a stationary, ill patient.

On the flip side, it takes surprisingly little time to burn a patient badly. At 120 degrees, it can take some minutes to raise skin temperature to dangerous levels. At 130 degrees, it is just one minute. And at 150 degrees, "it is just a few seconds," he says. "It is not a linear equation."

While no provider wants to harm a patient, the hospital environment is busy, and Lavanchy says it would be nearly impossible for every provider to guarantee that he or she would make sure that every time the blanket was hotter than 130 degrees, it wouldn't be rolled up or placed on a patient who was insensate or incapable of communicating discomfort.

"Engineers say the most effective control is one where you build safety into the design of something," he says. "For this, the appropriate design control is to make 130 degrees the maximum warming cabinet temperature. You might be able to get away with something higher sometimes for some patients, but it is best to design for the cases when you can't."

ECRI has created a Youtube.com question and answer video on the topic. It can be found at http://www.youtube.com/watch?v=abp-nGiqvMo.

The AORN environment of care standards related to blanket warming cabinets can be found at http://www.aorn.org/Secondary.aspx?id=20975&terms=blanket%20warmer#a.

For more information on this topic, contact Chris Lavanchy, Engineering Director, Health Devices, ECRI, Plymouth Meeting, PA. Telephone: (610) 825-6000. ■

Same strains still mean new shots

H1N1 still causing severe disease

Next season's trivalent influenza vaccines will contain the same strains as this year's vaccine — but it's still important to get the annual flu vaccine, according to the Centers for Disease Control and Prevention.

In a telebriefing, **Anne Schuchat**, MD, director of CDC's National Center for Immunization and Respiratory Diseases, said CDC is still studying the issue of how quickly immunity wanes after flu vaccination. To ensure protection, it is important to receive the vaccine every year, she said.

"We strongly recommend people get influenza vaccine every single year whether the flu vaccine changes or not," she said. "We know that duration of protection for any vaccine can vary by individual."

CDC reported that the prevailing strain this year was H1N1, the strain that emerged in the pandemic of 2009. It has continued to cause severe illness, hospitalizations and deaths, hitting adults younger than 65 particularly hard.

Almost two-thirds (61%) of flu-related hospitalizations were among adults 18 to 64 years of age, CDC reported. Antiviral treatment should be given to patients with severe illness as early as possible, CDC advised. ■

Transition to ICD-10 code sets delayed

On April 1, 2014, President Obama signed into law the "Protecting Access to Medicare Act of 2014," which directs the Centers for Medicare & Medicaid Services to postpone post-payment audits of the two-midnight rule until after March 31, 2015.

The act also delays the transition from ICD-9 to ICD-10 code sets. The legislation states: "The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD-10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d-2(c)) and section 162.1002 of title 45, Code of Federal Regulations."

The primary purpose of the law, commonly referred to as the latest "doc fix," was to avoid a cut in physician Medicare reimbursement that had been scheduled to take effect April 1.

The full text of the law can be found here: http://beta.congress.gov/113/bills/hr4302/BILLS-113hr4302enr.pdf. ■

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COMING IN FUTURE MONTHS

- Creating mentors in quality improvement
- How to work effectively with hospitalists
- Accreditation field reports
- Do you need an internship program?

CNE QUESTIONS

1. Name a skill that infection prevention may have that quality improvement may lack, according to Kelley Boston.
   a. Technology
   b. Facilitation
   c. Data collection
   d. Reporting

2. Which one of these is not a domain for the new AAMC public reporting principles?
   a. Transparency
   b. NQF endorsed
   c. Validity
   d. Purpose

3. How many enterprise-wide goals does Guido Bergomi estimate Cleveland Clinic has?
   a. 400
   b. 24
   c. 12
   d. 6

4. According to Pat Stone, PhD, FAAN, a survey of ICUs found that the overall reported adherence to infection control policies for three common infections was approximately:
   a. 80%
   b. 30%
   c. 50%
   d. 65%

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.

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. ■

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. Scan the QR code below or 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. ■

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Hospital Peer Review

2014 Reader Survey

In an effort to learn more about the professionals who read *HPR,* we are conducting this reader survey. The results will be used to enhance the content and format of *HPR*.

Instructions: Fill in the appropriate answers. Please write in answers to the open-ended questions in the space provided. Either fax the completed questionnaire to 404-492-5933, or return it in the enclosed postage-paid envelope by **July 1, 2014.**

In future issues of *HPR*, would you like to see more or less coverage of the following topics?

A. more coverage B. less coverage C. about the same amount

1. Joint Commission standards	O A	O B	O C
2. preparing for surveys	O A	O B	O C
3. discharge planning	O A	O B	O C
4. outcomes management	O A	O B	O C
5. changes in reimbursement	O A	O B	O C
6. credentialing	O A	O B	O C
7. risk management	O A	O B	O C
8. continuum of care issues	O A	O B	O C
9. Conditions of Participation	O A	O B	O C
10. National Patient Safety Goals	O A	O B	O C

Please rate your level of satisfaction with the following items.
A. excellent B. good C. fair D. poor

11. quality of newsletter	O A	O B	O C	O D
12. article selections	O A	O B	O C	O D
13. timeliness	O A	O B	O C	O D
14. length of newsletter	O A	O B	O C	O D
15. overall value	O A	O B	O C	O D
16. customer service	O A	O B	O C	O D

17. On average, how many people read your copy of *HPR*?

O A. 1-3
O B. 4-6
O C. 7-9
O D. 10-15
O E. 16 or more

18. How would you rate your overall satisfaction with your job?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

19. How would you describe your satisfaction with your subscription to *HPR*?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

20. What is your title?

O A. quality manager/director
O B. accreditation coordinator
O C. discharge planner
O D. utilization manager
O E. other _____

21. How large is your hospital?

O A. fewer than 100 beds
O B. 100-200 beds
O C. 201-300 beds
O D. 301-500 beds
O E. more than 500 beds

22. Do you plan to renew your subscription to *HPR*?

O A. yes
O B. no If no, why not? _____

_____

Please indicate yes or no for all of the areas for which you are responsible for case management in your facility or system.

23. quality	○ A. yes	○ B. no
24. discharge planning	○ A. yes	○ B. no
25. utilization management	○ A. yes	○ B. no
26. risk management	○ A. yes	○ B. no
27. accreditation	○ A. yes	○ B. no
28. other (please specify)	_____	

29. What is the highest degree that you hold?

- ○ A. ADN (2-year)
- ○ B. diploma (3-year)
- ○ C. bachelor's degree
- ○ D. master's degree
- ○ E. other_____

30. To what other publications or information sources related to your position do you subscribe?

_____

_____

31. Including *HPR*, which publication or information source do you find most useful, and why?

_____

_____

32. Which web site related to your position do you use most often?

_____

_____

33. Please list the top three challenges you face in your job today.

_____

_____

34. What do you like most about *HPR*?

_____

_____

35. What do you like least about *HPR*?

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36. What are the top three things you would add to *HPR* to make it more valuable for your money?

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