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INSIDE

AHC Media

Are we just teaching to the test?

Studies question value of quality measurement in current form

You can see the quote from the Agency for Healthcare Research and Quality on almost any Web page devoted to quality improvement: "Quality health care means doing the right thing at the right time in the right way for the right person and having the best possible results."

Getting there, obviously, requires effort, and part of that involves determining where you are and setting goals for where you want to be. Measuring and collecting data are part of that. But what if the data we are collecting aren't the things that will best get us to that right place, right time, right person place? What if all it does is get us to a place where we are doing better on that particular metric, which may or may not make a difference to actual patients? What if all that work is keeping healthcare from making the big changes that could take a real bite out of the tens of thousands of cases of unintended harm caused each year?

> WHAT IF THE DATA WE ARE COLLECTING AREN'T THE THINGS THAT WILL BEST GET US TO THAT RIGHT PLACE, RIGHT TIME, RIGHT PERSON PLACE?

Several recently published papers are making that case and challenging stakeholders to do better. First up is a study from **Elizabeth Howell**, MD, MPP, and colleagues looking at obstetrical quality measures and their association with maternal and neonatal mortality and morbidity.[1] The measures were early elective delivery between 37 and 39 weeks and Caesarean section rates.

The findings show that the rates for both of the measures varied widely by hospital in the New York area they considered, as did rates for

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complications. And the researchers found no relationship between the measures and morbidity and mortality.

Howell, an associate professor in the Department of Population Health Science and Policy, the Department of Obstetrics, Gynecology and Reproductive Science, and Associate Director at the Center for Health Equity and Community Engaged Research at the Icahn School of Medicine at Mount Sinai in New York City, says she was in no way surprised by the findings. "These measures look at only a small slice of deliveries, so there is a whole other set of moms and infants for whom these metrics are not important and to whom they are not linked. If you want to capture quality indicators for all deliveries, you are going to have to expand the array of measures you look at beyond these."

Looking at C-section and early delivery rates is a good thing, she says. It's valid and a great goal to reduce those rates. But "when we only have a few measures available in obstetrics — and early electability is the only one used on Hospital Compare — you have to wonder if we are capturing what people want to know."

An editorial commenting on Howell's work[2] added the recommendation to compare the information on outcomes for patients who had early deliveries or C-sections with patients who didn't, which might give a better idea of their meaning to that small slice of patients to whom this metric applies.

Expanding the data collected and reported is particularly important because delivery is one of the few areas of healthcare where consumers have a chance to do in-depth research of different hospitals and make a decision based on the information gleaned, she says. Someone with chest pain isn't going to take time to look up the quality data on a hospital website. But a young couple newly pregnant? They probably will, she says, particularly because they have been raised in an electronic world and expect information to be available at the click of a mouse or through an app on their phone.

Yet there is a paucity of quality data available, Howell notes. Some states — New York is one of them — have expanded quality data they require hospitals to report. Not all of it is endorsed by the National Quality Forum (NQF), but it's at least an improvement on what most states offer, she says.

"Obstetrics is one of those specialties that doesn't have the breadth and scope that one might hope," says **Peter Lindenauer**, MD, MSc, medical director of clinical informatics at the Center for Quality of Care Research at Baystate Medical Center in Springfield, MA. "It could get a lot more traction than many other public reporting issues do just because you have young informed people who are used to using the Internet to make decisions."

In 2013, Lindenauer and some colleagues published a paper on infection rates among obstetric patients across hospitals.[3] There were significant differences. He sees this as the kind of data that would be meaningful to patients and is readily available.

That study is an example of available work that can be drawn upon to beef up data available for parents-to-be, Howell says. Other recently published studies have focused on patient-centered care, which would address many more women and babies and would be relatively easy to include.

Howell also thinks there should

be more emphasis on maternal outcomes — like the maternal infection rates Lindenauer studied — because severe maternal morbidity occurs more often than most people think, and a certain number of the occurrences are preventable. "Think about your hypertension and hemorrhage protocols," she says. "We have to do more work in those areas, but those are the kinds of things that in the future we should be reporting alongside what is already there."

The campaigns conducted in conjunction with C-section and early deliveries are wonderful, Howell says, and she'd like to see similar ones done with other maternal/child metrics. "One measure doesn't cut it. We need to do similar things for other issues that occur in hospitals."

But she knows that will take time, and policy-makers at the state and federal level will have to see more research before they agree to more measures that will lead to standardization of labor and delivery. In the meantime, track what happens with every delivery where there is a complication. "How well do you take care of women in different situations? How often do these things occur, and what steps can you take to make sure they don't happen again?"

It's basic quality work, only it's directed at a wider array of patients and for data points that are likely more meaningful because they relate directly to the health and well-being of mother and child, she says.

Public reporting impacts QI efforts

Lindenauer was part of a team that published a study in October that looked at how hospital leadership viewed publicly reported quality metrics and how they influenced overall QI efforts.[4] Among the results: For more than two-thirds of the respondents, what the public saw did influence overall QI efforts. However, less than half of them believed that differences between hospitals reported in those public portals for mortality, readmissions, cost, and volume measures had any significant clinical meaning. Differences in process and patient experience measures, however, were considered meaningful. And around half of respondents were also worried that by focusing on the public reporting aspects of QI, they were missing out on other important opportunities to improve quality of care. The study found that hospitals with better or worse than expected performance were more likely to include publicly reported metrics in their annual goals.

"These are goals that just about everyone believes are important," Lindenauer says. "It's not that they are the wrong measures to focus on. People think that patient experience is important and that heart attack patients should get their aspirin. But there is a concern that these measures limit a hospital's quality department from making choices about where to focus quality improvement efforts. They feel compelled to achieve high levels of improvement in these particular measures and put a large amount of resources into moving the needle on performance for them."

That needle may already be at 95% on a particular metric, but hospitals are putting time, money, and manpower into getting it to 98 or 99, he says, when those additional points have a limited return on improving health, and at the expense of other measures and outright neglect of other conditions.

An accompanying editorial[5] included several suggestions for change. Chief among them was getting clinicians "actively engaged" so that the "connection between measurement and improvement [is] ensured." Further, data collection should be only about specific clinical questions. Payers should provide incentives for quality improvement, but with a degree of latitude to account for local conditions, rather than national priorities. The editorial calls for programs that include paid, dedicated time for clinicians who participate in this QI, a separate budget, and IT support. And rather than being accountable for measures, hospitals should be accountable for actual accomplishments.

Lindenauer has his own recipe for ameliorating the problem. First, he'd like to see more measures, not fewer. "If you are measuring across a broad range of conditions and markers, it becomes less of a concern that you are teaching to the test and you don't have to worry as much that you are missing something."

A more radical shift — and one that many are talking about — is to focus more on outcome measures rather than process measures. Although the leaders responding to the survey about which Lindenauer and his colleagues wrote said they viewed process measures as meaningful and outcomes measures like mortality as inadequate markers of whether one hospital is better than another, Lindenauer believes that perhaps hospital-specific mortality rates is something to be considered again.

"Purchasers aren't interested in buying processes," he says. "They are interested in outcomes. Patients are interested in outcomes. How you got there isn't as important. Sure, it's nice to have the map and to use those evidence-based processes, and for internal purposes, measuring processes is a good way to evaluate departments

and to find gaps and opportunities to improve. But for payer-sponsored measurement programs? I think outcomes are better."

Lindenauer says even at his own hospital, he can see how much focus is put on those publicly reported measures. There, it impacts variable compensation for physicians. "You can see our attitudes, where we feel we have more control and less concern, and you can see how that plays out on a national scale." The data from the survey he did of hospital leaders suggests that there is a recognition that these measures are less than perfect, and perhaps that is a bit of a salve to quality managers. They aren't alone in the fight to make sure that what hospitals are focusing on to improve quality is the right thing. He hopes that officials from the Centers for Medicare & Medicaid Services and the National Quality Forum will see his study. The latter organization has had a group of 52 stakeholders called the National Priorities Partnership whose job it is to help set the measurement agenda. *(The list of members is available at http://www.qualityforum.org/Setting_Priorities/NPP/NPP_Partner_Organizations.aspx.)* Perhaps some of them will see his study, too.

Until that happens, he thinks the data from his study might provide good talking points for discussions between leadership and the quality department, perhaps to figure out if there is somewhere that energy should be focused that is being left out because of all the interest in publicly reported data.

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New old chapter in TJC manual

For the first time, it's open to the public

There's nothing new in The Joint Commission's first chapter of the 2015 Comprehensive Accreditation Manual Hospitals, and yet, everything about it is new. The chapter includes more than two dozen standards, all of which appear in other chapters, all having to do with patient safety systems, creating a learning organization, and fostering a culture of quality. Those standards will still appear in the chapters from which they were culled. But for the first time, the chapter in its entirety is being published on The Joint Commission's publicly accessible website so that anyone, whether they are accredited hospitals or not, can see it.

"Why should we limit this to accredited organizations?" asks **Ron Wyatt**, MD, MHA, the medical director of The Joint Commission's Division on Healthcare Improvement. "If everyone can see this, then everyone will know what patient safety is," he says. "You can't assume that people know that. Even leadership may not have a clear answer."

In addition, seeing this chapter will help patients and their families to understand that there is a minimum standard that hospitals should meet, Wyatt says, and they will have greater awareness of patient safety.

The process of creating this chapter — and Wyatt emphasizes that it is the first chapter in the manual,

not something buried in the middle or as an appendix — started 18 months ago after several stakeholders suggested revising the sentinel events chapter. Wyatt and his team suggested rather than being reactionary, why not create a proactive, prospective method of dealing with the issues that lead to sentinel events.

He wrote a chapter, "but the first draft was 200 pages long," he says with a laugh. It was promptly turned down by commission leadership. He brought in risk managers, quality improvement staff and corporate liaisons — a total of 40 people. They suggested that he speak to the issue of patient safety. That was addressed in the manual, but throughout different chapters. So they went through it and brought a group of standards together that seemed to address Wyatt's dream of being proactive and prospective about sentinel events through enhanced patient safety and a supportive leadership and organizational culture.

"It's a road map to safety and to activating patients," he says. "It gives us free lessons of unsafe conditions and how to respond to them. It helps us learn how to use data for improvement and pushes us to become learning organizations."

The idea to publish this on publicly accessible Web pages wasn't Wyatt's, but still: "I was thrilled that no one said don't do this," he says. So far, the response from the wider public as well as hospitals accredited through TJC has been positive, but he is anxiously awaiting the initial feedback from consumers, for whom this chapter was designed. While some may say the chapter is too transparent to share with everyone, he thinks it's a stroke of genius. "I say go for it."

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Popularity of safety walks surges

But going walk-about may not always pay off

If you ask someone familiar with Lean management systems to name one of the things that makes those systems different from more traditional healthcare management, he or she may very well mention that leadership makes it a point to head to the front lines regularly. If there is a problem, they want to see it through the eyes of the person experiencing it. This notion has led to an increasing popularity of senior management safety walks, which take the suits from the C-suite down to the trenches where nurses and physicians do the real work of patient care. The idea is that if they see what really happens, they will be more adept at making policy decisions that ensure smooth operations and safer systems. It also supposedly helps them solve intractable problems by giving them a different perspective than they usually see from their office — less Pollyanna about safety and more realistic, say nurses and doctors.

This kind of safety rounding has been supported by organizations like the Institute for Healthcare Improvement and the Agency for Healthcare Research and Quality. But does the research on it bear out the theory?

A new study[1] in the October issue of the *British Medical Journal* looked at 43 papers on this practice and found mixed results. The best studies in terms of methodology showed little or no improvement from the practice, while the best outcomes are associated with having a large number of senior leaders exposed to the rounds. Other factors include ensuring the issues discovered were followed up on, that front-line staff felt comfortable speaking up — having an existing culture that didn't play the blame game — and what kind of program it was, whether single-unit or part of some broader program.

There are good, valid reasons for senior managers to walk around and see what's going on with front line staff, says study co-author **Sara Singer**, MBA, PhD, an associate professor in the department of health policy and management at the Harvard School of Public Health and the Mongan Institute for Health Policy at Massachusetts General Hospital in Boston. "Patient safety is important, and we are not where we should be. There is plenty of evidence that having a culture of safety has a lot to do with providing safer care. So if the priority of senior managers is evident to staff that safety matters, then front-line staff will look to that. They really do have the power to effect change, as well as to provide the resources that lead to safer care."

Senior leaders can also demonstrate that they care — for patients and staff — by doing these walk-abouts, says Singer. "It is one of the very few evidence-based practices where they can impact a safety culture. If you are a front-line worker, and your CEO comes down, it has an impact on you. It is a low-cost, simple, and potentially very effective way to engage your staff."

But, she warns, while it can be a great strategy, there are also great pitfalls to be aware of if you decide to create a leadership safety walk program.

First, the evidence on these walks comes not just from healthcare, but from other industries, particularly manufacturing. Some of the evidence that engages healthcare may not be appropriate to healthcare, she says.

Second, as in any case where you are asking front-line staff to speak up, you have to make sure that everyone in the organization feels comfortable doing so, that there is no culture of intimidation, that nurses aren't cowed by doctors, that there is no bullying of housekeeping by nurses. "Everyone needs to be on the same page, where everyone and anyone can speak up and no one will get a negative reaction for doing so, as long as the communication is done in an acceptable and polite manner," she says.

Third, be aware that there is a "dose response" to walk rounds. "More interaction with more people creates a deeper impact," she says.

Perhaps most importantly, Singer says that what others do may or may not work for your organization. There are many among the 43 trials she looked at that seemed to work for the individual facilities. "My educated guess is that if you create a program you think will work in your organization, it is better than a template program created for everyone. Many variants work because people gave thought to [the] needs of the particular facility and designed the program accordingly."

Having a safety rounding program can enable a hospital to transform its safety culture and give senior management a way to interact with front-line staff that they haven't had. "It gives them a way to respond in a way they haven't, too, and to encourage staff to speak up more than they have, as well. But it won't be any of that unless you go out in a genuine way ready to listen to them, ready to hear from them what is safe and what isn't, and ready to follow up with resources to correct the problems," she says.

"MORE INTERACTION WITH MORE PEOPLE CREATES A DEEPER IMPACT," SHE SAYS.

Even if it does all of that and the program works really well, you still may not find out about all the problems your hospital has when the leaders go out on their walking tours. "You have to look at problems from multiple sources," she says. "What you will hear from front-line staff tends to be about infrastructure and equipment, not the failures of communication that the Institute of Medicine would put at the center of safety problems."

It could be that those things that would lend themselves to a chart review just don't come up, she notes. A question like "what would make patients safer" may not elicit the response "if my colleagues would communicate better." On the floor, when asked that question, the nurse's thoughts may immediately go to the fact that she wants the med carts stocked more often. Try to think of good questions for leaders to ask while on the rounds that might tease out the kinds of safety issues that you know exist but are less likely to arise with common questions, Singer says.

Safety rounding isn't the right answer for every hospital, Singer says. If you aren't in a facility with a culture that will commit wholeheartedly to it, don't. "Do something else. There is less risk of a backlash. If you ask about problems and then don't do anything about them, you create a negative spiral around safety culture," she notes. "But if you are committed, this can be the bomb."

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NSQIP program finds 44 stars

"Meritorious" designation for stellar surgical programs

The top 10% of the 445 participants in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) were recognized in October for hitting the mark on a variety of data points deemed important to surgical outcomes. Although the merit recognition program has been around for five years, **Pegi Wasserman**, RN, BSN, the ACS NSQIP Perioperative Clinical Reviewer in the department of clinical excellence at Advocate Illinois Masonic Medical Center in Chicago was completely taken aback that her program was one of them. "I had no idea it even existed," she says.

The merit recognition program ranks participating hospitals on composite scores for eight data points. They are:

- mortality;
- cardiac: cardiac arrest and myocardial infarction;
- pneumonia;
- unplanned intubation;
- ventilator > 48 hours;
- renal failure;
- surgical-site infections (SSI): superficial incisional SSI, deep incisional SSI, and organ/space SSI;
- urinary tract infection (UTI).

Wasserman says that of all the issues that the task force worked on related to the metrics, the work on surgical-site infections (SSIs) has been the most gratifying. Over the course of 2013, the rates for infections in colon surgery went down from 30% to 16% — just shy of the 50% drop she and her quality improvement team were looking for.

The multidisciplinary task force initially met to go over literature on existing best practices. Seminal work done by the Mayo Clinic and Johns Hopkins in particular helped them create a skeleton of best practices that they then adapted to their own needs in Chicago. "We needed to look at what to change preoperatively, intra-operatively, postoperatively, and post-hospitalization," she says.

NSQIP, she explains, follows patients for 30 days post discharge, so that post-hospitalization piece is as important as any other and something that many other organizations don't include in their quality efforts.

Data was kept meticulously — Wasserman handled that role herself — and analyzed at six, nine, and 12 months.

Among the changes in care, Wasserman noted these 12 items:

- Two showers at home with chlorhexidine, and a bath cloth wipe down with chlorhexidine in the surgical holding area.
- All hair clipping done in the surgical holding area.
- Previously used bowel techniques were brought back into use: instruments used before closing were kept on a separate tray from those used for closing.
- Gowns and gloves are changed and the surgical site is reblocked for closing.
- The surgical team ensures that the dressing is on before the drapes are removed. "This is supposed to be done all the time, but it really isn't," she says.
- The patient is warmed intra-operatively to prevent hypothermia.
- Post-surgical glycemic index is monitored and controlled.
- Removal of Foley catheter within 48 hours.
- Removal of dressing on the second post-surgical day.
- Appropriate VTE and antibiotic prophylaxis.
- Patient teaching for good hand-washing techniques, chlorhexidine washing, and wound cleaning.
- Patient teaching on 12 warning signs of infection. The purpose, Wasserman says, is to help patients to know when to call their surgeon, and when to go to the hospital. In the end, the goal is to prevent readmissions and unnecessary trips to the hospital alike.

The numbers continue to hold steady, Wasserman says. One thing she noticed as she looked through data is that surgical infections for general surgeries also declined, as did urinary tract infections, which she is sure happened because of the change in policy to remove catheters within two days. Another positive impact that is probably harder to directly correlate, but which she thinks is definitely related to this program: an increase in top-tier patient satisfaction ratings of 35%, and a decrease of "needs improvement" ratings from 8% to 5%. "All of that came from this one initiative," she says.

The coming year will see a continued focus on surgical-site infections, and the hospital in general is looking at UTI rates. Renal failure has been up a bit in vascular cases, so Wasserman will be pulling charts to see what went wrong in them and find areas for improvement.

"All of the things in this composite score are important and inter-related," she says. "The only thing not included that we are working on

is venous thromboembolism. We are looking at that critically, particularly in orthopedics."

In Houston, Memorial Hermann Northeast Hospital also achieved meritorious status. **Tal Raphaeli**, MD, FACS, a colon-rectal surgeon at Houston Colon and Rectal Surgery, PA, says they have been involved in NSQIP before last year, but "only in a passive sense. We had not taken real control of the data to be able to identify areas for improvement. Once we saw the power of the data, it was clear that we had to be more active in using it."

The area of biggest concern for Memorial Hermann was post-operative pneumonia, which they have been able to "nearly eliminate" with some simple steps.

They created a checklist to give patients visual reminders and cues regarding pulmonary hygiene that can help prevent postoperative pneumonia. "The nurses on the floor bought in completely," he says, "and the patients have been eager to really be involved actively in their own care."

Back in Chicago at Advocate Lutheran General Hospital, Chief of Surgery **John White**, MD, is enjoying his fifth designation as head of a meritorious surgical program. One of the things he has learned is that there is no destination in quality improvement. "Despite this acknowledgement, we have found a great many areas we could improve upon each year," he says. "The true value in these measures lies not in the recognition for achievement but in the greater understanding of the human body and how to better protect it during and after surgery."

He gives the example of initially addressing surgical-site infections by changing how surgeons scrubbed their hands and how they prepped the patient's skin at the time of surgery. "We embraced the Surgical Care Improvement Program recommendations for antibiotic use," White continues. "Then we recognized that how we treat the incision after surgery is also important, so we began to standardize wound care. Finally, we are now aware that when patients are discharged earlier we must communicate more clearly with them or their caregivers about wound care to prevent delayed surgical-site infections. Meritorious care does not stop with discharge but with full recovery and ongoing health maintenance."

Surgeons may solve the problems posed by these eight metrics some day. But there will always be something new to focus on. "What will we focus on now? Everything!" White exclaims. "We believe that the future of surgery is to disrupt less normal tissue, to heal injured or diseased tissues and thus to promote a more rapid and full recovery. To accomplish this, we must continue to pay attention to every aspect of the patient's treatment program from pre-op assessment to full recovery and learn how to be better. We can always be better."

The complete list of programs that achieved meritorious status is available at https://www.facs.org/~/media/files/quality%20programs/nsqip/meritoriousposter2014.ashx

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Ebola fears remain high, despite new guidelines

CDC stresses best practices

If you are an accredited hospital, you already know what to do if Ebola comes to your door. At least that's the theory. But what we think we know how to do, and what actually happens may not always coincide.

The fears about Ebola continue to run high, although influenza is easier to transmit and likely to kill thousands in the next few months. Because of that heightened anxiety, the best thing to do is to be ready to reassure your community that you are ready to deal with any Ebola patient and contain the threat.

The Centers for Disease Control and Prevention (CDC) released new guidelines for healthcare workers in October (http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html) to help reduce the risk to them of any transmission from a patient.

There is much less risk from patients presenting with just a fever in the ED compared to patients with severe illness who are hospitalized. The more severe the disease, the higher the level of virus production, and the bigger the danger to those who come in contact. For those very ill patients, best practices would include ensuring the proper donning and doffing of protective clothing — something that has its own section on the CDC's Ebola website (http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html).

Best practices, according to the CDC, include taking a relevant exposure history and looking for symptoms of the disease. Because the symptoms are common to other illnesses, the combination of exposure and symptoms is important. If both history and symptoms suggest potential Ebola, the CDC says the patient should be immediately isolated in an area with a private bathroom or covered bedside commode, with all usual precautions used to prevent transmission by direct or indirect contact.

The CDC recommends the following:

- For patients coming in by ambulance that meet the criteria, hospitals need a designated space away from other patients where the patient in question can be seen.
- Minimize the number of people who provide patient care, and keep a log of everyone who enters the patient's room. Everyone who does so should wear appropriate safety gear based on how ill the patient is.
- Contact the local health department, which will help determine whether or not to test for Ebola.

The Joint Commission hasn't issued any new guidelines, but it did put together a list of the standards that relate to effective management of the disease. The Joint Commission's vice president and chief medical officer, **Ana Pujols McKee**, MD, says the organization is working closely with the CDC to release Ebola-related briefs and updated guidelines as needed, noting that "following the relevant CDC guidelines is a requirement for Joint Commission accreditation."

She says that The Joint Commission is stressing the importance of preventing transmission of Ebola, and the "evolving information around how to best care for [Ebola] patients means that health care organizations need to be on alert and ready to respond to changing requirements."

In addition to the CDC guidelines, the processes outlined in The Joint Commission's "Infection Prevention and Control" chapter of its accreditation manuals and related sections of the "Environment of Care" chapter are applicable to all infections or potential sources of infection that health care staff, practitioners and administrators might encounter, including Ebola. For that virus, McKee says it is important for organizations to focus on emergency management standards, too, which are "designed to assist health care organizations, both large and small, in developing and maintaining an effective program that covers a wide range of situations." ■

White paper compares Lean and IHI

They're complementary to each other, according to IHI improvement advisor

Even though he's an advisor for the Institute for Healthcare Improvement (IHI), **Richard Scoville**, PhD, is quick to tell you that Lean management — or its related iterations in healthcare, Virginia Mason's management system and Sutter Health's adaptation of it — are really quite good. The rationale behind a white paper comparing Lean and the IHI management programs was really just to explain the two systems to people, not to sell folks on the IHI program at the expense of the other. There is, he says, plenty of room for both, and plenty of insight that each system and its adherents can gain from the other.

Scoville says it's not a matter of either/or, but actually more "both/and because they are complimentary to each other."

Both are road maps to higher reliability, he says. What differs is "how they traverse the territory. We are trying to standardize a variable product — a product that is actually the producer and consumer at the same time. Creating an improvement model that works for that is difficult."

IHI is grounded in the work of W. Edwards Deming, while Lean grew out of the Toyota Production System and is often used in conjunction with Six Sigma. There are other management programs used in healthcare, as well, Scoville says. And in the end, it may not really matter what an organization uses, as long as it uses something as a guide. "Any map is better than none. Adapting one and getting people together to

discuss change, whether it's Lean, IHI's Quality Improvement model or something else — it's just a vocabulary, a jargon you can use to guide you on your path," he says.

IHI has set aside the notion of management system and focuses on processes, changing them when necessary and ensuring they are consistent. Lean goes further, Scoville says, by taking process changes and making them part of the daily work of staff. A checklist that is implemented as part of a QI project ends up being sustainable because it becomes embedded in the typical day of the CEO, the physician, and the housekeeper alike.

IHI's method can also learn from the Lean technique of going to the source of the problem — visiting the shop floor or the front line — and getting to see work flows and the issues faced by workers firsthand, he says.

Lean, on the other hand, could benefit from the broad array of methods used by IHI, rather than being hemmed in by a specific methodology, he says.

Scoville says that what is good about both systems is that neither is static. As applied in healthcare, they continue to evolve and adapt, and there is no reason to believe they will do differently in the future.

For more information on this topic, contact Richard Scoville, PhD, Improvement Advisor, Institute for Healthcare Improvement, Cambridge, MA. Email: richard_scoville@unc.edu ■

Emergency department hand hygiene, catheter placement remain IC challenges

Hand hygiene compliance varies widely

At a time when Ebola and other emerging infections may first present at an emergency department (ED), researchers are finding a wide range of compliance — or lack thereof — with infection control measures.

In particular, there is room for considerable improvement in hand hygiene compliance and use of aseptic technique during catheter insertion in emergency departments.

Researchers conducting a literature review found that hand hygiene compliance in EDs ranged from 7.7% to 89.7%.[1]

"A variety of factors may have contributed to variation in hand hygiene adherence rates," says **Eileen Carter**, RN, BSN, lead author of the study. "We reviewed studies that were conducted in several countries. Differences in cultural practices, data collection procedures, and access to hand sanitizer and hand wash, may have contributed to the variation we saw in hand hygiene compliance."

Caveats noted, but low compliance with hand hygiene and other infection control precautions fits the narrative described at the APIC conference earlier this year by **Jeremiah Schuur**, MD, director of Quality, Patient Safety and Performance Improvement for Emergency Medicine at the Brigham and Women's Hospital in Boston.

In a chaotic, often overcrowded ED, the prevailing mindset is that care must be administered quickly, engendering an "acceptability or normalization of deviance" with infection control measures, he said.

Catheters placed in ED may be lost to follow-up

In that regard, the literature review study also raises questions about aseptic technique during placement of central venous catheters and urinary catheters in EDs.

"There are a lot of lapses in technique for inserting invasive devices," says **Elaine Larson**, RN, PhD, FAAN, CIC, co-author of the study and associate dean for nursing research at Columbia University in New York, NY. "Most hospitals have a rule that if an invasive device is inserted under emergency conditions, then it should be re-inserted within 24 hours, but no one has ever studied that."

Indeed, the authors were unable to find any studies that looked at adherence to re-inserting invasive devices that initially were inserted in the ED.

"It's very hard to tease out this information from electronic databases," Larson says.

Another problem is that hospital nurses and physicians might not even know where and when a catheter was inserted, she notes.

"Say the patient went from the ED straight to the operating room," she says. "They don't know whether it was inserted in the ED or the operating room, depending on the charting."

Even as the health care field is trying to make electronic health records more useful, there remains

information that is not collected.

"If there is not a field in the record that says the catheter went in at this time in the emergency department, then this information could be noted in electronic notes," Larson says.

But the date and place of insertion might not be mentioned at all. In addition, there are research needs for more information about whether central lines and urinary catheters inserted in an ED increase the risk of infections.

"Nobody even knows if the rule to re-insert the device even makes a difference," she adds. "It seems like a good idea — imagine trying to put in a urinary catheter in the hallway, but we don't know."

Intervention studies that address ED catheter-associated urinary tract infections (CAUTIs) were largely educational based and aimed to improve the proportion of ED-placed urinary catheters that met medical appropriateness criteria, Carter says.

"Results were varied, indicating that education alone does not guarantee provider compliance," she adds.

Targeted HH campaigns work best

One thing the study does highlight is the importance of targeted hand hygiene campaigns. Studies from the U.S. and Italy showed sustained improvements in hand hygiene after a campaign. Observers used training materials from the World Health Organization prior to observing staff HH practices.

"Multimodal campaigns, which have focused on staff education and engagement, interdisciplinary champions, and performance feedback, have successfully increased hand hygiene rates," Carter says.

"However, ED hand hygiene improvement efforts should also consider unique barriers to compliance in the ED," she adds. "For instance, healthcare workers may provide care to patients in non-traditional care areas where hand sanitizer is not readily accessible, which was addressed by one of the studies we reviewed."

The literature review's chief finding is that there is a need for improved compliance to infection prevention practices in the emergency department, Carter says.

"Future studies should evaluate the role of the ED in the transmission of infections," she adds.

Larson says additional research questions include:

• What is the impact of ED patient crowding on hand hygiene and aseptic technique?

"When you have patients lined up in the hallway, can staff practice aseptic technique and hand hygiene — even if there is not a sink or hand rinse nearby?" Larson wonders.

• Do staffing levels in the ED have a significant impact on infection risk?

Or is the problem related to the level and type of staffing in the ED, she says.

"Is there enough staff in the ED to use aseptic technique, and is the staff able to practice good infection control?" she adds.

"It's possible to make aseptic technique a two-person job," Larson says.

One person can watch to make sure their colleague does not break technique.

• Do hospital employees follow their own organization's guidelines and re-insert invasive devices within 24 hours, and do they even know about these guidelines? ■

REFERENCE

1. Carter EJ, Pouch SM, Larson EL. Common infection control practices in the emergency department: a literature review. *Am J Infect Con* 2014;42:957-962

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CNE QUESTIONS

1. **According to a study by Lindenauer and colleagues, which of the following metrics did hospital leaders think had meaning when comparing hospitals?**

   a. Pricing
   b. Patient experience
   c. Mortality
   d. Readmissions

2. **The new Joint Commission manual's first chapter is focused on which area?**

   a. Sentinel events
   b. Process Improvement
   c. Creating a learning organization
   d. Risk management

3. **What kinds of issues are most likely to come up during safety rounds with frontline staff, according to Sara Singer, MBA, PhD?**

   a. Personnel issues
   b. Equipment issues
   c. Communication issues
   d. Workflow issues

4. **What area of standards did Ana Pujols McKee, MD, vice president and chief medical officer of The Joint Commission, say is of importance when it comes to Ebola readiness?**

   a. Infection control
   b. Emergency management
   c. Environment of care
   d. Leadership

CNE OBJECTIVES

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

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. 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.
3. 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.

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