Hospital Performance Story: Reducing Harm Across the Board

Laurie Godfrey RN, MBA, CPHQ
Improving Harm Across the Board
2012 Breakthrough in Reducing HAC HARM*: 60 to 28 harms/1,000 discharges

HAC HARM is inpatient hospital acquired conditions: CAUTI, CLABSI, SSI, VAP, Falls, Pr Ulcers
Cut “harm across the board” 24 patients per quarter to 10
2012 Readmission Journey: From 11% of discharges to 13.5% of discharges
2012 Breakthrough in Reducing Readmissions: From 400 per quarter to 360 per quarter
Strategies to Drive Results

Challenges:
- Accountability
- Physician Engagement

Strategies:
- Education of staff
- Empowerment of patients & families
- Transparency
- Monitoring of Measures and provide feedback to staff/physicians
- Engagement of Physicians
Pearls

• It takes a team: C Suite, Leaders, Educators, Physicians, All Staff

• Transparency & Sharing of Best Practices across entity/system

• Standardization of work processes:
  Safe Surgical Task Force
  Documentation prompts in Cerner EMR
  Readmission System Task Force

• Celebrate success
Pearls

What’s worked:

- Engagement of multi disciplinary staff: Infection Practitioners, Ancillary staff, Nurses, Physicians, Leadership
- HAC specific task force
- Fall Prevention Fair
- Review new products
- Transparency of data—we all think we’re the best but the data speaks the truth

Drivers of safety that produce positive outcomes:

- Leadership commitment
- CNS involvement
- Unit champions
- Public awareness of data
**Risk Profile: The Areas of Risk We Are Committed To Controlling**

*Annual discharges: 11180  HAC risk opportunities/discharge: 3.2*

<table>
<thead>
<tr>
<th>HACs</th>
<th>Estimated annual number of patients at risk in each area</th>
<th>Number of Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI</td>
<td># pts in IP units with catheter in place:</td>
<td>1677</td>
</tr>
<tr>
<td>CLABSI</td>
<td># pts in IP units with central lines:</td>
<td>553</td>
</tr>
<tr>
<td>Falls</td>
<td># of discharges:</td>
<td>11180</td>
</tr>
<tr>
<td>Pr Ulcer</td>
<td># of discharges:</td>
<td>11180</td>
</tr>
<tr>
<td>VAP</td>
<td># of patients on a ventilator:</td>
<td>694</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><em>Risk opportunities for harm across the board</em></td>
<td><strong>25284</strong></td>
</tr>
<tr>
<td>Readmit</td>
<td># of inpatients at risk of readmit:</td>
<td>11180</td>
</tr>
</tbody>
</table>
## Improving Patient Harm

<table>
<thead>
<tr>
<th>HACs</th>
<th>Baseline Events [2010]</th>
<th>Target Events</th>
<th>Current Events [2012]</th>
<th>Improvement Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Goal 40% Reduction</td>
</tr>
<tr>
<td>CAUTI</td>
<td>24</td>
<td>14</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>CLABSI</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Pr Ulcer</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>SSI</td>
<td>27</td>
<td>16</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>VAP</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>72</strong></td>
<td><strong>43</strong></td>
<td><strong>38</strong></td>
<td></td>
</tr>
<tr>
<td>Readmit</td>
<td><strong>1516</strong></td>
<td><strong>1213</strong></td>
<td><strong>1533</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Our Improvement Journey

## Improvement Scale:
The stages we move through

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Number of risk areas (0-11) at each stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDEAL</td>
<td>level represents zero harm</td>
<td>0</td>
</tr>
<tr>
<td>At Target</td>
<td>level represents meeting improvement target</td>
<td>4</td>
</tr>
<tr>
<td>Progress</td>
<td>level shows movement but not yet at target</td>
<td>1</td>
</tr>
<tr>
<td>Opportunity</td>
<td>level is an opportunity to launch aggressive action</td>
<td>2</td>
</tr>
</tbody>
</table>
## Our Hospital Risk Score Card

<table>
<thead>
<tr>
<th>Our Safety Mandate</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Volume (Discharges)</td>
<td>11180</td>
</tr>
<tr>
<td>Total risk: annual harm opportunities</td>
<td>25284</td>
</tr>
<tr>
<td>Risks per patients (Total Opportunities)/Discharges</td>
<td></td>
</tr>
</tbody>
</table>

### Number of Risk Areas

| Number of PfP Risk Areas Applicable (0 – 11)                                      | 11    |
| Number of PfP Risk Areas Applicable & Adopted                                      | 7     |

### Our Progress

| Number of PfP Areas with Major Improvement Opportunity                             | 3     |
| Number of PfP Areas at Improvement Target                                         | 4     |
| Number of PfP Areas at IDEAL                                                      | 0     |
HAC Reduction Strategy
Sharp Healthcare’s Plan for Patient Safety

Culture
Just, transparent, learning culture

Teamwork
Tools and strategies to improve teamwork and communication

Design
Processes and systems to support patient safety

Technology
Technology: Tools to enhance safety and reduce error

Continuous Improvement

Patient Engagement

Organizational Learning
CLABSI Prevention

• Started July 2010

• National Patient Safety Goal 7: Reduce the risk of healthcare associated infections (# 07.04.01 Implement best practices or evidence-based guidelines to prevent central line-associated bloodstream infections)

• CLABSI Reduction Workgroup (IPs, Nursing Dept. Managers & Leads, & Directors for Acute Care, & Quality, CNSs, Lead Educators)

• Reeducate staff on hand hygiene/“Back to Basics” education for central lines included in ICU CEP

• Education regarding Hibiclens bathing
CLABSI Prevention

- Antibiotic impregnated PICC catheter

- Central line Checklist attached to all central line dressing kits and laminated checklist hung on all IV poles for patients with central lines

- Biopatch – large-bore biopatch for dialysis catheters

- Central Line Maintenance Audits

- Curos strips available to hang on IV poles of patient with central lines

- Implemented “Daily assessment for need of line” in Cerner EMR for physicians
Patient and Family Engagement

• Planetree journey
• Empower patients to ask their healthcare provider to wash their hands
• Surgical Wound Care at home education & reference material
• Fall Prevention education pamphlet for patient/families
  “Call, Don’t Fall” signage
Patient Safety Culture

“Making patient safety more transparent has encouraged our healthcare staff to share patient events more openly. This shift is in alignment with our Just Culture environment.”

Karen Simpson RN, BSN
Patient Safety Officer
Defining Moment(s) In Our Journey

Our goal is to deliver the Sharp Experience to all our Patients and To Deliver the Best Care in the Universe

Right thing to do for patient:

Culture of Safety Survey: Start 2009
Just Culture questions added to Culture of Safety 2012
Team STEPPS: all new employees attend training
Six Sigma: Green Belt, Facilitator training
Planetree journey
Reapplication for Baldridge
Next big step to Reduce Harm

- Continue to stay focused
- Engagement of Nursing, Physicians, & Ancillary staff
- TJC TST Hand Hygiene project
- Review annual Culture of Safety Survey
- Sharing of Best Practices
Members of the Sharp Chula Vista Medical Center Quality & Safety Department