

The Q Report

WORKING TOGETHER TO ENHANCE QUALITY AND OUR PATIENTS' EXPERIENCE AT **UF&SHANDS**

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GREAT CATCH PROGRAM: PROMOTING REPORTS OF NEAR-MISS CLINICAL EVENTS

By Marvin Dewar

A challenge in promoting safety is getting a true report of the number of potential quality and safety events (“near-miss” events) that occur in clinical practice, and an adequate description of them. Near-miss clinical events occur in much greater number than actual patient harms, and increasing the number of near misses reported in a quality and safety program can paradoxically decrease the number of patient harm events.

Evaluating a near miss provides an opportunity to analyze failures in established processes and systems and to make changes before patients or others are impacted. However, safety events and near misses are widely underreported by staff for a number of reasons, such as potential embarrassment to themselves or others, or concern about repercussions.

The University of Florida Physicians team strives to create a culture in which people are comfortable reporting safety events and near misses.

UFP has established incentives for individuals who contribute to the improvement of the organization by communicating near-miss events. Just as the Customer Service is the Key (CSK) program is intended to promote a culture of service excellence, UFP developed a recognition award that promotes a culture of quality and safety excellence.

The Great Catch Program was implemented during the summer of 2009. Any provider or staff member reporting a “near-miss” event receives a personal note and a “You Make The Difference” pin from the practice CEO, thanking them for their contribution and emphasizing the significance of their role in improving patient and workplace safety. One contributor each quarter is selected to receive the Great Catch Award: a \$75 gift card and an announcement describing their contribution.

Following initiation of the Great Catch program, data show an increase year-to-date in patient safety event reporting of 41 percent over the previous year. Over the same timeframe, reports of near-miss events increased 100 percent! As a result of the program, we’ve made changes to improve medication storage (with frequently used medications moved to secure storage areas directly in procedure rooms); fostered collaboration with Florida SHOTS and Epic to develop an interface so that previous immunization information is available within Epic; and developed Well Child order sets to assist pediatricians and family physicians with ordering age-appropriate vaccines, labs and medications.

UFP will continue to enhance the Great Catch Program to recognize and reward the practice reporting the highest number of near miss. As programs like Great Catch help promote a culture change of safety and transparency, allowing potentially harmful errors to be prevented before they happen, we all should anticipate a safer and more effective place to work and to receive care.

— DR. DEWAR IS SENIOR ASSOCIATE DEAN, CHIEF EXECUTIVE OFFICER AND CHIEF MEDICAL OFFICER, UNIVERSITY OF FLORIDA PHYSICIANS



CONGRATULATIONS TO 4 EAST ICU STAFF AND PHYSICIANS

By Linda S. Allen

The 4 East Intensive Care Unit staff, nurses and physicians have accomplished what many thought impossible. From November 2009 to November 2010, there were zero central venous line infections, ventilator-associated pneumonias or pneumothoraces in their area. They accomplished this through teamwork, frontline staff involvement and participation in the Florida Hospital Association Cusp Program, a statewide initiative to help reduce infections in the ICU.

To prevent CVL infections, the team evaluated all staff, assessing their skill and their knowledge of changing central line dressings, monitoring and documenting central line insertion by physicians, scrubbing the hub and changing click locks with each IV drug administration. The unit also took a proactive approach to decreasing surface flora by wiping all areas of contact with chlorhexidine wipes. And they implemented the Institute for Healthcare Improvement (IHI) How-to Guide for preventing ventilator-assisted pneumonia and followed the Dobhoff Tube (DHT) Placement Protocol to prevent inadvertent placement of the tube into the lungs, which can cause pneumothoraces.

HCAHPS IN THE NEWS

By Debbie Robins

In 2013, the Center for Medicare/Medicaid Services (CMS) will begin paying hospitals for care based on two components – compliance with Core Measure requirements and patient satisfaction. This approach is known as “value-based purchasing” or “pay for performance” (P4P). Basically, the better your hospital scores in these two areas, the higher your reimbursement will be. Hospitals that don’t perform well risk losing millions of dollars in Medicare payments.

Shands at the University of Florida currently has good compliance with Core Measures. We provide care consistent with the recommended guidelines for managing patients with heart failure, pneumonia or acute myocardial infarction and for preventing surgical site infections. While Shands at UF’s performance is consistent with other academic medical centers, efforts are being led by our board of directors Quality Committee and Patient Safety & Evaluation Committee to improve this score and related patient outcomes.

Patient satisfaction scores are determined by conducting interviews with 300 discharged patients annually. Questions are asked during a telephone survey following discharge. The survey instrument used is known as the Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS. Survey questions focus on nine domains, which include:

- Nursing communication
- Physician communication
- Pain management
- Communication about medications
- Cleanliness of the hospital environment
- Quietness of the hospital environment
- Responsiveness of hospital staff
- Discharge information
- Overall satisfaction

Professional Research Consultants (PRC) is the vendor that conducts the patient interviews on behalf of Shands at UF. The most recent reporting period, which ended in March 2010, reveals we have opportunities to improve the patient experience. Improvement in key areas will help us meet our patients’ needs and expectations. Making rapid changes to improve will require a renewed commitment from everyone on the healthcare team to ensure we provide world-class services with caring and compassion. These efforts will call for active involvement of hospital staff and physicians to make sure we are moving in the right direction.

For more information about HCAHPS, go to <http://www.hcahponline.org/home.aspx>.

UF&Shands
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If you have questions or wish to suggest topics for future issues, please contact Bette Brotherton, vice president of clinical improvement at Shands HealthCare, at brothb@shands.ufl.edu or ext. 80067.

REPORTING PATIENT SAFETY CONCERNS

By Anne M. Meiring

To build a true culture of safety, every employee must accept responsibility for keeping every patient safe from harm. You can help reduce risk to patients by “speaking up” and completing a Patient Safety Report about anything that has caused or could cause injury to a patient. To err is human, but each of us must be accountable for reporting occurrences so the healthcare team is aware of potential risk to our patients. Reporting is made simple by going to the ShandsConnect Portal, linking under “Special SHC Resources” to “Patient Safety Reports” (PSRs).

What happens when a PSR is entered?

The Shands at UF Quality Department, senior management, and your managers and supervisors are made aware of patient events that harmed or could have harmed a patient. Analysis is done to identify trends, system issues and areas for improvement. We may form a Performance Improvement Team to address identified trends. When there is an adverse patient event, we often use a Root Cause Analysis to examine all factors that may have contributed to the outcome.

What benefit do we get from the PSR system?

Our PSR system allows managers and supervisors to analyze data to better understand patterns and determine what improvements are needed to decrease patient safety risks hospital-wide. Proactive reporting of situations that may have caused harm to one patient may help us prevent actual harm to the next patient. If you would like to follow up on actions taken to improve care after an event that you reported, please call the Quality Department at 352-265-0002.

Our data

A review of our data from July through September 2010 shows a high level of participation in reporting patient safety events at Shands. Most fell within these three categories:

1) Blood-/specimen-related

— These are commonly “wrong specimen in the tube” or specimens received unlabeled by the lab. The most frequent cause was that staff did not correctly identify the patient and label at the bedside.



Action: Staff are invited to voluntarily present ideas to improve compliance at special forums.

2) Treatment-, test- or procedure-related

— These events relate to variances in performing a test, administering treatment or conducting a procedure. The most frequent cause was a breakdown in communication or staff not following best practices.



Action: Best practices are continually being implemented.

3) Medication errors

— Two common causes are staff interruptions/distractions and not following best practices.



Action: The Medication Safety Committee is addressing issues, with staff involvement.

— MS. MEIRING IS QUALITY MANAGEMENT DIRECTOR AT SHANDS AT UF

NURSING POSTS QUALITY AND SAFETY RESULTS ON UNIT-BASED BULLETIN BOARDS

This year, throughout the University of Florida and Shands health system, we will be more transparent in sharing patient safety and quality care data internally and with our patients and visitors.

A great step in this direction? The new Quality and Patient Safety Boards throughout Shands at UF. In every patient unit, our nursing teams now post unit-specific, monthly performance data on bulletin boards that showcase our efforts to improve some of the health care industry’s biggest challenges to inpatient care.

The boards reflect our efforts to reduce pressure ulcers, urinary tract infections, patient falls, central line-associated blood stream infections and ventilator-associated pneumonia. For each initiative, we post our target goal and current outcomes, and we list action steps in progress. The boards include current patient satisfaction data reflecting overall quality of care, with a focus on our goal for each patient surveyed to rate his or her hospital experience as “excellent.”

Nursing staff development results are featured, along with unit productivity indicators that reflect patient length of stay and readmission rates, to facilitate the best practice of patient care.

RELYING ON HANDWRITTEN MEDICAL RECORDS RESULTS IN INSULIN OVERDOSE

By Amy Rosenberg, Pharm.D., and Eric Rosenberg, M.D.

Admitting Physician:

“The patient didn’t know his meds very well, so I copied his home medications from his discharge instructions that he got from his last hospitalization.”

NAME OF MEDICATION (PLEASE PRINT)	HOW MUCH	ROUTE	HOW OFTEN	END DATE	TODAY'S REMAINING DOSES
Resume home medications including:					
ASA 325mg	PO	PO	Daily		
Atenolol 50mg	PO	PO	Daily		
HCTZ 25mg	PO	PO	Daily		
Lantus 100 units	SC	SC	QAM or equivalent		
of home medication					
ZOCOR 40mg	PO	PO	Daily @ bedtime		

In fact, the patient was receiving 10 units of insulin glargine (Lantus) during the prior hospitalization and at home. The “g” above “Lantus 10 units” was misinterpreted as an additional “0” – Lantus 100 units.

Pharmacist:

“100 units seemed like a large dose of Lantus. So I double-checked. I also thought the online home medication list said the patient was taking 100 units of Lantus at home so I approved and dispensed the dose.”

The next morning, the patient’s blood glucose was critically low. Although the patient recovered with no long-term adverse outcomes, dextrose infusions were required that day to maintain the patient’s blood glucose.

Discussion:

Unusually high doses of insulin should prompt clinicians to investigate further and verify dosages. In this case the pharmacy department’s computerized medication order entry systems generated an alert because insulin glargine (Lantus) dose was greater than 80 units (this is the level at which the system is set to alert the pharmacist). However, because some patients require high doses of insulin (100 or more units per day), the alert is not accurate for all patients. In this case, the pharmacist received the alert and investigated further, but saw the same handwritten record the physician saw and overrode the alert.

Errors due to interpretation of handwriting are common and widely reported across the country. The most reliable strategy to eliminate errors due to handwriting or legibility is to eliminate handwriting as much as possible from the medical record. Although there are many other potential benefits to a fully electronic medical record, elimination of legibility errors is one major benefit of these systems.

Actions taken to prevent this error from occurring in the future:

Implementation of the Epic fully integrated electronic medical record will eliminate legibility errors at Shands at the University of Florida.



ENHANCING THE PATIENT EXPERIENCE AT UF&SHANDS

Each of us plays a part in fostering a culture that puts our patients at the heart of everything we do. Whether you are a Shands HealthCare employee or volunteer, or a University of Florida Health Science Center faculty, resident, student or staff member, “I Promise” means that you embrace your role – your Promise – in ensuring patients and their families have an excellent experience throughout UF&Shands.

So, what is your role? Do you interact with patients and families in a clinical setting? Do you interact with them in a non-clinical setting? Do you work behind the scenes to support excellent service to our patients and customers? How does your promise strengthen your relationship with patients, and with your own colleagues?

It’s up to each of us to honor our responsibility to help make every patient’s experience the best it can be.