Quality and Patient Safety

Quality & Patient Safety Structure

- Quality Medical Director - Dr. John Boyd
- Director Quality & Patient Safety- Audrey Hubbard
- Quality and Patient Safety Specialist - Amy Arevalo
- Infection Prevention- Karen Yates

Our Quality & Patient Safety Culture

- Just and Fair
  - Creating an open, fair, and transparent environment
  - Creating a learning culture
  - Creating a culture of safety
  - Designing systems and processes to promote safe passage for our patients
  - Managing behavioral choices
- Non punitive
- Focusing on our Processes and not on the Person

Quality & Patient Safety Shared Services/Partnerships

- Regulatory (System Leadership)
- Safety (System Leadership)
- Legal/Risk (System Leadership)
- Corporate Compliance (System Leadership)
- Patient Experience

Routine Activities

- Tracers
- Process Variation (Adverse Event) Reporting
- Partner/Facilitate Performance Improvement
- Facilitate Hospital Acquired Conditions (HAC)Teams
- Peer Reviews and RCA's
- Assist w/ Policy Procedure development and postings
- Track Patient Experience scores

Process Variation Reports

- Adverse Event reporting, investigation, and follow-up is intended to be privileged and confidential and not discoverable.
- An **Adverse Event** is defined as:
  - An unexpected occurrence, with or without injury that is not consistent with normal routine operations or patient care and has the potential to compromise the well-being of patients or visitors.
  - An event that results in patient/visitor injury or potential injury caused, or potentially caused, by a medical device or by a condition of the premises.
  - An expression of strong patient/visitor dissatisfaction, including threatened legal action.
- A serious Adverse Event or **Sentinel Event**, i.e., an event that results in, or has the potential to result in, death or permanent loss of function
- A **Near-Miss Event** is an event that could have resulted in injury, but did not because timely intervention prevented it from reaching the patient

Process Variation Reports

- Insite
- Nursing tab
- Hover over Forms
- Adverse Event Reporting System
- Event Reporting System
- Answer Questions on Report
- Click Submit

Tricks of the Trade
Process Variation Reporting System

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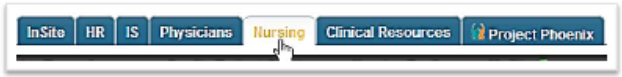
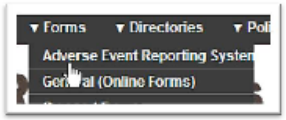
Go to Insite.sw.org

Click the Nursing tab

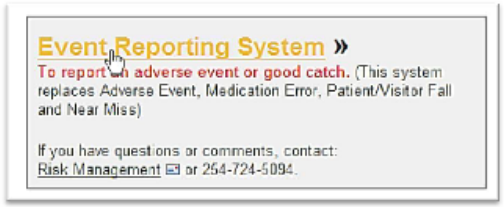


Hover over Forms

Click Adverse Event Reporting System



Click Event Reporting System

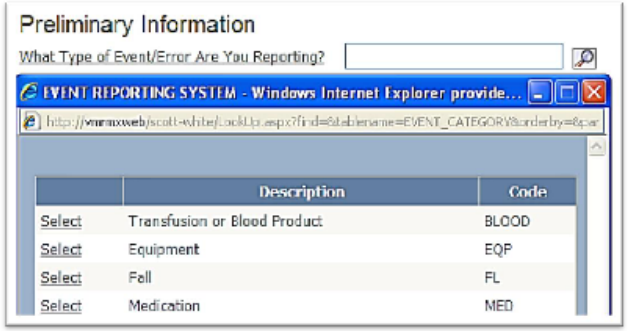


A new window pops up, fill in as many fields as possible.

Some examples of What to chart and Where to chart it

What	Where
Delay in Blood Transfusion, Delay in Type/Cross, Incomplete Transfusion, No Consent for Transfusion, No Order for Transfusion, Blood Order Not Processed, Transfusion Reaction, Wrong Component Transfused, Wrong Transfusion Technique	Transfusion or Blood Product
Entrapment, Equipment Malfunction, Equipment Misuse, Power Interruption, Equipment Unavailable, Equipment Unclean	Equipment
Baby Drop, Developmental Fall, Unassisted Fall, Fall Assisted by Non-Staff, Fall Assisted By Staff	Fall
Allergic Reaction, Infiltration, Other, Adverse Drug Reaction/Interaction	Medication
Privacy/Confidentiality, Aberrant Behavior, AMA, Dr. Armstrong/Altercation/Assault, Dr. Blue, Dr. Fleet, Dr. Rapid, Dr. Red, Elopement/Adam Alert, Exposure to Contagious Disease, Non-Fall Injury Caused by Person's Own Error, Patient Condition Change, Spill Biohazard, Spill Non-Biohazard, Suicide or Attempted, Transfer to Emergency Department, Transfer Related	Other
ID Band- Patient without, ID Band- Wrong Info on Band, Patient using Multiple Names, Orders Written on Wrong Chart, Orders Entered for Wrong Patient, Paperwork with No Patient Info, Paperwork with Wrong Patient Info, Specimen Mislabeled, Specimen without Label, Specimen Unrecoverable, Patient ID Not Verified	Patient Identification
Delay/Failure in Ordering Diagnostic Test, Delivery/Failure in Reporting Results to Physician, Delay/Failure in Physician to Review Results, Delivery/Failure in Providing Treatment, Discharge Related, Documentation Error, Hospital-Acquired Infection or Pneumonia/ Pressure Ulcer, Hygiene Related, Isolation Related, Monitoring Related, Non-Surgical Treatment Complication, Non-Surgical Treatment Error, Specimen Delay/Failure in Collection, Specimen Lost/Mishandled, Specimen Delay/Failure in Processing, Surgical Count, Surgical Cancellation, Surgical Error/ Complication, Surgical Break in Sterile Field, Surgical Packing, Surgical Retained Object, Transplant Related, Wrong Product/Item Given, Wrong Patient or Site, Wrong Test Treatment or Procedure	Medical Treatment

When the Type of Event is a Medication error



A new section shows up down the page: Medication Error Information

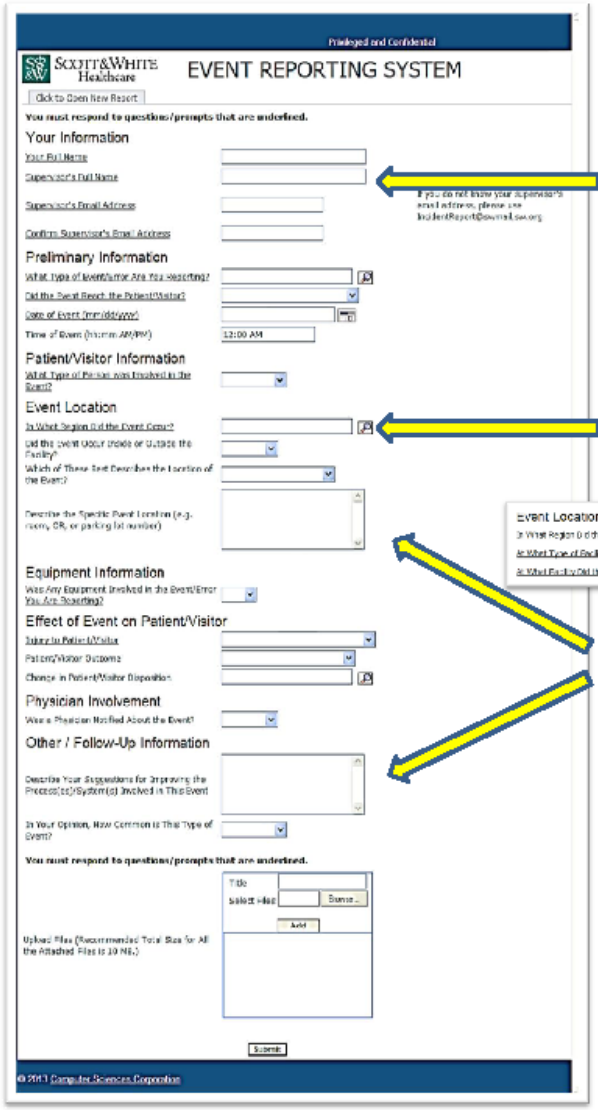
At What Point in the Medication Process did the Medication Error Occur?	
Administering	Giving the medication to the patient Eg. Giving the wrong dose
Dispensing	Getting the medication from somewhere Eg. Getting the antibiotic from the refrigerator
Monitoring	After giving the medication Eg. The antibiotic didn't infuse or infuse within the correct amount of time
Procurement (from outside of S&W)	Eg. Patient has a reaction to a cream compounded by an outside pharmacy
Transcribing/Documenting	Written incorrectly Eg. Wrong dose written

When the Type of Event is a Medical Treatment error

Delay/Failure in Ordering Diagnostic Test	Eg. HUC misses an order and doesn't put it in system
Delivery/Failure in Reporting Results to Physician Delay/Failure in Physician to Review Results	Eg. Nurse forgets to call MD
Delay/Failure in Providing Treatment	Eg. MD forgets to write labs
Discharge Related	Eg. MD has to reprint discharge paperwork
Documentation Error	Eg. Wrong date written on paperwork
Hospital-Acquired Infection or Pneumonia Hospital-Acquired Pressure Ulcer	
Hygiene Related	Eg. Nurse forgets to foam in
Isolation Related	Eg. Nurse doesn't wear gown when necessary
Monitoring Related	Eg. Settings/Alarm limits on monitor are not correct
Non-Surgical Treatment Complication Non-Surgical Treatment Error	Eg. Wrong type of blood product ordered and given
Specimen Delay/Failure in Collection Specimen Lost/Mishandled Specimen Delay/Failure in Processing	
Surgical Count Surgical Cancellation Surgical Error/ Complication Surgical Break in Sterile Field Surgical Packing	
Surgical Retained Object	
Transplant Related	
Wrong Product/Item Given Wrong Patient or Site Wrong Test Treatment or Procedure	Eg. MRI ordered for wrong patient

When the Type of Event is Other

Privacy/Confidentiality	Eg. Patient A discussed while staff in Patient B's room
Aberrant Behavior AMA	Eg. Patient walks out of hospital without MD discharge
Dr. Armstrong/Altercation/Assault Dr. Blue Dr. Fleet Dr. Rapid Dr. Red Elopement/Adam Alert	
Exposure to Contagious Disease	Eg. CMV exposure for pregnant woman
Non-Fall Injury Caused by Person's Own Error	Eg. Patient hitting head on xray machine because they are having a tantrum
Patient Condition Change	Eg. Patient aspirates tube feeds leading to desaturation and abdnormal HR
Spill Biohazard, Spill Non-Biohazard	Eg. TPN bag breaks open
Suicide or Attempted	
Transfer to Emergency Department Transfer Related	Eg. Patient hits head on wall while on stretcher in transfer to another floor



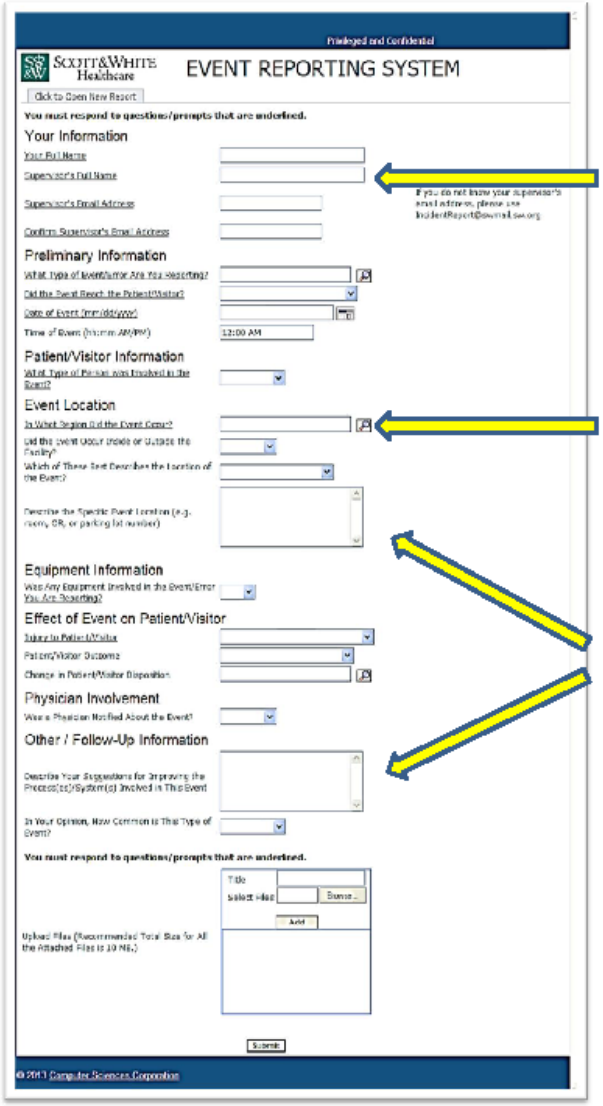
If you are filling this out in the **hospital** setting:

A few problem areas...

Supervisor's Full Name- If you have floated to another area, be sure to put the supervisor's name of THAT area.

Region- Click the magnifying glass and select Central Region. A new line will pop up. Click the magnifying glass again and select Hospital. Another new line will pop up. Click the magnifying glass AGAIN and select Chidlren's Hospital. It now should look like this:

When there are boxes for free text, be as descriptive as possible! Your words can make or break this.



If you are filling this out in the **clinic** setting:

A few problem areas...

Supervisor's Full Name- If you have floated to another area, be sure to put the supervisor's name of THAT area.

Region- Click the magnifying glass and select the region according to the table (on the next page). A new line will pop up. Click the magnifying glass again and select the type of facility according to the table. Another new line will pop up. Click the magnifying glass AGAIN and select the clinic name.

When there are boxes for free text, be as descriptive as possible! Your words can make or break this.

Regulatory Agencies

- Joint Commission on Accreditation of Healthcare (JCAHO)
  - Not for profit organization that assists healthcare organizations to maintain compliances with federal regulations. This organization deems a healthcare facility able to serve Medicare and Medicaid patients and get paid for that care.
    - Centers for Medicare and Medicaid Services(CMS)
      - Develops standards that health care organizations must meet in order to begin and continue participating in Medicare and Medicaid programs

Regulatory Agencies

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Tracers

- **What it is:** A tracer is an evaluation method in which surveyors select a patient or a process.
- **How it works:** Surveyors retrace the specific care processes by observing and talking to staff in that particular area. They go everywhere the patient went or follow through a process step by step.
- **What they are looking for:** Surveyors will look for compliance trends that might point to potential system-level issues in the organization. The tracer activity also provides opportunities for surveyors to educate the organization's staff and leaders, as well as share best practices from other similar healthcare organizations.

Quality Assurance (QA)

- Measures monitored to assure that key services or processes are functioning effectively (with minimal variation).
- Examples of QA initiatives include
  - Medication Usage Review
  - Operative and Other Procedure Reviews
  - Documentation and Communication Reviews
  - Blood and Blood Component Reviews.
  - Sedation Reviews
  - Critical Lab Reviews

Quality Control (QC) Initiatives

- Measures customarily related to equipment. QC measures are the responsibility of operational management to verify that the measurement is being conducted and that variation from acceptable parameters is addressed promptly.
- Examples of QC Initiatives:
  - Maintenance of temperature controls for medication refrigerators
  - Logs for point of care testing
  - Code cart checks

Quality Initiatives (QI)

- Activities associated with issues identified in QA or QC activities, or related to application of best practice for patient care or service.
- Examples of QI initiatives:
  - Prevention of Hospital Acquired Conditions/Infections
  - Ventilator Acquired Pneumonia (VAP)
  - Catheter Associated UTI (CAUTI)
  - Central Line Associated Blood Stream Infections (CLABSI)
  - Surgical Site Infections (SSI)
  - Falls
  - Pressure Ulcers
  - Adverse Drug Events
  - Hand Hygiene Surveillance

HAC (Hospital Acquired Conditions) Teams

- Adverse Drug Event (ADE)
- Catheter Acquired Urinary Tract Infection (CAUTI)
- Central Line Acquired Blood Stream Infection (CLABSI)
- Falls
- Pressure Ulcer Prevention (PUPs)
- Ventilator Acquired Pneumonia (VAP)

What is Your Role in Quality?

- Front line eyes and ears
- Open communication with leadership in identifying risk and areas for improvement
- Complete Process Variation Report
  - Near Misses
  - Caused Harm
  - No Harm
- Participation in staff engagement survey
- Accountability
- Document thoroughly, factually and timely

What is Your Role in Quality ? (cont)

- Provide the highest level of customer service
- Compliance with policies and procedures
- Know your Department
  - How do you measure up on Quality Indicators?
  - Huddle Boards- What is your department doing to improve quality and patient safety?

Quality is not an act, it is a habit.

Aristotle