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INSIDE

More hospitals make Top Performer status

Joint Commission annual report notes gains in quality

It's one of those cases where the focus is distinctly on the cup half-full: More than 1,200 hospitals, or just about 37% of those accredited by The Joint Commission, achieved Top Performer status on 2013 accountability measure data. That's an increase of more than 11% from last year. This is good. But it still means that just about two-thirds of the hospitals The Joint Commission accredits don't meet that mark.

Quality is, indeed, a long journey.

According to The Joint Commission's 2014 annual report, Top Performers must "1) achieve cumulative performance of 95% or above across all reported accountability measures; 2) achieve performance of 95% or above on each and every reported accountability measure where there are at least 30 denominator cases; and 3) have at least one core measure set that has a composite rate of 95% or above, and (within that measure set) all applicable individual accountability measures have a performance rate of 95% or above."

> "YOU CAN'T EVER STOP. YOU ARE ALWAYS LOOKING AT THE DATA, REVIEWING IT CONTINUOUSLY, AND LOOKING AT THE RESEARCH FOR THE NEXT THING."

One of the interesting things about meeting high quality standards is the feeling of confidence the public has in large academic institutions despite the relative difficulty they seem to have

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in meeting the high expectations. There are 35 academic medical centers among the Top Performers. That's up from 24 last year, and just 4 in 2011, which sounds like a vast improvement until you remember there are 125 of them reporting.

Forty-four hospitals went above and beyond and reported on at least five measure sets, rather than the required four — only one of which is an academic medical center, and none is among the places most people think of when they think about where they'd go if they were rich and famous and had a dread disease.

Hospital Peer Review talked to three of these 44 hospitals about what they did — and do — that makes them stand out, and what other facilities can learn from them.

Key initiatives include ongoing education

At Renown Regional Medical Center, a 538-bed facility in Reno that serves northern Nevada, 2013 data submission included children's asthma, and next year will include perinatal care. For the 2016 submission, the hospital's quality team is already working on sepsis, says **Laura Latimer**, director of performance improvement at the hospital.

Latimer says that the heart failure 1 measure offered the most "opportunity for enhancement" over the last year. "One key component we focused on was ensuring all patients with a diagnosis of heart failure scheduled a follow-up appointment with their primary care provider or cardiologist prior to being discharged from the hospital," she says. "We were able to achieve compliance on this measure through setting standard processes and integrating with key programs we already had in place."

The following were among the key initiatives, according to Latimer:

- accurately identifying heart failure patients through a tool in the electronic health record, quality consultant staff, and nurse navigator collaboration;
- ongoing education and training for nursing staff, hospitalist staff, and medical residents;
- interdisciplinary rounds with hospitalist staff and discussion around follow-up appointments;
- encouraging nurses to schedule the follow-up appointment soon after admission, rather than waiting until the day of discharge. ("The patient's appointment date and time is then included in their discharge instructions," she notes.);
- increasing utilization of home health visits and the community paramedic program;
- daily rounding by the heart failure nurse navigator and real-time tracking of all heart failure patients to ensure follow-up appointments are scheduled;
- providing ongoing feedback for continuous process improvement at weekly core measure meetings.

Early adopters

Across the country in Florida, Baptist Hospital of Miami was another one of the 44 that turned in more data than it had to. "We didn't wait for the government to

tell us what to look at," explains **Miriam Serrano Robles**, RN, BSN, performance improvement manager of the facility. "We are early adopters, and we don't just settle for the minimum."

The facility had been looking at the issue of venous thromboembolism for more than 10 years — "It's a hospital-acquired condition" — and had also been working to become a stroke center. So adding those two measure sets seemed a no-brainer. They also added immunization to the mix for a whopping seven measure sets.

Next up they are thinking of adding tobacco use to the list. "We started looking at that two years ago," Robles notes. "We have an action plan and processes in place and start training in January." There is an assessment in the electronic records, and once a patient is identified as a user, someone from the respiratory therapy department is cued to come in and provide smoking cessation education to the patient. The patient is also sent home with a program for quitting.

The pilot of the program was being completed at press time, and Robles expected some tweaks before a final was rolled out.

Like Renown, they are also working on sepsis, as well as blood management and elective deliveries. On the latter, they have gone from 30% five years ago to 0% currently. "The biggest issue around that was changing the culture and getting the physicians involved," says Robles. "There used to be this idea that in South Florida, you could pick when you had your kids. We got the head of the department and everyone at the table. We showed the doctors the data. If you want an early delivery, the head of the department will have to approve it."

Does Robles worry about complacency? "You can't ever stop. You are always looking at the data, reviewing it continuously, and looking at the research for the next thing," she says, adding like any true A student: "We have to ensure we are always moving forward."

Quality wins not taken lightly

At the University of Kentucky Hospital, setting the bar high is just what they do, says **Kristy Deep**, MD, MA, FACP, enterprise quality director and residency program director at the Lexington-based hospital. "We pride ourselves on a robust quality improvement program, and we collect a lot of data," she says. "Much of what we submit is what we are already doing anyway. Submitting for these annual measures is something we can do, confident in our performance."

She says that none of the quality "wins" are taken lightly, even the ones that have been relatively easy. "That just means that there has been low-hanging fruit, that our performance has not been what we wanted it to be and there are no-brainer things that lead to improvement."

Deep gives an example of iatrogenic pneumothorax. "When you use ultrasound, your risk of giving a pneumothorax goes down," she says. "So we invested in more ultrasound machines. We trained our staff and physicians, and we had a lot of improvements in our numbers. Those are easy, process of care wins."

Things like giving heart attack patients aspirin — those are completely in the control of the hospital, Deep says. Those kinds of core measures are simple. What is harder are the measures that are outside the control of the hospital. "Patient-level variables or clinical decision-making by a large number of providers, or outcomes measures like readmissions and mortality — those are the much harder wins, and much harder to tackle — as we continue to see."

Still there are a couple of quality projects that she has extreme pride in. Both relate to healthcare-acquired infections, and thus are on most people's radar and are extremely gratifying to solve. First, there was urinary tract infections. There was a high historical rate at the hospital. One thing they wanted to do was do some accurate benchmarking to clarify opportunities to improve, Deep says.

"In addition to The Joint Commission, we are a member of the University Health Consortium and so we had a lot of data, and we knew that even among our peers, we had higher rates than we would have liked."

Deep and her team looked for ways to reduce the use of catheters. Every day, every patient with a catheter has a chart prompt asking if the catheter can be removed. Every patient is assessed to see if he or she should have one to begin with. If the patient has a catheter, there are nursing-driven protocols — what Deep calls "standard work" to care for the site, ensure it is kept clean, and to be sure that when it is removed there are no repercussions. Patients and families are encouraged through signage to ask if a catheter is needed or can be removed, and physicians

are educated to reduce their use and reliance on them unless it is warranted.

While Deep says the rates are declining — "we are chipping away at the iceberg" — there is still a ways to go.

With central-line infection — another piece of indwelling plastic that Deep says is always a potential for problems with patients — there has also been a multipronged approach to reduce rates. A bundle including a drape, ultrasound guidance, provider shielding, gloves, gown, effective skin decontamination and continued cleaning with chlorhexidine all have worked to reduce infections. "It's just more standard work," Deep says. However, insertion site preparations represent just a small portion of infections. Maintenance of the site is another big problem, she says. The pediatric ICU led a project that introduced hub scrubbing and had significant improvements from that. "It is all a hard-wired process now — catheter maintenance, clean dressings, and de-devicing. We ask daily, is this something I can remove? Because if they don't have it, there is zero risk of infection."

Healthcare-acquired conditions are still important, Deep says. "You want to get to zero on these, and you want to stay there. We may all understand that this isn't attainable in the real world. But it has to be our mind set. So we have robust goal setting. We look at different domains of quality and safety and the intersect of importance, impact and ease of change."

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What makes a Baldrige winner?

Patience and a passion for patients

There is nobody who walks the path to the NIST Malcolm Baldrige Quality Excellence award and calls it a sprint. It is something deliberately undertaken with some knowledge that it will be a matter of years before you have any real chance of being one of the organizations named a winner. And St. David's HealthCare in Austin, TX, is no different. For them, it was a journey of more than a decade before they got the call in November that they were among the 2014 winners.

The joint venture with St. David's HealthCare Foundation, HCA, and Georgetown Community Health includes six hospitals, six ambulatory surgery centers, and several physician practices. Initially, the Baldrige method was viewed by a new CEO as a great method to assess the organization when he joined in 2003, says **David Thomsen**, vice president of quality for the organization. "He didn't talk about the award at all," Thomsen says. "It was just questions we used to assess our approaches and deployment across the breadth of the organization."

Indeed, even as word about Baldrige spread, it wasn't the award that was the idea in mind, but merely the benefit of the framework the Baldrige method provides. "Our mission is to provide exceptional care every day," Thomsen says. "This allows us to ask questions about how we lead, how do we use data, how do we mine data."

It took four years of simply asking questions and putting new structures in place before the organization even put together a state application, and another year before they received any recognition from Texas for their efforts. "We kept applying and getting feedback," he says. In 2013, there was a national site visit, and another this past year. "We simply had a methodical approach," Thomsen explains. "We took things slowly and let them sink in deeply until they were hardwired. We weren't concerned about the end point of an award, but about the process."

Tackling ED wait times

During the years they put the structure in place, Thomsen says the organization struggled with many of the same issues other healthcare organizations do. One of the items that was a big problem — and solving was a big success — involved tackling emergency department wait times.

"Understanding customer requirements is category three for Baldrige," Thomsen says. "How can we listen to our customer requirements about emergency department wait times?" Years ago, people didn't care as much about speediness. But now, there are freestanding EDs, urgent care centers, drug stores with clinics inside, and a population that can't wait three minutes for a meal, let alone an hour for a doctor with a crying sick child. "You don't want to rush something if there is a severe problem, but if it's not, you want to get in and out in less than an hour," he says. "You want to see a doctor in 10 minutes."

The organization looked at several issues including where, geographically, it had services. Texas is a non-certificate of need state, so there is a lot of competition. They did some research and located four freestanding emergency departments in specific areas based on demographic needs that would suit patients who didn't want to come to a busy hospital. They also changed the way they see patients, with immediate bedding. There is no triage, and every patient sees a physician within 10 minutes — down from about 30 minutes. Average length of stay is 45-60 minutes. Everybody associated with the ED knows with a few clicks on their phone or tablet or computer how long the wait time is in the ED.

The feedback report for the winning application came the week before Thomsen spoke to *Hospital Peer Review* and already he was getting ready to pull the team together for digestion, discussion, and consideration of how to improve. As a winner, the organization can't apply again for five years. "But there is an annual rhythm to this," he says. "We will still sit down and write the application every year even if we can't submit it."

They are also doing internal examiner training so that they will be better able to do internal critiquing during those off years, he says. "I see it as an investment in the future of healthcare."

Another element of investment is participation in the annual Quest for Excellence conference put on by NIST (scheduled for April; see http://www.nist.gov/baldrige/qe/index.cfm) — something Thomsen recommends for anyone interested in the Baldrige experience. "It helped us to really understand how the whole thing hangs together, and exposed us to a wide range of people in organizations in and outside of healthcare for whom this has worked," he says. "Service expectations of patients and consumers in general have changed dramatically over the years. The information you can get from FedEx or Ritz Carlton? That matters to us in healthcare. We find ourselves wondering how we can leverage the idea of the Apple Genius Bar for physician scheduling."

It pays off. The organization is not just successful in terms of quality, but financially successful, Thomsen says, having been able to provide some $50 million in community grants to non-profit organizations in the last year, and more than $200 million since 2007.

Thomsen acknowledges that the entire Baldrige journey from stem to stern may not be for every hospital. But it's right for St. David's. And understanding it is beneficial "whether you commit to the journey or not," he says "whether you are a barbecue joint or a school district or a small hospital" with a couple dozen beds. Reading the criteria, asking yourself the questions, even filling out the application every year, whether you send it in or not, can be a good exercise.

It's all about the feedback

That said, just about every Baldrige organization will also tell you the best part of the exercise (if sometimes most harrowing) is going through the feedback report. Indeed, if there is one thing that winners say they will miss it's the five years of feedback.

Debra Dooley, MBA, executive director of business intelligence for Hill Country Memorial Hospital, another of the 2014 Baldrige winners, is hoping there will be an informal group of winners that sends applications around during the five years. If there is, she'll find it.

Hill Country started the journey to an award just about eight years ago, when the leadership noted the facility was performing in the 45th percentile of hospitals in a national healthcare benchmarking program. "We are a small community hospital," she explains. When the 86-bed facility was built in 1971, 93% of the community gave to the building fund. The new leadership considered it unacceptable to be at that level of performance.

Dooley had gone to a quality conference and heard Sister Mary Jean Ryan — the first Baldrige recipient in healthcare — speak. It got her thinking about frameworks.

Initially, she and a group of other members from leadership and management just researched the Baldrige criteria and started asking and answering the questions. Where they couldn't answer, there was a gap, and where the gaps were largest every year, they worked to fill them. "Over time, we improved our rankings," she says.

The organization submitted an application first in 2010, then again

in 2011. It skipped 2012 to dig in a little and work on some of the issues identified in the cherished feedback report. In 2013, Hill Country achieved a site visit, and was recognized for best practices in leadership.

It was a remarkable shift, she says, for a small organization. "We had so many informal processes in place," she notes. "A systems discipline was difficult for us, and we had to transfer knowledge, so that it wasn't just a single person with the necessary information of a particular process."

Think of something like patient satisfaction, says **Emily Padula**, RN, MHI, executive director of integration and outreach. Customer experience scores were good, "but we had relied on our wonderful people for too long, that they would do great work all the time, rather than showing them what great pre-op teaching looks like, for instance."

They created front-line team councils to determine the best processes of care and appropriate measures of success. "We weren't just telling them to fix something, but giving them the ownership of it, asking them to tell us what it looks like for pre-op teaching to be successful," Padula explains. "The front-line team is the knowledge expert. We just facilitate them."

Among the other initiatives the organization created because of Baldrige was the "Strategic Breakthrough Initiatives" (SBI) program. Dooley explained that the hospital often had a plan for a quality project and an end goal in mind, but the teams weren't consistent in achieving the goals they set. When they looked at what better performing organizations were doing, they were better at action planning. For instance, a hospital working a particular core measure would have a team that reported weekly to executives for a quarter to make sure that something was hard-wired into the system. "We asked ourselves, what are the short-term action plans that would move us toward our goals?"

Creating solid action plans

The first issue they used the SBI program on was to improve elective induction births under 37 weeks gestation. "We were at about 7% and had a goal of 3%," Dooley says. "We involved the physicians and researched best practices. We put scheduling tools in place. If someone wanted to screen outside the parameters, the obstetrics medical director had to approve the schedule."

> "IF WE WANT TO GET TO A CERTAIN PLACE, WE HAVE TO FIGURE OUT HOW TO GET THERE."

Last year, there wasn't a single such early elective induction.

There are other metrics that the hospital has achieved in the last few years that are also remarkable. It is the top hospital for patient satisfaction for joint replacements among 5,000 nationally, and it leads every hospital in the state of Texas for value-based purchasing. These aren't stats of a facility in the 45th percentile of anything.

"If we want to get to a certain place, we have to figure out how to get there," explains Padula. "We assign the team lead, they get a coach and a team. The team meets weekly and also meets with executives weekly to update them, to brainstorm, and to talk about barriers." The executives help them overcome those hurdles and coach them through difficulties. At the end of a quarter, the project is handed off to a long-term owner; a check-up is scheduled a year later to make sure the changes have been effective.

This emphasis on creating solid action plans with a focus on moving forward quickly has been a great success. While Dooley says participation isn't required, it is very much encouraged, and so far everyone in middle management has been on a team and about half the staff members have been involved. Among the staff, quarterly personal goals — linked to organization and department goals — often include suggestions of engaging in activity with one of the strategic breakthrough initiative teams.

Participants gain, too: They learn project management skills and to use Lean tools they might not otherwise have access to. And while there is never any penalty for not participating, there may be rewards for those who do, Dooley notes.

It takes a special person to work at Hill Country. Just one in 10 people who apply is accepted, says Padula. Each person who applies is put through a standardized value screening, including physicians. The CEO teaches every orientation section on the facility's culture, and also evaluates staff quarterly on how they live the values and vision of the hospital.

It's not something they write on a piece of paper and forget, but something they all live and believe in, she says. "Each value has a definition and a set of behaviors that are associated with it. We all have to

commit to them and sign them."

These are all things that have become more important through the lens of Baldrige. The feedback meeting from the last application for the next few years was due to occur around press time. "Then we will look for gaps, look at our strategic plan, our action plan, our SBIs and keep working," Dooley says. "We just have to keep climbing."

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Improving transitions within the hospital

Two projects show how to reduce errors, harm

Transitions of care have been a bugaboo of medicine for years. And the problem isn't getting easier. With accountable care organizations and the increased emphasis on various spokes of the healthcare wheel being able to talk clearly across the radius to each other, it has become more and more important to find simple, proven ways to ensure that handing a patient from one part of the system to the other happens quickly, yet with all the pertinent information.

Two projects may offer some help in those areas. First, from Pittsburgh UPMC system comes the Ticket to Ride program, which came about after several patients who had been traveling within a hospital from one unit to ancillary testing — radiology, for instance — appeared without adequate information for care to proceed. It could be that there wasn't a complete patient history, explains **Carol Scholle**, RN, MSN, the nursing clinical director at UPMC Presbyterian Hospital, or there weren't recent vital signs in the record.

Around the same time, there were external pressures to consider the topic of transitions, as well, says **Deborah Pesanka**, RN, MS, corporate investment specialist for the UPMC system, as The Joint Commission's National Patient Safety Goals were focusing on transitions of care.

The system decided if it was going to tackle the problem, why not start at Presbyterian, which had something like 12,000 transfers between units and ancillary departments every single month. They could come up with some ideas, test fixes, and then roll them out to the rest of the system if they worked.

As an outcome measure, Pesanka says they decided to look at how many patients were going out of one unit without any issue and arriving at their destination with a condition A (cardiac arrest) or a condition C (in some other sort of crisis). Many patients were having to travel great distances, up to a quarter mile, to a test or procedure. Some were decompensating because they ran out of oxygen or their breathing became labored during the long trip.

So distance was a known factor. In addition, there appeared to be issues about communication between the transporter and the unit and the transporter and the ancillary provider. "The transporters felt like they were moving cargo," Pesanka notes. "They were not engaged or empowered at all in terms of safety."

They designed process measures as they designed changes. They considered each trip to an ancillary department as a flight, and created a "preflight" checklist. Transporters were encouraged to go through a checklist the same as any pilot would do — where are they going, is this the right patient, is all the right information here, is there enough oxygen for the trip? More importantly, they began to introduce themselves to the patients. Many of the transporters were not accustomed to doing these things. And the patients loved it, Pesanka says.

Project was handled by front-line staff

The transporter checklist led to one for the unit nurses, as well as one for the ancillary technicians on arrival. This made sure everyone was on the same page regarding the patient and his or her care, says Scholle. "It was never a drop off, always a hand-off."

The entire project was handled by front-line staff — transporters, technicians, receptionists, health unit coordinators, respiratory therapists. Managers played little role, Scholle notes. "The front line knows what is broken and have the ideas to fix it."

The initial iteration of the project has changed since it started at

Presbyterian and has then been rolled out throughout the UPMC system. There is now a red sticker added if a patient has an invasive procedure done that needs an assessment for bleeding on return to the unit. Front-line workers have asked for restraints to be added to transports, as well as for ideas on how to work with patients who have disabilities or use service dogs or sign language interpreters. Those particular projects will be coming forward in the next couple of weeks.

"This can work anywhere," Pesanka says. UPMC has everything from a 900-bed academic medical center to a 52-bed facility that still uses paper documentation and volunteer transporters rather than paid staff, and it works for all of them. "It's a scalable program."

Scholle says there were some departments that took longer to get it hard-wired into. Drivers had to call people out who hadn't completed part of their checklist, and staff members who had thought of themselves as delivery people had to reach deeper to become something more. "We were asking them to be accountable and to hold other people accountable. That was hard for some of them," she says.

But it works. Patients don't leave without their ticket. And after a year, conditions A and C dropped by 43% at pilot site. "I don't think we can get to zero," says Pesanka. "There will be clinical reasons why they will have an event off unit. But we tackled what we could impact."

The things going on at your hospital may be different, as may be the solutions. But the point is this: ask the staff. Ask them what's not working and how it might be fixed and then test the product out.

At Children's Hospital in Boston and eight other pediatric facilities, they have tested and validated a way to hand off patients that reduces harm by ensuring that more, and more accurate information gets transmitted between providers of whatever sort. The I-PASS program was first piloted at just a single hospital *(see article in the January 2014 issue of* HPR*)* before spreading out around the country for further testing and validation. The latest iteration was published this fall in the *New England Journal of Medicine*.[1]

While the I-PASS bundle has been tested only at pediatric facilities, lead author **Amy Starmer**, MD, MPH, of Children's Hospital in Boston, says it not only can be replicated in other kinds of facilities, it has. There have been inquiries from 48 states and 17 countries — thousands of requests for materials from the website, where anyone can make use of materials for free or request more in-depth consulting services related to the project (http://ipasshandoffstudy.com/).

The main element of the I-PASS bundle is a mnemonic device along with training modules. In the studies, there were reductions in preventable adverse events of 30%.

The anecdotal feedback she's getting from other hospitals that have tried it since the studies have been published is positive, although it's not instantaneous satisfaction. "It's not just a mnemonic you slap up on the wall and hope leads to change, though," Starmer says. "You do need to transform the culture of communication."

She says we are so ingrained in how we interact — whether we transport patients like cargo or are used to some kind of shorthand method of speaking to other doctors. But change can improve outcomes if you are willing to do the work. And the work? Well, it was a three-year process in the pilot she oversaw. It took the life cycle of residents to get the new mode of behavior through to the point that it was standard operating procedure.

"It's fantastic to know we can do something about the issue of hand-offs," she says. "There are probably some errors that don't relate to communication, but communication is an issue that cuts across every single aspect of medicine. It's not just about heart failure patients or just about orthopedic patients. It's potentially about every single patient."

Figuring out how to improve the way providers in and out of the hospital get information about the patients they care for is, thus, monumentally more important than figuring out how to help every single patient in any single disease state, according to Starmer.

I-PASS is going to roll out in 32 hospitals around the country in the next part of the study — half in pediatric facilities, half in other kinds of hospitals. Starmer and her peers are also looking at issues of standardizing communication with patients and family. That may require a different kind of ticket, or pass, but she says she's totally up for the ride.

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Top 10 tech hazards include new worries

Six new concerns have experts concerned

If you look at the previous iterations of ECRI Institute's top 10 tech hazards lists, you will see some items that seem to make the list every year. But this year, there are six new things added by the experts who were convened to go through event reports, to review the literature, and to share the results of their investigations in order to come up with a relevant list of technology-related items that people in healthcare need to worry may cause harm to patients in some way.

Alarm hazards, for instance, has been at the top of the list for four years, while data integrity went from number four to number two this year. Then there is recall and safety alert management, which made it to the list for the first time at number 10 — an issue of how organizations manage all the various equipment and machinery they have, and the potential recalls and alerts related to those machines and equipment that may come in during a given year.

Just think about all the machines you own in your home and car and whether you can keep track of the recalls and notices related to them, and imagine the problem keeping track of such things is for a hospital — and yet how vital it would be to know about a recall on a ventilator part or an alert about some vital piece of machinery in an NICU. "This item points to the potential to serious consequences for healthcare facilities and patients," says **Rob Schluth**, senior project officer in ECRI Institute's Health Devices Group. "Our experts are concerned that hospital tracking programs are not keeping pace with the growth in the number of medical device recalls issued each year." He notes that the FDA reported there were more than 1,100 such recalls for medical devices in 2012, more than double the number a decade earlier.

The 45-year-old consulting and research organization, which also serves as a PSO, involves staff from multiple areas, including engineering, risk management, and patient safety in the discussion to create the list. Schluth says the group doesn't consider what has been on the previous year's list or its ranking, although they understand that having the same list year after year would eventually lead to people paying less attention than if new things appeared now and again.

He went over the current list with *Hospital Peer Review* and talked about each entry.

• **Alarm hazards.** Inadequate alarm configuration policies and practices. ECRI Institute is aware of several deaths and other cases of severe patient harm that may have been prevented with more effective alarm policies and practices, he says. This is about more than alarm fatigue, which has been the subject of concern and discussion by The Joint Commission and other regulatory, professional and research bodies. Among the other things to worry about are whether alarms have been set to activate at appropriate levels — heart rate or blood pressure alarm limits, for instance — or making sure the volume of the alarm you set is appropriate.

• **Data integrity.** Fourth on the list last time the list was released, it bumps up two places this year, he says. The focus is on missing and incorrect data in electronic records and other systems. This is not simply misspellings of names or incorrect addresses. It could be as serious as test results, medication orders, or other data for one patient mistakenly appearing in the record for another patient.

• **Mix up of IV lines.** This is a new entry, Schluth says. "This is the first time we have included something outside the pump," he says, noting that this issue involves more than just the use of Luer connectors for different applications, which has been in the news. Rather, this is about having a patient with multiple IV lines and mixing up the tubing — connecting the tubing to the wrong medication bag, putting the tubing in the wrong infusion pump channel, or connecting the tubing to the wrong infusion site. Such errors could lead to infusing the wrong drug, or at the wrong rate, or in the wrong place or some combination. "This has always existed, but it hasn't gotten a lot of attention," he says. "It's really a low-tech issue, but it requires vigilance, and mistakes can and do happen."

There hasn't been a sudden spike in the number of such errors, he explains. "The purpose of the list isn't to give a mathematical accounting of problems and list them in rank order of their

occurrence," Schluth says. Certainly things that happen very often get the attention of the people who sit around the table hashing out the list. But what matters more is helping the people using the list drive positive change. "We want to promote safe patient care," and if the occurrences are rarer but still of concern, ECRI will make note and offer solutions and resources. "We look for issues where you can take the information and really make a difference. It may be an issue where it can be a fatal hazard, or a common hazard that is easily avoidable. Either way, we try to identify topics that will help make a positive difference. Each year we do it fresh, without regard to where something was on the list last time."

• **Inadequate reprocessing of endoscopes and surgical instruments.** According to the ECRI report, of the 13 immediate threat-to-life discoveries during Joint Commission surveys in 2013, seven related to inadequate sterilization or reprocessing of equipment. "Our accident and forensic investigation group gets something on this topic just about every year," Schluth says. "It isn't going away." Among the chief issues: an initial cleaning of items at the site of use. While it may be fine not to rinse your dishes before they go into the dishwasher, it's not okay to leave all the work to the autoclave.

• **Ventilator disconnections not caught because of mis-set or missed alarms.** While Schluth says this could have fit into the first item on the list as a subset of alarm errors, they opted to make it its own item. "We didn't want to dilute the issue," he says. "Alarm hazards are a National Patient Safety Goal, and we want to draw particular attention to them." Slicing and dicing the issue into smaller bits makes sense when there are so many ways mistakes can happen. Again, alarm volume, not setting alarm parameters correctly, or relying on factory default settings or other people's work rather than checking to make sure everything is set appropriately are common issues ECRI cites in the report.

• **Patient-handling device use errors and device failures.** This is another new entry to the list. It evolves from a study by the Occupational Safety and Health Administration (OSHA) that showed hospitals as one of the most dangerous places to work. Chief complaints among staff are musculoskeletal injuries that come from lifting and positioning patients, he says. "There are techniques and specifically created tools you can use to facilitate these kinds of movements — patient lifts, transfer boards — and using them is vital to avoiding injury to caregiver and patient alike," he says.

The item made the list because often the very things designed to make such work safer and easier are not used or not used properly, or may have mechanical parts that have weakened and need repair. "They may be unavailable, or broken or on another floor," Schluth says. "The ancillary issues around using those technologies are what we are concerned about."

• **Dose creep.** Unnoticed variations in diagnostic radiation exposures. As diagnostic radiology moves from film to digital, Schluth says, there are definite advantages. One is that digital plates have wider dynamic range. "You don't have to be as precise with settings to get a good quality image, and you worry less about over- or under-exposure except at the very far extremes," he says. That means there are fewer repeat scans. But hidden in that is that in adjusting the radiation dose to get a clear image, you are increasing settings to do so and the settings stay there, so that the next time someone comes in it is not reset to a lower level, but stays at that higher level. Over time, the dosage creeps up. That may not be a significant problem for one patient and one scan. But for a patient who has to have multiple scans over multiple weeks, it's an additional risk. If a dose doesn't have to be that high to get a clear image, it shouldn't be. "Tools are becoming available to deal with this — software and a standard for measuring exposure index. Healthcare facilities should be looking into incorporating these into their processes. This is a fixable problem. It won't kill someone, but why over-expose the patient if you don't have to?" he says.

• **Robotic surgery.** Complications due to insufficient training. This item was on the list last year, and the concerns remain the same, says Schluth, only a little more so as robotic surgery is more widespread now than it was before.

"How do you manage the use of this technology?" he asks. "This isn't like introducing a new surgical procedure to your hospital. How do you decide who participates? What training do they need, and how will credentialing be managed? How do you set up the OR? Where will people stand now that there is all this space taken up by machinery? How will the new physical environment impact their job? These are all things that have to be considered."

• **Cybersecurity.** Insufficient protections for medical devices and systems. Schluth notes that there are more and more devices connected to each other, to hospital networks, to servers. The risk of malware only increases. "You have to be vigilant, and it can be a real headache." The harm may not be physical — although you can't rule that out, either — but the complications of your systems being down and unavailable can be tremendous. And protecting patient data remains a significant issue, Schluth continues. There are reports in the media regularly about hospitals and other healthcare organizations that have had data stolen or have otherwise had patient information mishandled. It's not a place you want your hospital to be.

• **Overwhelmed recall and safety alert management programs.** Every facility has some form of alert management process, Schluth says, but a lot of them are old, and the volume of alerts has increased so dramatically that your program may not have evolved with the volume of alerts. "Whatever you were doing a decade ago may no longer be sufficient. A process that might have been treated as a routine clerical task really needs to be managed today as a robust patient safety initiative." For instance, what had been directed by clerical staff hoping to get people to pay attention to an email blast now has to be leadership-driven with buy-in from key players to make sure that everyone who uses a piece of equipment and who needs to know about an alert or recall knows. "Part of it is just knowing what devices you have in inventory," he says. "When you receive an alert or recall, you need to identify affected devices, locate and fix them if necessary, and document those fixes. It's a way of closing the loop. It can be difficult to do that effectively with an old-fashioned paper process."

Schluth says he hopes that hospitals will look through the list and the report and see what is relevant to their facilities. Maybe no hospital will need to worry about all of them, but no hospital will need to worry about none. "There are things our experts have tracked as deserving a place in the conversation," he says. "Prioritize which you need to tackle first. Start a conversation. We have information there for a starting point, some practical tips for preventing hazards and resources, as well."

The entire report can be found at www.ecri.org/2015hazards.

For more information contact Rob Schluth, Senior Project Director, Devices Group, ECRI. Plymouth Meeting, PA. Telephone: (610) 825-6000. ■

Breaking News: CMS surveyor worksheets revealed

The Centers for Medicare & Medicaid Services (CMS) finalized surveyor worksheets for quality assessment and performance improvement (QAPI), infection control, and discharge planning. They are used by surveyors to see whether organizations are complying with the Conditions of Participation. *Hospital Peer Review* will look at the worksheets in the next issue.

Meanwhile, you can find out more at the CMS website at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-15-12.html?DLPage=1&DLSort=2&DLSortDir=descending ■

COMING IN FUTURE MONTHS

- More on new CMS surveyor worksheets
- AHRQ report shows decline in preventable patient harm
- The market for quality improvement managers

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CNE QUESTIONS

1. **Seven of the Joint Commission's 2013 immediate threat to life findings during surveys related to what issue?**

   a. IV tubing connections
   b. Robotic surgery
   c. Equipment reprocessing errors
   d. Data integrity issues

2. **The first SBI project that Hill Country Memorial Hospital undertook related to:**

   a. ER wait times
   b. Pre-op teaching
   c. Early elective deliveries
   d. Patient satisfaction

3. **What measure set will Renown Regional Hospital begin reporting next year to The Joint Commission?**

   a. Sepsis
   b. VTE
   c. Perinatal care
   d. Children's asthma

4. **The I-PASS project has been tested at 9 children's hospitals. Next up, it will be tested at how many more children's hospitals?**

   a. 16
   b. 32
   c. 8
   d. 24

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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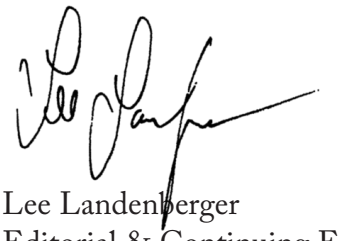

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