“Optimizing a Quality and Safety Program in a Community Hospital with Limited Resources”

Patient Safety and Healthcare Quality Improvement 2016
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Learning Objectives:
At the end of the session, participants will be able to:

• Identify 4 principles to align hospital quality projects with existing data sources to improve efficiency and impact.

• Identify resources and strategies for cross cutting patient safety and quality workgroups to ensure project success.

• Describe 3 strategies to utilize, reinforce and sustain safety reporting as a component of highly reliable patient care.
• 162 bed Community Teaching Hospital in Boston, Massachusetts
• Community Teaching Hospital of Brigham and Women’s Healthcare
• Member of the Partners Healthcare, Inc. Network
Challenges for a Community Hospital

Quality and Safety Mandates impact all hospitals

• CMS Quality Measures/Joint Commission Measures
• Joint Commission Hospital Standards burden
• Safety Reporting assessment and follow up
• Staff survey for Safety Culture, Staff Satisfaction
• Magnet Nursing criteria
• Infection Control reporting DPH, NHSN
• Mass Health, Boston Public Health Commission, DPH Opiate, Veteran mandates, Leapfrog, DMH
Opportunities for a Community Hospital

• Relative size can facilitate rapid tests of change

• Relative size can allow for implementing and sustaining culture shifts

• Training or Educational Challenges can be diminished

• Potential cross service or interdisciplinary work may be easier to facilitate
## The Work is the Same

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<th>Patient Safety</th>
<th>Infection Control</th>
<th>Nurse Sensitive Indicators</th>
<th>Value Based Purchasing</th>
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Safety and Quality Projects Cross Broad Patient Care Issues

Wake Up

ADE FTR Delirium Falls AS VTE VAE

Get Up

Falls PrU Delirium CAUTI VAE VTE Readmissions

Soap Up

CDI CAUTI SSI VAE CLABSI Sepsis

American Hospital Association
HRET
Partnership for Patients

BRIGHAM AND WOMEN’S Faulkner Hospital
Centered on the Care of the Patient and Family

- Does this initiative improve safety for patient and family?
- Does this initiative ensure the highest quality care for the patient and family?
- Does this initiative support the best possible patient experience?
  - Efficiency and cost as seen from patient viewpoint
- Will implementation support joy and meaning in work for staff?
4 Principles to align Quality Projects and Data Sources

1. Align Projects

2. Use new mandates as opportunities

3. Choose metrics you can manage

4. Use existing resources differently
#1 Align Projects when Possible

- **Look for Overlapping content in Different Projects**
  - Just Culture, AHRQ Safety Culture Survey, CRICO RAPP grant
    - Non punitive response to error
    - Follow up on reporting
  - Restraint Regulations
    - TJC/CMS/DPH/DMH reporting and standards

- **Find shared Process and Stakeholders for Same Issue: Avoid Silos**
  - CAUTI, CLABSI
    - Nurse Sensitive Indicators, Magnet - Nursing
    - Infection Control NHSN reporting - Infection Control
    - Leapfrog Managing Serious Errors (section 7) - Patient Safety
    - Hospital Quality (HAC and PSI 90) - Hospital Quality
  - Patient Violence/OSHA/DPH
    - Data Bases for Security, Occupational Health, Safety Reporting
    - Patient Safety, Risk Management, Occ Health, Security
# 2 Use New Mandates as Opportunities

- **Identify Institutional Priorities**
  - Does the Project connect to stated Hospital Strategic Plan or Goals?
    - Connection to the Organization’s Annual Priorities will ensure Senior Leadership support
    - Improved Staff Acceptance improves Change Management process

- **Utilize Regulatory and Emerging Issues**
  - Opiate Addiction Epidemic
    - DPH Regulatory Requirements/Pain Management/ Staff Safety/ Diversion
  - Antibiotic Stewardship
    - CMS/TJC/CDC Regulatory, Leapfrog reporting, Sepsis, Readmission
  - Zika and Ebola
    - Emergency Management, Infection Control

- **Identify Quality and Safety Elements within Changes**
  - Electronic Health Record (Epic) implementation
    - Patient Safety Risk, Compliant Documentation (CMS, TJC, DPH), Quality Data capture
Choose Metrics you can manage

1. Involve Quality Stakeholders and Data Experts at the start of the project
   - Time to EKG improvement Project
     - Baseline data gap
   - Decreasing falls for Addiction Recovery patients
     - Multi-variant analysis
     - Research Study or Improvement Project

2. Understand the constraints of the Data Source
   - Epic Workbench Reports
     - Desktop application designed for current patient review
     - Time frame constraints, no ability to recapture missing data
   - UHC, NSQIP, NHSN
     - Data reported by Quarters vs. Month; by Unit or Hospital
     - Data fields prescribed and definitions prescribed
     » Enhanced Recovery After Surgery: Colorectal

3. UseExisting Databases and when possible, ones you can modify
   - Patient Safety Reporting Database
   - Infection Control Database
#4 Use Existing Resources Differently

- Find Untapped Talent and Bandwidth
  - Student Interns
    - Delta Beckwith database and Quality Intern analysis for Safety Committee
  - Student Nurses
    - Literature Review: Falls Risk Assessment Psychiatry
    - Surveillance Survey Skin

- Build on Best Practice Literature and Strategies
  - Not everything requires original research
  - Hospital Engagement Network (HEN 2.0)
Hospital Engagement Network 2.0

About

Adverse Drug Event (ADE)  
Airway Safety  
Catheter-Associated Urinary Tract Infection (CAUTI)  
Central Line-Associated Bloodstream Infection (CLABSI)  
Clostridium difficile Infection (CDI)  
Culture of Safety  
Early Elective Delivery (EED)  
Failure to Rescue  
Health Care Disparities  
Iatrogenic Delirium  
Injuries from Falls and Immobility  
Obstetrical Adverse Event  
Patient & Family Engagement  
Pressure Ulcers  
Radiation Exposure  
Readmissions  
Sepsis  
Surgical Site Infection (SSI)  
Venous Thromboembolism (VTE)  
Ventilator-Associated Event (VAE)

Topics

Search...

Resources

Upcoming Events

Engage

Data Base

The Model for organizations that integrates it into their daily operations. The framework is designed to ensure everyone on the team can see the real-time impact of their actions.

What are we doing to reduce hospital-acquired conditions (HACs)?

Hospital-acquired conditions (HACs) are infections and injuries that patients acquire while in the hospital. They can be preventable and their prevention is the first step towards reducing hospital-acquired conditions.

How will this benefit our hospital?

Hospitals are working to improve patient care and reduce hospital-acquired conditions. The Data Base provides a tool for improving patient care in different areas.

What changes can we make that will result in improvement?

Sustainable improvement may require developing a new system of communication or modifying a clinical workflow. The change packages, checklists, and resources available through this website can provide change ideas that may be effective in your organization. We also encourage you to share challenges and effective practices with your peers through the LISTSERVs, fellowships and during educational events. As a participating HEN 2.0 hospital, you are part of a broad network of people working to reduce inpatient harm and your colleagues across the country can speak to some of their experiences.

Track Your Data in the CDS  
Download the EOM  
Access Additional Process Improvement Resources
Resources

- [http://www.hret-hen.org](http://www.hret-hen.org)
- [https://www.jointcommission.org/leading_practice_library](https://www.jointcommission.org/leading_practice_library)
- Professional practice groups
- Intentional use of Conferences
- Leverage relationships into working groups
  - Partners Clinical Compliance Leaders: Mock TJC survey
  - rL Solutions Boston Users Group (BUG)
**Total Harms per 1,000 Discharges**

- **Most Recent Month Harms/Discharge (% Improvement)**
  - Most Recent Month: Jun-16
  - Number of Harms Prevented to Date*: 146
  - Cost Savings to Date: $1,294,336
  - (Based on average $NA cost per HAB)

- **Estimated Number of Harms to Prevent in Order to be at Goal Rate by Next Month**: 0

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**Total Harm per 1,000 Discharges**

- **Baseline**
- **Goal**
- **Brigham and Women's Faulkner Hospital**

![Graph showing harm per 1,000 discharges from Oct-15 to Oct-16](chart.png)
# Community Hospital Elements for Success

## What Hospital Needs

- Senior Leadership Support
- Working Relationships between and across disciplines, service lines, programs and departments
- Front line staff involvement and engagement in any of the projects or initiatives

## What Quality/Safety Can Do

- Create Partnerships with external resources to support the teams
- Enter at the start of projects
- Recruit and retain smart young people at the beginning of their careers
- Support and intentionally create space for learning
Example: Highly Reliable Patient Care through Safety Reporting

1. Align: Implement EHR, Use AHRQ Safety Culture Survey, Implement Just Culture

2. Use Mandates as Opportunities:
   – Mandate A: Monitor patient safety during new EHR implementation
   – Mandate B: Find strategies to address AHRQ Survey results
   – Mandate C: Implement Just Culture constructs to respond to AHRQ Survey

3. Use Metrics you can Manage
   – Patient Safety data touches on all aspects of highly reliable care: high quality, safe, patient centered
   – Built in platform for change, potential Champions
   – Existing data collection process already exists

4. Use Existing Resources Differently
   – Feedback loop to reporters
   – Creating vehicles to inform staff of impact of reporting
   – Evidence of use of reported material to impact patient care and safety
Hospital Wide Feedback Project

Last Week in Patient Safety!

- Newsletter
  - Debut 4/6/15
  - Weekly document sent by email to Department Leaders group, Chiefs, Senior Leadership
- Leaders send to staff
- Highlights “Good Catch” events and storytelling
- Provides area specific data on reporting
- Content allows for printing and posting for all staff
- Provides talking points
Feedback to Reporter

Would you like follow-up on this report?

Yes
No

Was follow-up given? (Patient Safety Use Only)
No

Follow-up Details (Patient Safety Use Only)
pending

July 13, 2015 Feedback Question was implemented

Month
July 15'  75
August    71
September 87
October   97
November 102
December 112
January 16' 117
February  82
March     113
April     83
May       98
June      85
July      71

Count
Creating a field in the Resolution section that is visible to Leaders who review/close. Drop down allows Patient Safety team ability to tag reports as related to Electronic Health Record and/or new workflow. Field then pulls to report for trending.
A daily report was created to assist Leadership in overview of all safety events that were related to EHR or new workflows.

### Brigham and Women’s Faulkner Hospital

#### Epic Related Safety Reports

(Report Date is within Calendar 2016) and ((File Status is not equal to "Incomplete") and (File Status is not equal to "Deleted") and (File Status is not equal to "Deleted-Inc") and (Did Epic or new workflows factor into this event is equal to "Yes") and (Facility is equal to "FH")

<table>
<thead>
<tr>
<th>File ID</th>
<th>Event Date</th>
<th>Location Where Event Occurred</th>
<th>General Event Type</th>
<th>Specific Event Type</th>
<th>Severity Level (Reported)</th>
<th>Brief Factual Description</th>
<th>Resolution Comment</th>
</tr>
</thead>
</table>
| 25696   | 01-01-2016 | 6 North                        | Healthcare IT      | System - ECare / EPIC | 1-No Harm – did reach patient | 60 year old patient discharged home on 1/1/16. Patient has a discharge order. Unable to print AVS because discharge readmit order needed to be reconciled. The order was notified and tried reconciling the order and help desk was called and notified. Patient ended up leaving without any papers but fortunately she knew about her medications and follow up appointments. Tried printing the discharge summary and gave it to patient. The problem was fixed somehow after the patient had already left. | 1/5/16 Note: no other pattern of similar problems with printing known. Likely build related reconciliation issue and user error contributing factors. C. Barney
01/07/2016 As noted, issue resolved after patient discharged. Will follow-up with patient by phone to extend apology (01/07/2016 SSE). |
What Happened?

Increased Reporting
- 25% increase in safety reporting starting at Go-live and sustained safety reporting engagement from front line staff
- 75% of reports are “near miss”

Increased Collaboration
- Hospital leaders use safety reporting to work on identified issues using actual data from incidents rather than anecdote
- Real time review of 100% of reports

Improved Process
- Patient Safety Site Lead integration into Leadership Report outs allows for tracking and responding bi-directionally
- Rapid identification and correction of Patient Safety gaps
Six Months of Safety Reports by Location

March 2016 – August 2016

1,331 safety events
Near miss rate: 73%
Safety Event Volume

Last Week in Patient Safety Implemented

Epic Implemented

Feedback to Reporter Implemented

Month

Count

Epic Related Events

Non-Epic Related Events

January: 159
February: 162
March: 185
April: 186
May: 167
June: 109
July: 154
August: 106
September: 136
October: 183
November: 167
December: 211
January '16: 200
February: 216
March: 175
April: 169
May: 191
June: 221
July: 199
August: 223
Opportunity Summary

• Seize the moment of a big system change to harness the energy of staff regarding reporting

• Build reporting system to address issues that staff are reporting

• Implement systems that publicize, value and celebrate reporting including “good catch” events

• Establish trust and confidence that there is a closed loop process for safety event reporting

• Maintain increased reporting while building Just Culture constructs
Sustained Improvement Wheel

**Align Projects #1**
- AHRQ Safety Culture Survey
- Just Culture

**Improved Outcomes #5**
- Patient safety reporting drives new projects & reinforces current projects, provides better data for new work

**Use Mandates as Opportunities #2**
- EHR implementation
- Safety risks (ECRI) of new EHR

**Use Metrics you can Manage #3**
- Modifying the Safety Reporting System
- Feedback to reporter
- Trended data reports

**Use Existing Resources #4**
- HEN/BUG Collaborations
- Patient Safety Newsletter

**Improved Patient Care Safety and Quality**
Questions?
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