SESSION TITLE: Hot Topic!
Improving Quality and Patient Safety: A Collaborative Approach

SPEAKER NAME: Anthony P. Dawson, MSN, RN
Laurie A. Saletnik, DNP, RN

SESSION NUMBER: 9008, 9103R, and 9142R

DATE/TIME: Monday, March 4, 2013, 8-9am & 9:30-10:30am
Tuesday, March 5, 2013 8:15-9:15am

CONTACT HOURS: 1.0 CH

OVERVIEW:
This session will focus on the key aspects of quality and patient safety in the perioperative setting. The speakers will share key practices and performance improvement (PI) processes by providing real life examples of PI projects, how they engage, and how they collaborate with their peers and colleagues, especially in other hospital departments, in order to improve perioperative care. A primary focus will be key regulatory requirements, meeting the needs of today’s health care reform, increasing efficiency, decreasing costs while maintaining a safe environment for patients and staff. In addition, the speakers will review in detail how to organize your existing quality program into an easy one, two, three step format. Our speakers will share best practices that can benefit every program.

OBJECTIVES:
1. Provide an overview of health care regulatory compliance.
2. Compare key regulatory requirements for quality and patient safety.
3. Describe collaboration that works.
4. Identify key strategies in developing a successful and sustainable program.

BIOGRAPHY:
Anthony P. Dawson, MSN, RN, is the vice president for operations, New York Presbyterian (NYP) Hospital/Milstein. His responsibilities include managing the Milstein hospital's day-to-day operations and operating budget for radiology, laboratory, perioperative services, the cardiac catheterization laboratory, endoscopy, radiation oncology, infusion/chemotherapy, physical and occupational therapy, and the emergency department. In addition, he supports Milstein’s senior vice president and chief operating officer in managing the capital budget for these departments and plays a leadership role in implementing the hospital's strategic vision for clinical services. Previously, Mr. Dawson was vice president for quality and patient safety. Mr. Dawson joined NYP in 1989 as a staff nurse and has had progressive levels of patient care and management responsibility. After two years as a black belt, Mr. Dawson was a master black belt in performance excellence; responsible for coordinating the hospital's clinical quality and patient safety functions, as well as managing the hospital's key institution-wide quality initiatives and Joint Commission compliance efforts. Before becoming a black belt, he was the clinical director of perioperative services at NYP/Weill Cornell. Mr. Dawson received his MSN from Hunter College, Bellevue School of Nursing; his BSN from Columbia University School of Nursing; and his diploma in general and psychiatric nursing from St. Michael's Hospital in Dublin, Ireland. Additionally, he completed the Institute for Healthcare Improvement Patient Safety Officer Training in 2006. He is currently enrolled as an Administrative Fellow in the Health Care Management Academy.
Laurie A. Saletnik, DNP, RN, is the first director of nursing for perioperative services at the Johns Hopkins Hospital in Baltimore, Maryland. In this role, Laurie is responsible for over 50 ORs and the associated perianesthesia areas across the organization. These areas provide services for multiple surgical specialties, both outpatient and inpatient, adult and pediatric populations. The newly opened perianesthesia areas have combined both surgical and interventional patients on each floor. Laurie has been a nurse in the perioperative setting for over 28 years. Laurie received both her master of science in nursing and doctorate of nursing practice from the Johns Hopkins University School of Nursing. She has been a member of AORN since 1987 and has published and presented nationally on a variety of perioperative topics. Laurie has also been fortunate to have had the opportunity to consult with other organizations regarding perioperative nursing internationally.

**CONTACT INFORMATION:**

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<th>Name</th>
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**FACULTY DISCLOSURE:**

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**COMMERCIAL SUPPORT:**

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<tr>
<td>Laurie Saletnik</td>
<td>Johns Hopkins Hospital</td>
<td>(travel expenses)</td>
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**REFERENCES:**

- Romig, M., Goeschel, C., Pronovost, P. & Berenholtz, S. () Integrating CUSP and TRIP to improve patient safety. *Hospital Practice*
- Joint Commission () Patient Safety Goals, Retrieved
- PerioperativeStandards and Recommended Practices (2012) AORN
We Are Not Alone

“Today, hospitals and health systems are on the frontlines of this broken system. They persevere every day in the face of mounting challenges, chief among them:
- Uncompensated care for patients without insurance
- Perpetually rising costs
- The inability to hire enough nurses and other skilled providers
- Perverse payment models that encourage waste and inefficiency
- Growing demands of an aging population
- Overcrowded emergency rooms
- Lack of broad technology adoption and, therefore, system-wide interoperability
- Rising liability costs”

Center for Health Transformation, 2008

Collaboration

1: to work jointly with others or together especially in an intellectual endeavor

2: to cooperate with or willingly assist an enemy of one’s country and especially an occupying force

3: to cooperate with an agency or instrumentality with which one is not immediately connected

www.merriam-webster.com/dictionary/
Perspectives on Quality

- Let's explore some recent media reports and lapses in quality and the impact it's had on various industries including health care.
- What are the economic consequences?
- What about the impact on individuals and their families?
- What about the lasting effects?
- Hospital-Acquired Conditions
- Value Based Purchasing

Creating a culture of safety is paramount if you want to build a system of continuous performance improvement

NYC Hospital Reopens After Being Shuttered by Sandy

Months after Hurricane Sandy, hospitals are still feeling the impact. The affected hospitals extend beyond New York University Langone Medical Center and Bellevue Hospital that shut down after storm damages. Neighboring hospitals have absorbed their emergency patients and even medical residents.

NYU Langone isn't expected to fully reopen until January, and Bellevue won't reopen until February, Kaiser Health News reported.
The study, published in the journal *Surgery*, has found that medical mistakes such as these occur quite frequently, on the average of about 500 times per year. The study found that between September 1990 and September 2010, more than 9,700 medical malpractice claims have been settled. And nearly half of those cases were ones in which surgeons left an object inside the patient by accident (the most common object was a sponge). The other half were cases of surgeons operating on the wrong part of the body or performing the wrong procedure. And perhaps most disturbing, 17 cases were of surgeons operating on the wrong side.

**Medical Mistakes – 2010 OIG Medicare Chart Audit**

- 1 in 7 Medicare patients experienced at least one serious harm event from medical care with the event contributing to death of approximately 15,000 patients (1.5%).

In 1 month, an estimated 134,000 hospitalized Medicare patients experienced harm from hospital care with the event contributing to death of approximately 15,000 patients (1.5%).
The End Results

When we work in systems/hospitals/care centers where quality is eroded, we know that satisfaction diminishes

Lower employee satisfaction contributes to work force shortages

Health care professionals/para professionals run our complex systems but they also possess the competencies to make improvements part of their daily work

Past, Present, and Future

The 1980s and DRGs
- Medicare and other payors looked to reign in costs by developing payment guidelines that capitated providers and put financial penalties on patients
- After system failed due to customer feedback payors switched from making customers adjust to making health care providers adjust
- This evolved into tying payments to quality and efficiency targets
- The sales pitch for this change was that standardization was needed to reduce medical errors and practice variations. Cost savings was an added bonus
2008 - Still a Problem

“One in 200 patients who spends a night or more in the hospital will die from a medical error. One in 16 will pick up an infection. Deaths from preventable hospital infections exceed 100,000, more than those from AIDS, breast cancer, and auto accidents combined.”

2010 – 2018 Health Care Reform Timeline

- **2010**
  - Market Basket & Productivity Cuts
  - Dependent Coverage to Age 26

- **2012 - 2013**
  - Value Based Purchasing
  - Readmission and HACs Penalties
  - Pharmaceutical and Medical Device Fees

- **2014**
  - Individual Mandate/Health Exchanges Open
  - Medicare & Medicaid DSH Cuts
  - Insurer Fees

- **2018**
  - Full Impact of Medicaid DSH Cuts
  - Cadillac Tax
**Perioperative Environment**

Patients are asleep – cannot assist in error prevention – think site side verification

High velocity environment

Complex environment

OR Teams are not “true team”

Communication is a major issue

Safety may not be a high level commitment

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**The Challenge**

*Hospital services are a highly regulated by many agencies:*

- Occupational Safety and Health Administration (OSHA)
- Centers for Medicare and Medicaid Services (CMS)
- The Joint Commission (TJC)
- American College of Surgeons (ACS)
- American Society of Anesthesiologists (ASA)
- Association of periOperative Registered Nurses (AORN)
The Challenge cont.

Related guidelines are also published by:
The Centers for Disease Control (CDC)
Food and Drug Administration (FDA)
Environmental Protection Agency (EPA)
Association for the Advancement of Medical Instrumentation (AAMI)
American National Standards Institute (ANSI)
American Institute of Architects (AIA)
Association for Professionals in Infection Control and Epidemiology (APIC)

The Joint Commission

The National Patient Safety Goals (NPSG) were established in 2002 to help health care organizations address specific patient safe concerns.

The first NPSG was effective in January 1, 2003
No new goals were added in 2011
TJC added one new goal for 2012 – the NPSG focuses on catheter-associated urinary tract infection (CAUTI)
CAUTI account for as much as 80% of HAIs in hospital
There are 5 NPSGs that you need to be concerned with
NPSGs cont.

National Patient Safety Goals – Specific to Perioperative Services
- Improve the Accuracy of Patient Identification
- Improve the Effectiveness of Communication among Caregivers
- Improve the Safety of Using Medications
- Reduce the risk of Health Care-Associated Infections
- Universal protocol

Many of these have additional elements of compliance:
- 77 Elements of compliance
- 57 Direct Impact

What are Hospital Acquired Conditions (HACs)?

HAC is a condition that a patient developed during his/her hospital stay for which there are care guidelines and protocols that makes this condition reasonably preventable

A serious adverse event is an error in medical care that is clearly identifiable, preventable, has serious consequences for a patient, and represents a real problem in the safety and credibility of a health care facility
Hospital-Acquired Conditions

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burns
  - Electric Shock

Hospital-Acquired Conditions

- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
Hospital-Acquired Conditions

• Surgical Site Infection following:
  - Coronary Artery Bypass Graft (CABG) - Mediastinitis
  - Bariatric Surgery
    » Laparoscopic Gastric Bypass
    » Gastroenterostomy
    » Laparoscopic Gastric Restrictive Surgery
- Orthopedic Procedures
  » Spine
  » Neck
  » Shoulder
  » Elbow

• Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)
  - Total Knee Replacement
  - Hip Replacement

“If health care was an airline…”

“If health care was an airline, only dedicated risk takers, thrill seekers, and those tired of living would fly on it.”

Patient Safety (2005)
by Charles Vincent
Impetus for Change

- Escalating Costs
- Funding & Reimbursement Cutbacks
- Key Industry Drivers
- Quality & Safety Concerns
- Consumerism

Value Based Purchasing: 2012 Implementation

All hospitals get a cut
- 1% of annual payment (excluding DSH, IME, GME) withheld in FY2013
  - Rising 0.25 percentage points to a full 2% by FY2017

Savings from cuts get spent on incentive payments
- Medicare program remains “budget neutral” – i.e., no savings back to program

Hospital VBP net impact
- Loss from the cut + the incentive payments added back
- Incentive payment based on performance score
How Will My Hospital Be Evaluated?

- **Three domains:**
  - Clinical Process of Care (13 measures)
  - Patient Experience of Care (8 HCAHPS dimensions)
  - Outcome (3 mortality measures)

- Hospitals are awarded points for Achievement and Improvement for each measure or dimension, with the greater set of points used.

- Points are added across all measures to reach the Clinical Process of Care and Outcome domain scores.

- Points are added across all dimensions and are added to the Consistency Points to reach the Patient Experience of Care domain score.

FY 2014 – CMS Finalized Domains and Measures/Dimensions

There are thirteen clinical process measures:

1. AMI-7a Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival
2. AMI-8 Primary PCI Received within 90 Minutes of hospital Arrival
3. HF-1 discharge instructions
4. PN-3b Blood cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
5. PN-6 Initial antibiotic Selection for CAP in Immunocompenent Patient
6. SCIP-Inf-1 Prophylactic Antibiotic Received within One Hour Prior to Surgical Incision
7. SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients
FY 2014 – CMS Finalized Domains and Measures/Dimensions (continued)

1. SCIP-Inf-3 Prophylactic Antibiotic Discontinued within 24 hours After Surgery
2. SCIP-Inf-4 Cardiac Surgery Patients with controlled 6a.am Postoperative Serum Glucose
3. SCIP-Inf-9 Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2
4. SCIP-Card-2 Surgery Patients on a Beta blocker Prior to Arrival That Received a Beta Blocker during the Perioperative Period
5. SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
6. SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours

Patient Experience Dimensions

1. Nurse Communication
2. Doctor Communication
3. Hospital Staff Responsiveness
4. Pain Management
5. Medicine Communication
6. Hospital Cleanliness and Quietness
7. Discharge Information
8. Overall Hospital Rating
The Challenges We Face 2013 and Beyond

- How nimble can we be and how can organizations move beyond the Paper Record/Electronic Health Record and roll out analytics for clinical decision support?
- What’s keeping organizations from using real time metrics to improve overall accountability, reduce readmissions, and reward performance improvement?
- What are we missing as perioperative nurses to improve quality and impact value-based purchasing?
- How can perioperative nurses use data to drive change and improve clinical quality and safety?

Barriers to Team Performance

- Lack of time
- Lack of information sharing
- Hierarchy
- Defensiveness
- Varying communication styles
- Lack of role clarity
- Conflict
- Lack of coordination and follow-up
- Distractions
- Fatigue
- Workload
- Misinterpretation of cues
What is High Reliability?

Consistent performance at high levels of safety over long periods of time.


What does "high reliability organization" mean to you?

"An organization that is transparent, does what it says it will, and communicates well while keeping the focus on patients first"

"High reliability means that given a specific situation, regardless of the time of day, person on shift, etc., the patient will receive the same care."

"An organization where each patient receives the best quality care, every single time (always). Also means that processes are in place to prevent sentinel events or never events."

"Consistency- the culture of always"

"Standardizing care/processes to ensure the right thing is done 100% of the time. Eliminate variation."
High Reliability

- Organizations achieve **collective mindfulness**: everyone is acutely aware that small failures can lead to catastrophic adverse outcomes (e.g. “We Put Patients First”)
- Improve processes with **powerful tools** that eliminate deficiencies (e.g. MERS-th and Teach-back)
- **Safety culture** – ensure performance of improved safety processes over long periods of time; remain constantly aware of the possibility of failure (e.g. Safety Culture Survey)


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Three Requirements for Achieving High Reliability

**Leadership**

- Commitment by Board and Senior Leadership: Long-term Process (10-15 years!)
- Embedded into Mission and Vision Statements: High Priority
- Measurable Goals and Ongoing Monitoring

**Safety Culture**

- Trust, Report, Improve
- Regular Reporting
- Communication about improvements

**Tools for Process Improvement**

- Establish processes/policies and ensure all staff are practicing
- New generation of quality method
- Recognize causes vary between organizations

### Designing a more reliable process (continued)

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<th><strong>Standardize the Process</strong></th>
<th><strong>Human Factors Science</strong></th>
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<td>“Intent, vigilance, hard work”</td>
<td>Decision aids and reminders built into the system</td>
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<tr>
<td>Education/training</td>
<td>Desired action is the default</td>
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<tr>
<td>Personal checklists</td>
<td>Redundancy</td>
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<tr>
<td>Feedback of compliance data</td>
<td>Take advantage of habits and patterns</td>
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<td>Common equipment</td>
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Source: IHI

### Designing a more reliable process

Prevent initial failure using **intent and standardization**

**Redundancy** functions: identify failure and mitigate

Critical failures: **learn** from critical failures and then **redesign**

Source: IHI
Comprehensive Unit-Based Safety Program (CUSP)

Focus on teams at the unit level
- Improve patient safety and safety culture
- Integrate safety practices into daily work
- 5 step program – empowers staff to assume responsibility for safety
- Cyclical improvement

CUSP

5 Step process
1. Training
2. Engage staff to Identify Defects
3. Senior Executive Partnership/Safety Rounds
4. Learning from defects
5. Implement tools for improvement
Creating an CUSP Team

Representative of all people working on the unit
• Multidisciplinary
• All levels, all roles
• Differing levels of experience
• Open invitation for others to join
• CUSP executive
• Surgeon champion
• Project leader

Staff Safety Assessment

1. Please describe how you think the next patient in your unit/clinical area will be harmed.

2. Please describe what you think can be done to prevent or minimize this harm.
Colorectal CUSP Experience

Focused on prevention of SSI
- Team composition

Interventions

- Appropriate antibiotic prophylaxis
  - Appropriate dosing

- Appropriate skin preparation
  - Preop preparation
  - OR skin prep
  - RN prepping

- Instrumentation
  - Dirty versus Clean
  - Set Revision
Interventions

• Briefing/Debriefing
  • Revision of tool
  • Logbook
• Temperature Control
  • Preop warming
• Updating of preference cards
• Patient teaching
  • Teach back education

Impact

• SSI rates
• Efficiency
• Potential cost savings
• Improved teamwork/collaboration
Cardiac Surgery SSI Team

- Multidisciplinary team
- Regular meetings
- Review of SSI rates
- Creation of task list with assigned accountability

Collaboration with Environmental Services

Renewed focus with opening of new clinical towers
- Rounding
- Terminal cleaning logs
- Monitoring
- Video education