November 2, 2011

OAHQ State Newsletter

FALL 2011 EDITION

OAHQ President's Update:

By: Jody Ciccone Snyder, RN, BS, MPH, CPHQ

2011 President, OAHQ

WOW! The 2011 summer is over. What a summer it was to remember. Those high temperatures and humidity levels with historical, record breaking events caused us to wish for some cooler days. They are upon us now. Enjoy the change of the seasons.

Well, healthcare is similar. Heated conversation at meetings sometimes; longing for some cooler, more constant activities of improvement with sustainability.

We all contribute to our professions in so many different ways, each having an impact.

OAHQ is *your* organization. It represents what we are and is here to serve you, to inspire you professionally. We are committed to the quality healthcare professional and promoting opportunities for certification. We continue to offer the highest level of educational opportunities to achieve the CPHQ designation. Three opportunities have been scheduled for Fall 2011 throughout the state. The Annual Conference is exciting and stimulating.

Membership benefits have been enhanced. Rewards will be announced for referral of new members. Publication opportunities are available for our OAHQ Newsletter. Rewards will be given for article submissions in our OAHQ Newsletter. Submit articles for *your* newsletter to share your quality improvement stories. There will be more information forthcoming.

Remember the Board meetings are open for you to attend, should you choose.

Contact any of the Board members for meeting information. The OAHQ website lists Board members contact info and the Board meeting schedule. We are currently expanding the Board membership to maintain geographical diversity.

To be successful as an organization, we need *you*. Don't forget to maintain *your* OAHQ membership. Please volunteer to support *your* organization. Opportunities are endless and are needed for: Leadership, Board membership, conference planning, and so much more. The future looks promising as we work together to achieve the goals we have set for the organization Remember, YOU are OAHQ.

Please know it has been my pleasure to serve you once again as your OAHQ President.

Enjoy the Fall and upcoming holiday season. Support and remember our military troops and their families.

Be Safe. Take care of one another. LIVE, LAUGH, LOVE.

…….. Jody Ciccone Snyder

MEMBERSHIP UPDATE!

We have some great innovative ways to help stimulate new growth in membership!

Effective with 2012 Membership:

Free: Starting **January 1, 2012** we are offering one year free membership to those who have newly acquired their CPHQ in 2011!

$: We are offering five dollars off to any past member who returns to the organization, that has not been a member for more than two calendar years.

Prize: We are encouraging all of our existing members to help bring new members in. Any existing member who brings in five or more eligible new members will be eligible for a free 2012 OAHQ conference (eligible new provider –cannot have been a member in 2011).

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Special points of interest:

- ***2012 Conference Dates Set: May 3 & 4***
- ***Submit articles for the OAHQ Newsletter: You may be the winner of a $25 gift card! (Board members not eligible)***
- ***Help us name the newsletter-put your creative powers to work—if name is selected, you will win a $50 gift card!***

The STEEEP Journey

By: Kathy Crea, Pharm.D.

As we all reflect on the journey to Safe, Timely, Efficient, Effective, Equitable, and Patient-centered care (STEEEP) as outlined in the IOM Report 'Crossing the Quality Chasm',[1] at times it seems as if we may never reach our ultimate goal. It is necessary to identify and celebrate the progress that has been made in each of our organizations. There are many important elements in the development of a culture that supports and balances efficiency and standardization with a priority around safe behaviors, learning and improvement from errors, and recognition of the impact of stress, fatigue, and burn-out on human performance. This article reviews some of the many factors that contribute to the development of a culture focused on quality and safety.

Leadership - The importance of leadership support in driving this process cannot be underestimated - it is critically important that all level of leadership are visible and working with the management team and front-line associates to identify recurring issues that make it hard to do one's job.....it's no longer just the way we have done it for years. When associates perceive that leadership feels this is a true priority, without mixed messages about numerous other priorities, it begins to shape the message in a powerful way. Executive Walkrounds is one mechanism by which regular visits to patient care units and ancillary departments provide an opportunity for front-line staff to express concerns related to the equipment, workflow, handoffs with other units and other issues to the leadership team. A next generation of walkrounds is Executive Safety Partnerships in which a monthly discussion occurs with safety and administrative leadership and front-line staff - where a deliberate prioritization of issues occurs and one or two items are chosen for resolution over the next month.[2] This more intense version of walk rounds exposes a larger percentage of associates to the process over time and is designed to provide structure around learning from defects and continually improving processes.

Error Reporting and Analysis - An easy-to-use event reporting system is one way to identify problematic processes, equipment, or behaviors. This process needs to be easy to use and more importantly, the information needs to be reviewed, analyzed, prioritized and issues resolved - with feedback to the reporter and units, which can be a challenge. It is important to remember that voluntary reporting only brings forward a very small percentage of all of the potential issues occurring every day, however it is a starting point. This is one component of a learning culture - learning from issues identified within an organization. Another component is learning from the errors and events of others. It is important that organizations regularly review the safety literature and reflect on one's own risk of a similar event. Health systems may share errors and event analyses between hospitals, clinics, and physician offices in an effort to standardize where appropriate, identify best practices and continuously look for opportunities to improve their own processes.

Analysis of Risks and Harm Events - There are several ways in which risks and events of harm are assessed and analyzed. The use of probabilistic risk assessment, LEAN and six-sigma methodology, root cause analysis (RCA), failure mode and effects analysis (FMEA), and common cause analysis are all methods by which identified issues are reviewed, prioritized, and resolved through action plans. Monitoring the progress of action plan implementation is needed to assure follow-through. When an event recurs, one of a few things has usually occurred: the real root cause was not identified, the action plan didn't adequately address the root cause, the action plan wasn't implemented, or the action plan didn't have adequate follow-up to assure a sustained change. "Drift" is common, meaning that a practice evolves over time such that it's no longer followed as designed. If the management team is not close enough to the front line operations, they may not recognize drift on their own unit. This increases the risk of short cuts and potential patient harm.

The STEEEP Journey…….continued

Team Training - An increasing number of organizations are using formal team training to improve teamwork behaviors and communication. Recognizing that the most common root cause of safety events is communication/handoff issues, more structured communication processes are increasingly being developed and implemented. Procedural areas such as perioperative areas, intensive care units, obstetrics units, emergency departments, radiologic and cardiac procedural areas, and behavioral health units have demonstrated improvements with teamwork training through improved efficiencies, reduction of communication gaps, and reduced clinical errors. [3,4,5,6] Studies are beginning to link outcomes to improvements in teamwork and safety culture. A statistically significant reduction in surgical mortality (18%) was demonstrated in VA hospitals that implemented briefings, debriefings, and checklists with each surgical procedure. [7]

Safety Culture Measurement - It is important, and recommended by several organizations, such as The Joint Commission and the National Quality Forum, to regularly measure the culture of an organization through a safety culture survey. The most commonly utilized surveys are the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture or the Safety Attitudes Questionnaire (SAQ) developed by Bryan Sexton and colleagues, although there are other safety surveys.[8] An adequate response rate (>60%) is a critical factor in assuring accuracy of results and interpretation. Regular assessment every 12-24 months is a common method to identify the potential impact of various initiatives designed to improve the culture of safety in an organization. Actions designed to improve the culture should focus on specific domains that are found to be areas of concern at the unit level, as culture is very unit-specific. The use of debriefings with front-line staff to interpret the results, identify key issues of concern, and development of an action plan have been shown to improve safety culture results.[9]

Best Practice Implementation - Organizations such as the National Quality Forum (NQF), Institute for Healthcare Improvement (IHI), Institute for Safe Medication Practice (ISMP), and Agency for Healthcare Research and Quality (AHRQ) have identified best practices related to patient and medication safety, many of which can be found on their websites. Some of these have been adopted by organizations such as Leapfrog as standards for healthcare insurers and comparative rankings. Implementation of the safety practices may vary slightly by organization, but the safety principles remain the same. There are websites associated with these organizations that provide toolkits, sample order sets and policies, and many references.

Organization	Website
National Quality Forum (NQF)	www.qualityforum.org
Institute for Healthcare Improvement (IHI)	www.ihi.org
Institute for Safe Medication Practices (ISMP)	www.ismp.org
Agency for Healthcare Research and Quality (AHRQ)	www.ahrq.gov
AHRQ Patient Safety Network	www.psnet.ahrq.gov
AHRQ Web Morbidity and Mortality Rounds	www.webmm.ahrq.gov

The STEEEP Journey…….continued

Measurement of Quality and Safety - One major hurdle has been the lack of a consistent and universal measure to identify our progress in decreasing overall harm to patients. There are several measures generally focused on one type of event of harm – such as Adverse Drug Events (ADEs) or Surgical Site Infections. Examples of these measures include the Agency for Healthcare Research and Quality (AHRQ) Patient Safety, Quality, and Prevention Indicators,[10] Adverse Drug Event and Global Trigger tools from the Institute for Healthcare Improvement (IHI) [11], Hospital-Acquired Conditions (HAC)[12] also known as selected Never Events, Serious Safety Event Rate by Healthcare Performance Improvement (HPI), Sentinel Events voluntarily reported to The Joint Commission culture assessment tools, Core Measures by The Joint Commission [13], and many others by various organizations such as infection rates, fall rates, pressure ulcer prevalence. The Global Trigger tool is a tool to monitor overall harm over periods of time, is retrospective, and may be perceived as resource intensive. Some organizations are working to automate this type of trigger tool to avoid retrospective chart review and encourage action at the time of the event.

Everyone agrees that patient safety is a priority - who would disagree?! However a multi-pronged and well-defined plan, led by administrative and physician leaders, is needed to cultivate an environment where safety and continual improvement becomes a habit and part of 'how we do things around here'.

1.Institute of Medicine. Crossing the Quality Chasm. Committee on Quality of Health Care in America. Washington DC: National Academy Press, 2001.

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3. Mann SR, Marcus, B Sachs. Lessons from the cockpit: How team training can reduce errors on L&D. Contemporary OB/Gyn. 2006; 51; i1:34(8).

4.Pronovost P, Berenholtz S, Dorman T, et al. Improving Communication in the ICU Using Daily Goals. Journal of Critical Care. 2003:18(2):71-75.

5.Morey J, Simon C, Jay RJ, et al. Error Reduction and Performance Improvement in the Emergency Department through Formal Teamwork Training: Evaluation Results of the MedTeams Project. Health Services Research. 2002:37(6):1553-1581.

6. Sexton JB. Teamwork Climate and Postoperative Sepsis in the Surgical Operating Room. Association for Psychological Science Sympsoium. New York (27 May 2006).

7. Neily J, Mills PD, Young-Xu Y, et al. JAMA. 2010;304(15):1693-1700.

8.Colla JB, Bracken AC, Kinney LM, and Weeks WB. Measuring Patient Safety Climate: A review of surveys. Qual Saf Health Care 2005; 14:464-466.

9. Tool Tutorial. A Check-Up for Safety Culture in "My Patient Care Area". Jt Comm J Qual Patient Saf. 2007; 33(11): 699-703.

10. Found at http://www.qualityindicators.ahrq.gov/. Accessed November 1, 2011.

11. Griffin FA, Resar RK. *IHI Global Trigger Tool for Measuring Adverse Events (Second Edition).* IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2009. (Available on www.IHI.org).

12. Found at https://www.cms.gov/hospitalacqcond/06_hospital-acquired_conditions.asp. Accessed November 1, 2011.

13. Found at http://www.jointcommission.org/core_measure_set/. Accessed November 1, 2011.

NAME THE NEWSLETTER!!

Do you have a "catchy phrase" that you would like to see used by OAHQ for the quarterly Newsletter heading? What if we told you that you could win a **$50 VISA gift card** if your idea is chosen for the best newsletter title **submitted to Laura O'Neill by 12/31/11**?! Get those creative juices flowing and send in an entry for the OAHQ 'Name the Newsletter' contest. The winner will be announced at the OAHQ Spring Conference May 2 and 3, 2011 at the Embassy Suites in Columbus, OH. Christmas is coming…send in your ideas today!

Are you ready for 2012?

Mark your calendars NOW for the Upcoming OAHQ Conference!

By: Sue Weaver, RN, BSN, CPHQ   President-Elect, OAHQ

The Ohio Association of Healthcare Quality has begun planning for the 2012 Annual Conference. Our 2012 conference will be held on Thursday, May 3, 2012 and Friday, May 4, 2012 at the same great location as last year – Embassy Suites – Columbus airport. The conference is titled, "The Changing Tides of Quality".

The team has been working diligently on getting speakers arranged to meet the needs of our participants. Thus far, we have commitments from high caliber individuals such as Dr. Maulik Joshi, MD, Sr. VP of AHA and Dr. Derek Robinson, MD, CEO, CMS, Region V. Dr. Joshi will be speaking on Hospitals and Care Systems of the Future. Dr. Robinson will be speaking on Healthcare Reform from the CMS Perspective.

Additional speakers who have committed are Cathy Duequette, PhD, Sr. Vice President of Rhode Island Hospital, Jane Adams, RN, BSN, Adams Consulting, Dianne Ditmer, PhD, Desila Rosetti, Healthcare, Craig Clapper, Consultant, and Betty Brown, RN, President, National Association of Healthcare Quality. As you can see, the conference is going to be another excellent educational opportunity for professional and personal growth.

Additional information will be periodically sent out to those on the OAHQ e-mail list.

CPHQ REVIEW COURSE(S)

By: Sue Weaver, RN, BSN, CPHQ

One of the goals of the Ohio Association of Healthcare Quality Organization is to provide as many educational opportunities to as many individuals who are interested. In an effort to meet these goals, we have our annual 2-day conference which was mentioned above. Additionally, in 2011, three CPHQ Review courses were scheduled. Two of those classes were held in October. One was at Kettering Memorial Hospital, Kettering, Ohio and the second at Aultman Hospital, Canton, Ohio.

Those in attendance appreciated the information provided by instructor Linda DaMert. All of the evaluations were excellent. Attendees commented on the knowledge level of the instructor plus the fun way Linda provided the education. Attendees who attended the classes include individuals studying to take the CPHQ exam and current CPHQ's who want to keep up-to-date.

If you missed out on the two classes held in October, it is not too late. There is one additional class which is being offered at St. Vincent's Hospital, Toledo, Ohio on November 29 and 30, 2011. Please contact Laura O'Neill @ oneill397@windstream.net if you are interested in attending. All of our classes have been approved for 15 CPHQ hours or 15 RN CE hours.

Treasurer's Report:

By: Sue Weaver, RN, BSN, CPHQ

Checking Account Balance as of October 27, 2011: $20,886.23
Savings Account Balance as of October 27, 2011: $12,242.73

In 2012, I will change roles from Treasurer of this great organization to President. I was introduced to the role of Treasurer three years ago, when I was asked by a Board member to "help out" when the position was vacated. Of course, being a team player (or just a soft sell) I said, "yes." It was one of the best things I ever did. The interactions and networking that I have been exposed to because of this experience has provided me with tremendous professional and personal growth.

THANKSGIVING THOUGHT:

As we express our gratitude, we must never forget that the highest appreciation is not to utter words, but to live by them.

………………John Fitzgerald Kennedy

Some Ideas for Preparing for a Regulatory Survey: Second Generation Tracers

By: Carol L. Wise, MS, RN, BC, CPHQ

Recently, I attended the Joint Commission's Executive Briefings. If you have not had an opportunity in the past two years to attend, I would encourage you to consider going. The content and suggestions have been very valuable for me in the recent past. I took the information shared and crafted a two day mock survey that we held within our facility. We used a JCR surveyor to lead the effort for this intensive review. I focused on areas where the faculty at Executive Briefings indicated that the standards are proving to create challenges and where there are changes in the survey processes..

One area that we focused on was Endoscopy and "other scopes":

The Joint Commission will be doing more second generation tracers in the future. One area that is being closely scrutinized is endoscopy and high level disinfection practices. Thus, we opted to do a system tracer on endoscopy cleaning and high level disinfection. I would encourage you to look in your organizations to make sure that you are aware of all of the areas where scopes might be used, particularly outside of surgery. You may find that various scopes are used in your clinic settings as well. As you do the tracer, observe how the staff prepares the cleaning agent for the scope when doing the initial wash. Do they measure the disinfectant so that a precise mix of water to disinfectant is used. Too much... and the scope can be damaged over time. Too little…and you know the result that this can cause! Is a timer used to determine if the scope has soaked for an appropriate amount of time? If it says, "soak in 'x' solution for two minutes," the surveyors will watch to see if this occurs. Look at where the cleaning is occurring as well. Is Cidex used? If so, is there an eye wash station in close proximity? Once the scopes are disinfected, do they go to Central Sterile Supply (CSS) for further processing? How are they hung to dry? The surveyors are looking to make sure that the end of the scope is not touching a towel placed beneath it to drain. This creates a wet environment that can then cause re-contamination of the scope should the two come into contact with one another.

You may need to consider other scopes or devices that are being used on patients, such as bronchoscopes that may be done outside of the main surgery department or anal probes, etc. Where are laryngoscopes disinfected? Remember that the clean and dirty areas need to be segregated in your departments.

Finally, what competencies are documented for the employees who are doing the cleaning? There is an expectation that the competency not be merely a "verbalized" competency or a test. The surveyor we had looked for evidence of documentation of a demonstration of the process. It is important to think about which staff may be doing the disinfection. If the equipment goes to CSS, it may be a team who has a thoroughly spelled out policy and well documented competency. In other areas, such as clinics, it may be that assistive personnel or nurses are doing the disinfection. Would you be able to produce evidence of competency on those who do not routinely do this disinfection in other areas of the hospital?

It is my understanding that because surveyors have noted that the need for improvement regarding the management of scope disinfection and high-level disinfection in many organizations, the staff at the Joint Commission are developing a Booster Pack. It was indicated that it will be available in the not-too-distant future. I would highly encourage you to do some second generation tracers in your organizations as well. We found we do many things well, but it was helpful to truly get a better picture of all of the locations that this occurs and particularly of the documentation of competencies around disinfection practices.

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