Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

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JUNE 2008

VOL. 15, NO. 6 • (pages 49-60)

Wrong-site surgery: We're not doing all that we can

Dramatic wrong organ error shows there is still much work to be done

The error was as dramatic as it was unimaginable: Surgeons at Methodist Hospital in St. Louis Park, MN, recently removed the wrong kidney from a patient with kidney cancer. Hospital officials in local media interviews called it a "tragic medical error," and few would disagree, but it was also a dramatic reminder for quality and patient safety professionals that preventing wrong-site surgeries remains a major challenge.

Of particular interest was the fact that the local media reported the original error occurred in the charting. Still, say patient safety experts, in an error such as this the blame cannot be placed on a single process.

"I am highly skeptical of the concept that this was 'just a charting error,'" says **Leah Binder**, MA, MGA, CEO of The Leapfrog Group. "An error of this magnitude requires several errors, and several [missed] checks and balances. While the odds are unlikely they will find 12 different points where this could have been caught and they missed them all, there is no way you could say it was one error."

Peter Angood, MD, vice president and chief patient safety officer for The Joint Commission, agrees. "The [Joint Commission's] universal protocol [for preventing wrong-site, wrong-procedure,

Key Points

- Adverse events are rarely due to any single error, but rather to a series of errors.
- Patient involvement is a critical component in efforts to minimize wrong site, wrong side surgeries.
- Do not assume you have been given correct information; double check it every step of the way.

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wrong-person surgery] has three steps; everyone focuses on the last two, but the first is the pre-operative verification process," he notes. "This should begin as soon as the patient is booked and repeated every time the patient goes through pre-operative procedures to verify the correct site, the correct patient, the correct side."

Although the universal protocol has been in place for several years, Angood notes, "the number of reported wrong-site events remains higher than we would want." In fact, he adds, Minnesota has a mandated state reporting system in place, and in its experience about half of the reported "never" events are wrong-site surgery and/or retention of foreign bodies. "They follow the universal protocol, but even with that, errors persist," he says.

Both the verification process and the timeout process (step three, occurring immediately before the surgery) state that all relevant medical records, images, and equipment should be checked and assessed prior to starting the procedure, Angood continues. "The universal protocol is designed to stop these errors from happening and [detecting] failure at some point or several points," he observes. (The universal protocol will be undergoing some significant changes soon. See story, pg. 51.)

"In such breakdowns human error is the one given — you will have it," adds Binder. "Several stages must be checked before the patient goes into surgery, and you have to build that in [to your processes] and enforce the protocol, which is extraordinarily difficult to do. Anyone who thinks it is easy has never worked in a hospital."

Begin with the physician

Hospitals with in-depth processes designed to prevent such errors begin as early in the care process as they can. "Our process starts with the physician's office — with the surgeon booking the procedure," says **Allynn Petersen**, MS, RN, CNOR, administrative director, surgical services at William Beaumont Hospital in Royal Oak, MI. "We are mainly a private practice academic institution, and when the surgeon books the case in our scheduling office, we have no other alternative but to assume they are boarding the correct patient."

However, she adds, one of the checks her facility has put in place is to add pre-screening nurses who actually confirm the site — including laterality — and the procedure with the patient. "That is done sometimes up to two weeks ahead of the surgery," she says. "And we have caught some laterality issues with that process."

Once the error is caught, the anesthesiologist and surgeon are notified and the operation is rescheduled.

Involvement of the patient is an important part of the universal protocol. In fact, The Joint Commission has enumerated a list of implementation expectations for the protocol, and in the pre-operative verification process those expectations include verification of the correct person, procedure and site:

- "With the patient involved, awake and aware, if possible;"
- "Before the patient leaves the preoperative area or enters the procedure/surgical room."

Healthcare Benchmarks and Quality Improvement (ISSN# 1541-1052) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304 and at additional mailing offices. USPS# 0012-967. POSTMASTER: Send address changes to **Healthcare Benchmarks and Quality Improvement**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcmedia.com. Hours of operation: 8:30-6 Monday-Thursday, 8:30-4:30 Friday, EST.

Subscription rates: U.S.A., one year (12 issues), $549. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $92 each. (GST registration number R128870672.)

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Editorial Questions

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• "From the time of admission to when the patient is examined by a nurse, and the anesthesiologist, there needs to be reinforcement of what the procedure point is to be and where the problem is," notes Binder. "Surgeons should be examining and re-examining the imaging and the diagnosis over and over, like a military drill. You need to read the chart and really, really confirm with the nurse and/or the anesthesiologist every aspect — you have to follow certain protocols to make sure you have done what is required to prevent never events."

However, says Petersen, things are not always so cut and dried. "Many of our physicians also bring their charts from the office, especially when they have more than one patient that day, and they have that as a resource," she says. "If there are X-rays from radiology, they do have to have them available, but not all procedures require them." For example, she points out, "we use them in reference to spinal surgery for location, like which disc you are removing." In terms of a kidney removal, she adds, "I don't know that they would."

"The surgeon should read the chart and the imaging — actually look at it," Binder counters. "If there are any questions, they should ask — and the same with the nurses and others on the team; there are many stages at which this could have been caught."

In order to do this, she adds, you need a healthy environment of communications. "It has got to be acceptable for the nurse to blow the whistle and say, 'This can't be right,'" says Binder. "You must create an environment where mistakes can be addressed and prevented."

Still, says Petersen, "Once it was scheduled I can see where they had a difficult time stopping this. To me, this almost started way back when — they could have told the patient the wrong side, or had a mistaken reading of an X-ray, which led to the 'charting error.'"

Even though it is possible for a patient to be given bad information, Petersen says, "I do like our piece of verification with the patient — that's always a good one."

She also notes that under the universal protocol, the surgeon would have to mark the site the patient agreed on. "We involve the patient and review what's on the schedule with [the] consent [form]," she says. "If they all agree it is the left kidney and the doc agrees, you're kind of done." Nonetheless, she concedes, it's still possible that all that might have taken place in this case. "That is kind of scary," she shares.

Universal protocol to become more 'prescriptive'

The Joint Commission will soon be releasing a revised version of the universal protocol, reports **Peter Angood**, MD, vice president and chief patient safety officer for The Joint Commission. "Last year we had a follow-up summit to discuss the universal protocol," he shares. "We revised it, and we are just in the final stages of the approval process; we will be releasing it later this spring."

As with many of The Joint Commission guidelines and standards, the current version of the universal protocol avoids being too prescriptive. For example, when it comes to the pre-operative verification process, it states as follows:

"An ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the preoperative preparation of the patient, up to and including the 'time out' just before the start of the procedure."

"The three main steps — verification of the procedure, marking the site, and the time out — are still the essence of the protocol," says Angood. "But each will have more detail and are a little more prescriptive, so for example they will have steps the providers should be following in each of these components."

The Joint Commission is aware of the need to maintain a certain balance, he continues. "We want organizations to take steps on their own accord without our being too prescriptive, but we had 60 different organizations and societies [providing feedback] and everyone agreed we needed to be more prescriptive," Angood notes.

Set the right tone

Binder says that to minimize errors such as these "we have to make safety that No. 1 priority — and to do that, it needs to be on the CEO's list of No. 1 priorities. (To learn more about garnering CEO support, see our article about "getting boards on board" on pg. 54.)

"Then, when you have done that, you have to look at your systems and put in place those processes and systems that will check against human errors." Leapfrog's own survey, she adds,

"helps hospitals check on their own safety practices."

Targeted collaborative initiatives are also important, says Petersen. "For example, we are currently involved in the Keystone OR project," she notes, which involves the Michigan Hospital Association and Johns Hopkins. "In that program, we have a briefing and debriefing process, where the team members participate in identification of the patient, adding anything else that might pertain to that patient such as whether it might be a particularly difficult procedure, whether certain instrumentation is available, or how much blood we have," she notes.

Binder offers this final word of caution. "Something that is written on a chart is not the final word on diagnosis," she says. "Even if the radiologist wrote a diagnosis on the chart, it is helpful for others to look at the imaging. So, for example, if the chart says left kidney but the X-rays seem to show it is the right one, somebody should speak up and say that doesn't look right. You should have in place as many ways to check these things as possible, and team members should be held to the highest level of accountability."

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Christiana slashes sepsis mortality rate

Performance earns system the Codman Award

In a campaign that earned it the prestigious Ernest Amory Codman Award from The Joint Commission, Christiana Care Health Services of Wilmington, DE, reduced the mortality rate for patients with severe sepsis from 61.7% to 30.2% by addressing three major areas of sepsis care: identification of patients with sepsis, resuscitation strategies, and ICU management.

This 49.4% decrease in mortality rates was accompanied by a 34% decrease in average length of stay; a 188.2% increase in the proportion of patients discharged to home; and increases in patients receiving antibiotic therapy within the first hour before or after issuance of a Sepsis Alert and decreased average time from emergency department triage to first antibiotic administration.

Christiana's "Sepsis Alert" program, grounded in the concept of collaboration between all health team members, used as one of its primary tools a Sepsis Alert packet, which included:

- a care management guideline;
- a treatment algorithm;
- an ED treatment order set;
- kits with single-dose vials of antibiotics;
- multidisciplinary education about sepsis and the importance of prompt, aggressive management.

Among the key strategies were:

- early and appropriate antibiotic administration;
- rapid fluid resuscitation;
- early central venous catheter placement;
- vasopressor administration;
- venous oxygen saturation measurement and analysis;
- assessment for activated protein C administration.

The program is described in detail in an article in the April 2008 issue of *The Joint Commission Journal on Quality and Safety*.[1]

Campaign is trigger point

"For years I had been concerned about the inconsistent resuscitation of patients with shock," recalls **Marc T. Zubrow**, MD, FACP, FCCP, FCCM, director of critical medicine for the Christiana system and medical director of e-care and lead author of the article.

Shock patients, he explains, fall into several categories. "Trauma patients have protocols, cardiac patients go to the catheterization lab, but in sepsis and other types of shock, it was very difficult to organize physicians into systematic treatment," he notes.

This all changed in 2004 when the nationwide

Key Points

- Special packet for staff members includes treatment algorithm, care management guidelines, and ED treatment order set.
- Strategies stress proper antibiotic administration, rapid fluid resuscitation, and early central venous catheter placement.
- Rapid response teams become vectors to administer treatment outside the ED.

Surviving Sepsis Campaign (http://www.survivingsepsis.org) was launched, says Zubrow. "We started talking about [the campaign] and sepsis resuscitation and everyone was onboard," he recalls. "We brought our concept to senior management and by February 2005 they told us to go ahead."

Although Christiana adopted the Surviving Sepsis guidelines, "What we did uniquely is that we made it institution-wide," says Zubrow. "In most other places they just did it in the ED, which is a smaller area with a defined doctor and nurse population. We have two hospitals and 1,100 beds."

Spreading the message

In order to accomplish system-wide change, Zubrow explains, "we had to develop a way to get the protocol to the floor patients and different nursing vectors; it was a huge organizational challenge."

To do this, Zubrow brought all the key "players" to the table: intensivists from medicine and surgery; critical care nursing; ED physicians and nurses; the pharmacy department; and respiratory therapy.

"There was also a subset of people, because we have rapid response teams, and they became our vectors to administer the treatment outside the ED," Zubrow notes.

The nurses were "not only on board, but enthusiastic," says Zubrow, while not surprisingly, the physicians presented the greatest challenge. "You have to be careful of taking away the doctor's ability to individualize his patient treatment," Zubrow explains.

Whenever a physician expressed reluctance, Zubrow would meet with them one-on-one and ask what he could do to convince them to fully participate in the program.

"We also conducted a huge PR effort, with videos, talks to all the different [stakeholder] groups, and going on the rounds of every department to bring them up to speed on the problem and why we had to make those changes," says Zubrow. "Once they were on board and could see good results, there was no problem because everyone loves to be a winner. We now have so much momentum that there is institutional buy-in everywhere; it's spectacular, and very gratifying."

Tips for quality managers

His experiences with this initiative have provided some valuable lessons for quality managers, says Zubrow. "No. 1, you have to engage all the players and make sure they understand why you are doing this," he says. "Then, recognize that nobody believes in not doing their best, so you have to give them the tools to succeed — education, simplification of the treatment process, and so on."

To motivate your physicians, he says, you must show them, for example, that if they follow the protocol for every patient, that those patients will get their antibiotics faster and receive better care. "Trauma people talk about the 'golden hour' of trauma," Zubrow notes. "I talk to them about the golden hour of shock — you have one hour to be a hero."

In addition, he advises, "you need to do lots of education and you need to do it repetitively. We found that if you do not regularly put out a new bulletin or poster then the program starts fading from radar screens."

Finally, Zubrow recommends, "Track your data to make sure the times are going where they need to go."

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How do you get your board on board?

IHI leaders shares secrets

How do you engage the top leadership of your facility in the pursuit of quality improvement? This has been one of the greatest challenges for quality professionals and is now a key objective of the Institute for Healthcare Improvement's (IHI) "5 Million Lives" campaign.

In a recent article in *The Joint Commission Journal on Quality and Patient Safety*[1] the IHI's **James Conway**, MS, who honchos the 5 Million Lives initiative, shared some of the key learnings from the campaign.

HBQI posed the following question to Conway: If your hospital is currently not participating in 5 Million Lives and your board is not "on board," what can the quality manager do to help get them on board?

"I think the first thing is to show them the evidence," says Conway. "[Recently] the *Journal of Healthcare Management*, which is read by a lot of health care executives, hit my desk. There is an article 'Board engagement and quality,' which reports on the findings of a survey of hospital and health system leaders. It found that 60% of hospitals have a board quality committee, and in those facilities that do, the outcomes are better."

There is research going back to the 90s, he continues, that shows hospitals where there is engagement of governance and executive leadership have better outcomes, he adds.

Another key issue, he says, is what the IHI calls "will-building." "A lot of times boards don't understand about the harms, the tragedies, and the waste that occur in their facilities, and in the absence of them knowing that it's hard for them to be engaged," he points out. "If we want people to take the time to address critical issues they need to understand there are critical issues in quality and safety."

When working with boards, Conway says he regularly asks them how often patients are seriously harmed or die uneccessarily in their organization. "And it's a rare board that knows the answer to my question," he says. "If they do not know the current reality, how can they be engaged?"

The board, he emphasizes, has the ability to set the hospital's vision. "In 'The Fifth Disclipline,' probably one of the best books on how to lead change, author Peter Senge said that you have to have a great goal or vision, but you also have to confront the realities of practice. If you put vision and reality together it will create tension — and you can use that tension to drive change."

In the past, he notes, health care professionals were trained that a good presentation was one that did not make anyone axious. "What we need to do is be much more balanced in the reports that managers give to boards," he emphasizes. "You have to talk about failures in care in ways that boards can understand. — and often we haven't done that."

Board members, he notes, are people who long ago realized the power of quality and safety in their own businesses, but have not thought of the valuable role they can play in health care. "We must tell stories about our work in a way they can understand and apply their learning to our particular challenges," Conway says.

Key Points

- Show your board members the evidence — that means, the bad news as well as the good.
- Select the appropriate 'storytellers' to go before the board; real-life examples will make a stronger impression.
- Make sure the board understands the 'big picture' in terms of organizational quality and safety performance.

What boards should do

In order for board engagement to have optimal results, there are six things boards should do, Conway writes in his article:

• **Set aims:** Conway notes, for example, that Israel Beth Deaconness in Boston set a goal of eliminating preventable harm by 2012. "You've got to engage the board in setting strategic goals, as oposed to bogging them down in details," he advises. "For example, eliminating bloodstream infections is not a strategic goal, but eliminating preventable infections is because it is at a whole system level rather than a specific intervention."

• **Get data and hear stories:** Reiterating his previous point, Conway notes that data must be presented in a way that the board understands what is going on. "Often when we present data to people we talk about things with a bit of spin, as opposed to presenting the realites of what works

and what does not," he says. "Certainly we want to tell about the good things and celebrate exceptional care, but we also want to make sure the board understands the operations fully." Another valuable strategy, he says, is telling stories. "One thing a quality manager can be very helpful in is identifying the stories that would be very helpful for the board to hear — having a particular patient or staff member tell of a tragedy," he notes. "Nothing captures the attention of a board member like hearing a story around harm. Also, give them good data that allow them to understand harm."

• **Establish and monitor system-level measures:** One of the things a quality manager should be doing is sharing how the hospital is doing in the area of mortality and overall harm, compared to what is expected, Conway notes. "You shouldn't get lost in the weeds, but let the board understand how well you are doing as an organization," Conway advises. "Boards can tell me, for example, how well their facility is doing in medical errors in oncology, but not in overall medical errors."

• **Change the environment, policies, and culture:** "Other industries have learned that when someone tells of an error they don't always assume it was the fault of a bad person, and that attitude is determined largely based on what you think is important," says Conway. "With respect to boards, I have done research that shows an extraordinary gap between how the board thinks things are going and how the frontline thinks things are going. You have to establish a culture that allows what middle management loses sleep over to become understood by the board."

• **Learn:** "Middle managers can play an extraordinary role as teachers of curriculum — they can bring a much richer and more reality-based view," says Conway. "Also, the frontline people are proud of their staff and have so many wonderful stories to tell, which allows the board to connect with the passion of the organization."

• **Establish executive accountability:** Increasingly, the compensation of boards is heavily incented by quality and safety outcomes, and that is moving to a greater degree into middle management, notes Conway. In other words, there is a growing relationship between compensation and bonuses and results compared to overarching goals. "At a very practical level, if I set my annual goals and do not engage middle management there is no way we will ever achieve those goals," He asserts.

Additional advice and tools for quality managers can be found on the IHI web site (www.ihi.org), says Conway. "Specfically, there is a how-to guide for the 5 Million Lives 'board onboard' intervention, which includes a campaign and materials," he notes. "There is a lot of important information there for quality managers."

More specifically, he adds, "The top question we get from quality and risk managers across the country is, 'How do I do dashboards?' and they will find some very nice examples there from our organization."

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Reference

1. Conway J. Getting boards on board: engaging governing boards in quality and safety *Jt Comm J Qual Patient Saf* 2008;34:214-220. ■

SHEA estimates preventable HAIs

Message is undeniable

In the absence of any meaningful literature that identify the number of preventable hospital-associated infections (HAIs) that occur in the Untied States, the Society for Healthcare Epidemiology of America (SHEA) was asked by Congress's Committee on Oversight and Government Reform to provide such an estimate. In a just released report, SHEA concludes that there are as many as 23,000-64,000 preventable deaths from HAIs every year.

The results were further broken down as follows:

• Bloodstream infections: 18%-82% of infections may be preventable, translating into 5,520-25,145 preventable deaths each year;

• Ventilator-associated pneumonia: 38%-71% of infections may be preventable, translating into 13,667-25,537 preventable deaths each year;

• Urinary tract infections: 17%-69% of infec-

tions may be preventable, translating into 2,225-9,031 preventable deaths each year;

• Surgical site infections: 28%-54% of infections may be preventable, translating into 2,133-4,431 preventable deaths each year.

"We were asked to try to come up with an estimate of the deaths associated with HAIs that are preventable," notes **Patrick J. Brennan**, MD, president of SHEA, and one of the study's authors. "There is no study that directly answers this in a meaningful way so we pulled from studies related to interventions in the four major HAIs."

The best information available, he notes, involved a study by the Agency for Healthcare Research and Quality (AHRQ), published in 2007, related to the prevention of HAIs, and a 2002 paper by the Centers for Disease Control and Prevention (CDC) that estimated the annual incidence of mortality from HAIs.

The researchers at the Center for Evidence-based Practice (CEP) at the University of Pennsylvania Health System, with which SHEA collaborated, noted that the CDC's data suggest there were 1.74 million HAIs and 99,000 estimated deaths. Two-thirds of these deaths were related to bloodstream infections and ventilator-associated pneumonia.

Next, they used the AHRQ report to estimate the fraction of HAIs that could be prevented. Third, the national survey and AHRQ data were combined to calculate the number of preventable HAIs and deaths each year.

"We took the HAI reductions observed in various studies and from there arrived at an estimate range," says Brennan.

Limitations noted

In the paper, Brennan and his co-authors note the limitations of their research. "It's important to take a look at the limitations of this method," he emphasizes. "There is considerable uncertainty because the components stem from estimates in low-quality studies."

Nevertheless, he continues, "I think it's fair to say there is a significant burden of death and disease related to HAIs that can be prevented. The exact magnitude is difficult to estimate, but we tried to do that."

There does exist a good deal of evidence for ways to reduce HAIs, he continues. "We know, for example, that that timing of antibiotic administration could be improved upon, and that is an evidence-based practice to prevent surgical site infection," Brennan shares. "We also know that a number of processes, when bundled together, can reduce bloodstream infections and ventilator-associated pneumonia. In addition, a key for preventing urinary tract infections is removal of the catheter — which is sometimes easier said than done, however."

Nonetheless, he concludes, "to the extent that major risk factors can be eliminated, the incidence of HAIs ought to be reducible "

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Key Points

- Perhaps as many as 82% of deaths from bloodstream infections could be prevented, according to SHEA study.
- Compliance with timing of antibiotic administration to prevent surgical site infection is cited as needing improvement.
- Removal of the catheter to prevent urinary tract infections is 'sometimes easier said than done,' says expert.

New care model transforms facility

'Collaborative care' decreases LOS

ThedaCare's Appleton (WI) Medical Center has cut its average length of stay by 20% and improved quality, safety, and patient satisfaction by transforming the way it provides care. This new approach, which it calls "Collaborative Care," has been piloted in the hospital's redesigned general medicine unit since February 2007. Based on the program's success, ThedaCare plans to begin rolling it out to other facilities.

The model was created internally, "from the vision of our nursing leaders," says **Mary Beth Heatherington**, RN, CSN, chief nursing officer. "We started to hear from our physicians that we didn't have continuity in communications. We

were working in silos — which we realized was no different than what was happening across the country — and decided we had to find a better way."

Reports from the Institute of Medicine about errors and health care costs, as well as a system-wide move toward Lean methodology, informed the changes, she continues. "Lean tools and processes were used as a framework to develop the model," she explains.

The experimental unit is the hospitalist unit, Heatherington continues. "Their goal is to provide more leadership, and this is perfect because they are here '24/7,'" she says. "We had to involve them in the whole building process, so we had two of the group as primary builders of the model — so others would see they were on board."

The model, she continues, was developed by frontline clinicians. "It started with value stream mapping [value stream mapping is a Lean technique used to analyse the flow of materials and information currently required to bring a product or service to a consumer] then three vertical value streams, followed by seven rapid improvement events," says Heatherington.

"Our cornerstone goals were to increase quality of care while providing that care at a lower cost," adds **Shana Herzfeldt**, RN, BSN, supervisor of medical services for the unit. "We redefined the nursing role: Our RNs act more as case managers; we look more closely at patient stay and how we can progress our patients rather than being tied to bedside tasks." In order to accomplish that, she notes, LPNs now do more task-oriented activities such as passing meds and changing dressings. "Clinical nurse specialists are really doing personal care for the patient," she says.

"The RN actually becomes a coordinator of care," adds Heatherington. "When the patient is admitted they meet with the pharmacist and the physician, to create a 'problem' list and a plan of care together."

Key Points

- Nursing role is redefined; RNs now act more as case managers, with LPNs handling task-oriented activities.
- Central nurses' station removed; alcoves created for atmosphere conducive to communication and collaboration.
- Lean tool used to establish improvement targets and realize a reduction in errors.

Collaborative rounding is added

This collaborative process extends to rounding. "It is now a coordinated bedside care conference," says Herzfeldt. "We meet outside the patient's room, and discuss the plan.

"Something else that is unique about this process is that we used one of our Lean tools — the Jidoka framework — which is a method for preventing errors," says Heatherington. "It requires the nurse and physician to stop and ask if everything that was ordered has been ordered, and if not, find out why. It also identifies the highest 'hitters' to target for improvement." Heatherington says that as a result of this framework, "we have had a reduction in errors."

Getting the rest of the staff on board with this new model "took a good six months," says Herzfeldt. "We had six weeks of off-site orientation for this unit because it was a first," she says. "The staff were chosen through an interview process, knowing they needed to be flexible because of what their roles would entail."

Focus was both on the process and the computer system, she notes, since an electronic medical record is now being used. "This way, all the caregivers can see every document on every care plan, rather than seeing care in silos," she explains, adding that physicians went through computer training as well.

Physical design different

The actual physical layout of the unit was changed as well, notes Herzfeldt. "We focused on three things — process, people, and physical environment," she explains. "On the physical side, we asserted that the less a nurse has to remember, the more efficient she will be."

Accordingly, the unit has a more open concept, with no centralized nurse station, but rather alcoves that encourage collaboration. "The unit also has nurse servers, which contain 90% of what nurses need as far as meds and supplies at the bedside — including linens, so they don't have to leave the room to go to central supply," says Herzfeldt.

Each room has ceiling lifts to prevent back injury, walkers, IVs, dyna-maps to do vitals, and computers, so documentation can be done real-time. "Every room has a bathroom with a shower,

and the special flooring does not get slippery when it gets wet, so that helps prevent falls," says Herzfeldt, adding that all beds have a built-in alarm system that indicates when the patient gets out of bed — another fall prevention strategy.

The rooms also are equipped with numerous "visual cues," Herzfeldt continues. "When doctors write orders you have a yellow light [on the 'call light' fixture outside the room]; when you start processes you turn on a green light, which tells the RN that orders need to be acknowledged; and when pharmacy delivers meds, they turn on an orange light. In addition, if specimens are needed, there are colored magnets that can be placed on the whiteboard (which is in every room) to identify the type of specimen needed."

Patients have been enthusiastic about the new model, says Heatherington. "We have gone up about 30% in the number of patients who give us a 'top-box' rating on our patient satisfaction survey," she says. What's more, she adds, "Our quality results have improved in terms of compliance with CMS bundles."

Collaborative Care will be the new model of care for the system, she continues. "We've developed the model of care and now the renovation that supports it," she explains. "And what we spent is not necessarily more expensive than what you would spend for a traditional unit."

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NEWS BRIEFS

Patients like quality, satisfaction surveys

A on-line survey of 2,015 U.S. adults conducted by Harris Interactive for *The Wall Street Journal Online* showed that U.S. adults are gaining confidence in the fairness and reliability of healthcare quality assessments. The Wall Street Journal Online/Harris Interactive Health-Care Poll said most adults favor the use of patient satisfaction surveys to determine health care quality above all other quality measures. More than half of those surveyed said it is also fair to measure healthcare quality based on the use of electronic medical records.

The survey also said that 87% of the respondents were interested in using web-based consumer ratings tools, suggesting that an initiative to allow consumers to rate their doctors could be highly successful.

"These findings suggest that as quality measurement in health care becomes more readily available to consumers and they become more familiar with these measures that trust in the process will increase," Katherine Binns of Harris Interactive said in a prepared statement. "At the end of the day, however, it's feedback from their peers — other patients — that matters most to consumers." ▼

Cigna stops paying for 'avoidable' conditions

Effective Oct. 1, 2008. Cigna HealthCare will no longer reimburse hospitals for certain "avoidable" conditions and surgical errors. Cigna said it will not reimburse for surgical procedures performed on the wrong person or site, and may not reimburse for certain "avoidable hospital conditions" when permitted under its hospital contracts. Included among the cited conditions are infections from urinary and central-vein catheters, use of the wrong blood type during transfusions, bed sores, and hospital-acquired injuries. ▼

States participating in QI institute

Nine states — Colorado, Kansas, Massachusetts, Minnesota, New Mexico, Ohio, Oregon, Vermont and Washington — will develop and implement strategies to improve health care quality and efficiency under a new project called the State Quality Institute and sponsored by the Commonwealth Fund. Each

state will convene a team of public officials, health care providers, insurers, employers, and others to identify challenges and policy options in areas such as value-based purchasing, data collection and transparency, and care coordination and disease prevention. The teams will receive help from experts and share their experiences and successful practices. ▼

More hospitals offering palliative care

According to a new analysis by the Center to Advance Palliative Care (CAPC), U.S. hospitals continue to implement palliative care programs at a rapid pace. Based on data from the 2008 American Hospital Association's Annual Survey of Hospitals, the study found 1,299 hospitals provide palliative care programs, up from 632 in 2000. About 31% of the 4,136 hospitals appropriate for palliative care programs, which excludes psychiatric and rehab hospitals, have a program, CAPC said. The rate increases to 47% for hospitals with more than 50 beds and 77% for hospitals with more than 250 beds. "Palliative care represents a paradigm shift in how we treat serious illness in America," said CAPC Director Diane Meier. "Ten years ago there were almost no hospital palliative care programs in the U.S." ■

AHRQ resource features 100 innovations and tools

The Agency for Healthcare Research and Quality. (AHRQ) has launched a new web resource that allows users to learn, share, and adopt innovations in the delivery of health services. The resource, which is called the Health Care Innovations Exchange, is available at www.innovations.ahrq.gov.

AHRQ's Health Care Innovations Exchange is the federal government's repository for successful health care innovations. It also includes descriptions of attempts at innovation that failed. The web site is designed as a tool for health care leaders, physicians, nurses, and other health professionals who seek to reduce health care disparities and improve health care overall.

"Sharing information about important new developments in methods of delivering effective health care is typically a hit-or-miss process," said AHRQ Director Carolyn M. Clancy, MD. "Such information exchanges often occur only within organizations, through conferences, and by chance over the Internet. AHRQ's updated innovations exchange will encourage information sharing, reduce duplication and save time and money."

The web site will contain 100 examples of innovations in the delivery of health care services and attempts at innovation; that number will increase as the site is updated every two weeks. Profile examples include an intensive care unit's successful efforts to shorten patient stays by setting and adhering to daily care goals; an initiative by geriatricians, nurse practitioners, and social workers to help seniors avoid institutional care by visiting seniors at home; and a patient/physician e-mail communication system that overcomes the inconvenience of automated phone systems and accommodates the difficult schedules of both the physician and the patient.

Through learning and networking opportunities offered by the Health Care Innovations Exchange, users will be able to:

- Read articles and perspectives on the creation and adoption of innovation;
- Read expert-generated commentaries on specific innovations;
- Comment on specific innovations;
- Participate in topic-specific presentations (e.g., Webinars) and discussions;
- Join on-line forums that connect innovators with organizations that adopt them. Participants will identify new approaches to delivering care,

COMING IN FUTURE MONTHS

- ■ Perinatal safety team achieves 93% reduction in birth trauma rates
- ■ Developing standard protocol helps cut failed sedation rate in half
- ■ Anticoagulant safety program slashes facility's medication errors
- ■ Study shows 'code blues' are much deadlier on the night shift

develop effective strategies for implementation and evaluation, and share tips and information.

In addition to offering a venue for learning and networking, the AHRQ Health Care Innovations Exchange offers a new home for AHRQ's QualityTools — a collection of tools used in quality improvement efforts.

In other news from AHRQ, the agency reported that the number of hospital patients stricken by *Clostridium difficile*, or *C. difficile-associated* disease — an infection that can lead to diarrhea, blood poisoning, and even death — increased by 200% between 2000 and 2005. The sharp upturn follows a 74 percent% increase in the number of cases between 1993 and 2000.

AHRQ's analysis also found:

• There were more than 2 million cases of *C. difficile* in U.S. hospitals between 1993 and 2005;

• Two out of three infected hospital patients in 2005 were elderly;

• On average, patients with *C. difficile* were hospitalized almost three times longer than uninfected patients;

• The in-hospital death rate for patients with *C. difficile* was 9.5%, compared with 2.1%;

• The highest rate of *C. difficile* infection in hospital patients was in the Northeast (144 stays per 100,000 population) and the lowest (67 stays per 100,000 population) was in the West. ▼

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NCQA to expand quality program

The National Committee for Quality Assurance (NCQA) has released for public comment updated standards for Physician and Hospital Quality (PHQ), a program that evaluates how well health plans measure and report the quality and cost of physicians and hospitals. The proposed changes would make the program available to accredited and non-accredited health plans and add new requirements to respond to demand from employers and regulators across the country.

"Provider quality will only improve when measurement is based on trustworthy information," said NCQA President Margaret E. O'Kane. "Consumers and employers must be able to rely on the information that's published about their doctors and hospitals or used to design networks."

The updated standards are more explicit about how plans involve physicians and consumers in measurement programs. They require plans to use standardized measures such as those endorsed by the National Quality Forum, and they require plans to consider quality, and not just cost, when they act on measurement results. ■