

Adventist Health  
Adventist Health Howard Memorial Hospital  
1 Marcela Drive  
Willits, Ca

<https://www.adventisthealth.org/howard-memorial>

Contact:

Kristy Bowen, Director Quality and Risk [bowenkl@ah.org](mailto:bowenkl@ah.org) (707) 456-3016

Erin Harmon, Accreditation Associate [HarmonEM@ah.org](mailto:HarmonEM@ah.org) (707) 456-3305

Application Title: Road to Zero without compromising Patient Satisfaction

Focus Area: Quality Improvement & Patient Safety

Executive Leader Statement:

“Adventist Health Howard Memorial Hospital started its journey to zero in 2017, with the worse safety score in their corporation. During 2018 they persisted in the journey toward zero and achieved top decile performance. In the span of one year, Howard decreased their hospital acquired infections by 100%. Top decile performance is still not zero, Howard hospital is committed to the quest of zero. The culture of Howard will push the performance to achieve zero safety events”.

Linda Given, Patient Care Executive

## The Journey to Zero Executive Summary

Adventist Health Howard Memorial's journey to zero started with the Howard experience day event. It was at this event that the report was given that in the year 2017, Howard had 22 safety events, the worst in the company. Normally a very exciting and happy event, it made the crowd quiet. Because these events touched their neighbors and were a direct result of patient care. Everyone at Howard Memorial owns patient care. This began the journey that took Howard to only 8 events in the year 2018. While not zero it did show employees that we could all have impact. So, at the second Howard experience days we gave the results of cutting the events by half and raised the challenge to cut it in half again. So far in 2019 there are only 3 events. Taking into consideration the case mix of patients and the complicated surgeries, not a bad score, but still not zero which is the goal. Patient Safety Incidents were something the physicians took on, case review on every event. While the journey is not done, the progress demonstrates that inspiring the whole hospital toward a goal can be done.

Linda Givens, Patient Care Executive

## Journey to Zero

In a small town of just over 5,100 lives, Willits covers an area that is beautiful, remote, and isolated from large hospitals. The road from a non-existent hospital where lives were lost to that of a top-class Critical Access Hospital was a long one. Our community is 83 miles to the closest large trauma center and often the roads to travel there can be closed, flooded or mudslides. Approximately 87 various zip codes seek care here. Amid this isolation exists a population that can be challenged by socio-economic boundaries and lack of transportation or resources to make doctors appointments or afford needed medications or supplies.

It is within this community and the surrounding areas that our hospital has faced big challenges in keeping our patients from safety events while in the hospital. Some were developing prior to arrival and some while in our care. Once we had re-assembled a new team from the foundation up with increased focus and support from Executive leadership, we were able to move forward in identifying the precise needs of our patients and make changes to our clinical practice and process.

In the Clinical year October 2016-September 2017 our CAH hospital had a total count of 22 safety events, including 3 c-diff and 1 CAUTI patient.

With all transparency at hand, we were the worst in our system. There were no excuses, no words to explain how we hadn't evaluated our own efforts with 22 lives. From this standpoint we moved forward to change processes that had been in place for years, if not decades.

We implemented the following across the **entire** hospital:

-everyone owns safety events because every patient is family

-recognizing need for devices and offering front line staff alternative devices and tools. For instance, onboarding the Purewick catheters as an alternative to Foley's for females, screening patients for need of Foley with f/u daily with providers, re-trained for peri-care to front line staff, we went from having 3 CAUTI's to zero

-education for samples sent for c-diff testing, 2 step testing for c-diff for potential colonization, originally this was a send out, now offered in house with a turnaround time of <1 hour, screening tools utilized to identify high risk patients, prompt initiation of isolation plus with signage and change in infection banner in the EHR, education to patient and family, alerts to housekeeping and staff, this minimized over utilization of antibiotics, we went from 3 c-diff cases to 1

-all patients on antibiotics are offered pro-biotics within 24 hours to foster good gut flora

-Healing requires good nutrition, our patients are offered room service with fruits and vegetable from our own 5-acre organic garden

-daily safety huddles with all leaders including executives M-F at 8:15 which includes barriers to discharge, high risk patients, daily count of days since last "event" with real time problem solving just to name a few

-Hard stop with coding for review of any safety event from Patient Care Executive and Quality Director, includes coders/CDI

-ALL safety events have a Root Cause Analysis with stakeholders and CNO to check for process failure and improvement opportunities within 48-72 hours after event with education and outcomes delivered to staff and executives

-Event status reported to Governing Board, to Quality Committee and to front line staff in breakrooms

-Executive Team full awareness of all events and always speak to their origin and count

With so many interventions we challenged with roll out to front line staff and encountered some barriers with testing done. The drive for change coming from Leadership and our Executives pushed continued focus on the items mentioned above. We utilized experts in their fields to speak at staff meetings, anyone from lab to the Infection Preventionist. All areas of improvement not only were recognized by front line staff but followed up by the entire team. We made every effort to notify the "house" if we were investigating a possible "event". Close calls are where we gained knowledge for potential pitfalls and we used this to move forward.

Medicine has never been a static environment of boxes and check sheets. It evolved with every patient and every hour. We tried to pull at our resources to ensure that there were no surprises along the way. There was a time that we didn't have a count or know the origin of these. The fact that we brought 22 harms down to 8 in the span of one year shows remarkable improvement. This is particularly important given that our average census in 2017-2018 safety year was around 13 and in 2018-2019 it is now 23. This is huge growth for a Critical Access Hospital with 25 beds.

While working on these opportunities we have maintained the highest HCAHPS in The Adventist System for California and Hawaii. We maintain and exceed top decile with a score of 81.5% compared to the system at 75.0%. We live and breath that safety is owned by all and fostered by communication that comes from our physicians and front-line staff to the patients. This can be reflected in our HCAHPS score with 91.8% for Communication with Doctors and 86.4% Communication with Nurses. This ability to communicate is just one part of the sustainability efforts with safety. If our patients and community understand the “why” behind interventions and preventions then they have a bigger bite of the responsibility and they are part of the journey.

Maintaining current results, fostering educational opportunities for staff, which they then bring back and share best practice techniques and always talking about where we were and where we are going. This journey to zero started here long before we experienced The Joint Commission Survey and discovered that our mission aligns with theirs. After all, how could we possibly fathom that one life is ok to compromise in any way when it can be preventable. The idea has been adopted as culture here.

The biggest success in moving closer to our goal is in sharing hard lessons learned to other hospitals and networks in hopes that there might be just one take away. We have found that when you create a change against the gradient you will always find opposers and critics, but if you persist often you end up being the innovator. There was a lot of resistance among the hospitals when we adopted the Purewick device as an alternative to female foley catheters. We were the first to trial it and adopt it as a standard. Because of this YTD we have not had a CAUTI in 603 days. This is a big success and now we have noticed that other markets are adopting the same device. The same with bringing in the two step testing for c-diff. Some said we couldn't do it, some said there were no resources for the equipment, but here we are getting it done in house in <1 hour.

These are all efforts that took the entire team to think outside the box and every effort to move a dial for the better good of this community. Medicine is always in motion and we plan to move with that tide as new innovative methods come out and keep this front-line technology close at hand while keeping our patients close to our hearts with exceptional care.