

February 14, 2012

Quality Matters, Ohio

President's Update: Sue Weaver

Happy New Year. I hope that each of you have transitioned into 2012 smoothly.

This is my first letter to the members of OAHQ so let me introduce myself. My name is Sue Weaver. I am the 2012 President of the Ohio Association of Healthcare Quality (OAHQ). My background includes several years working in healthcare arenas including hospital, insurance, nursing school, and home health. In the early 1990's I got involved in OAHQ because a colleague was a member and thought it would be a great opportunity for me to learn and gain the knowledge to achieve my CPHQ certification. To this day, I thank that individual because my membership in OAHQ has provided me with everything she promised and more.

Becoming a member was easy. I went to meetings and attended all the educational sessions that were offered. After my first year, I realized what an opportunity this organization offered me both professionally and personally. By the second year, I was hooked and ran for office. I have been an officer ever since, either at the local level or the state level. I achieved my goal of becoming a CPHQ and have enjoyed the rewards that distinction offers. Enough about me --

Can you believe 2011 has come and gone? As I reflect on what OAHQ has accomplished in this past year, I can honestly say it makes me proud. We started off

the year by continuing to work on our strategic plan. In addition we began working toward enhancing our website, making changes in membership structure, providing more educational opportunities for our members, offering incentives to new CPHQ's and the list goes on. The highlight of the year was, of course, the 2011 "Enhancing the Landscape of Quality – our State Conference held in May. The speakers were excellent and the new venue proved to be a favorite of the attendees. We offered CPHQ review courses and are proud to say that many of the individuals passed their certification exam and can now proudly add CPHQ to their names.

The Ohio Association of Healthcare Quality also plays an important role in communication. We publish a quarterly newsletter with timely topics for our members. This newsletter provides updated information on educational opportunities, articles by experts in quality, and an opportunity for each member to pro-

vide an article to share with other OAHQ members.

If you are interested in some volunteer work, OAHQ has some great opportunities. Volunteers work on the newsletter, membership, educational events, and bylaws. If you are interested in these volunteer opportunities, please contact Laura O'Neill at oneill397@windstream.net.

Please look further into this newsletter to find out information on the 2012 OAHQ Conference being held on May 3 and 4, 2012 at the Embassy Suites, Columbus Airport, abstract opportunities for the conference, and CPHQ review course offerings planned to date.

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Special points of interest:

- OAHQ Conference on May 3 and 4, 2012!
- CPHQ Certification Course to be held on Apr 23-24, 2012 **OR** on Apr 30 and May 1, 2012

NAME THE NEWSLETTER

CONGRATULATIONS!!!!

Jennifer Colwill, MSN, RN,CNS
Cleveland Clinic

Jennifer's submission of "Quality Matters, Ohio" was selected by the Board.

Jennifer will receive a \$50.00 gift card.
Thank you to each of you that submitted.

B. Jody Ciccone Snyder, RN,BS,MPH,CPHQ
2011 Past President, OAHQ

New Role: Patient Safety Officer

By: Kathleen Goldman RN,BA CPHQ,CPSO
Patient Safety Officer
Clinical Quality Department
Kettering Medical Center



Politics aside, we live in a country that prides itself on a continually evolving Healthcare system. We have achieved amazing technological advances in fields like robotic and laser surgery. We continue to see strides in chemotherapy and pharmacology, focusing on curative and palliative treatments for the acutely ill as well as those with chronic illness. We strive to provide the highest quality, state-of-the-art care to patients and families, our community and the region. Our best efforts are focused on meeting the expectations and demands of multiple shareholders. But, to accomplish these monumental yet imperative tasks and initiatives, we need the cooperation and collaboration of nurses, physicians, technicians, pharmacists, housekeepers, dietitians, accrediting agencies, insurance companies, medical equipment companies, and many others. What may get lost along this difficult and noble path is the reason for our existence in healthcare, the patient.

Enter the Patient Safety Officer. Patient Safety Officers (PSO)'s are individuals who may encompass and embrace a wide variety of roles, often wearing several hats (RN, Safety Officer, Infection Control Officer, Accreditation/Compliance Manager, Risk Manager, the list goes on...). The greatest of these roles however, comes from being a definitive voice for the patient. This specific function allows for true advocacy, through development and implementation of deeply embedded safe care within the existing culture. As a member and/or leader of a team, the PSO will work to find opportunities to help shape a healthier culture.

Having a Patient Safety Officer to work with may mean different things in different institutions. A Patient Safety Officer (PSO) functions with all levels of staff, management, administration, & physicians, to help establish and promote safety concepts and initiatives. Additionally, the PSO explores ideas, processes, and systems that work well (i.e. bedside reporting) and/ or are rooted in evidence-based care, as well as those in need of review, revision, or removal. With serious event reporting the PSO may be able to identify trends and work toward solutions to difficult patient safety issues within the organization. Some organizations have explored new directions while evaluating and uncover-

We're on the Web!
WWW.oahq.org

Patient Safety Officer.....continued!

ing underlying issues behind adverse events using Just Culture principles, as well as other tools. The PSO works with staff that may have deeply ingrained ideas of what patients need or what has always worked in the past. By encouraging accountability the Patient Safety Officer is available to discuss and support staff when facing challenges, so that patient advocacy and accountability are always perceived as being the right thing to do.

Kettering Medical Center in Dayton, Ohio is a leader in recognizing the value and impact a Patient Safety Officer can have on patient safety. I appreciate the opportunity to take the lead in this role for my organization.

As a newly nationally certified Patient Safety Officer(CPSO), I would encourage others to contact the International Board for Certification of Safety Managers(IBFCSM) for information on eligibility criteria, fees, and study information. The website is

[www. IBFSCM.org](http://www.IBFSCM.org).

Thank you,
Kathy

SAVE THE DATE!!

It is that time of year when OAHQ is finalizing their 2012 Conference Speakers. Our list of speakers includes Dr., Maulik Joshi, MD, Sr. VP of AHA and Dr. Barbara Connors, CMO, Region III, CMS. Dr. Joshi will be speaking on Healthcare Reform and Dr. Connors on Hospitals and Care Systems of the Future. Dr. Connors will be discussing Healthcare Reform from a 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 Consultant , Craig Clapper, Consultant, Lee Hamilton, J.D., President of NAHQ, Dr. Rebekah Wang, Kettering Health Network, Dr. Rick Snow, Ohio Health and Ohio Hospital Association, Dr. Ed Bope, Columbus VA, and Melissa Walters, Treasurer of National Association of Medical Staff Services. There are many additional speakers who have the same level of knowledge and talent as those mentioned above. This conference proves to me worth your time to attend.

The conference will be two days filled with experts on all areas of healthcare. Our goal is to improve our conference each year and to make it better than the last. The team working on this conference feels we will accomplish that with our array of talent being shared.

The brochure for the conference will be out no later than April. Look for it in your e-mail.
It will be an exciting time for everyone.

**OAHQ Annual
Conference
May 3 and 4,
2012
Embassy Suites,
Columbus Airport**



“The Changing Tides of Quality”

Respectful Management of Serious Clinical Adverse Events

By: Kathy Crea, Pharm.D., BC,PS Riverside Methodist Hospital

The Institute for Healthcare Improvement released the first edition of this white paper in October 2010. There was much activity and interest in the white paper with discussion at national and international organizations and meetings. The document includes a comprehensive checklist to guide the organization in assessing current status and progress towards an optimal program. Many improvements to the white paper were suggested by readers, many of which fell into two major areas: increasing focus on compassion and empathy for all involved in an event and very strong recommendations for the inclusion of reimbursement and compensation in discussions of disclosure and resolution. Other comments referenced the large scope of the recommendations and challenges to implementation without a "burning platform", or poor outcome within an organization.

The Innovation Series white paper set out to meet three objectives:

1. Encourage and help every organization to develop a clinical crisis management plan before they need to use it.
2. Provide an approach to integrating this plan into the organizational culture of quality and safety, with a particular focus on patient and family-centered care and fair and just treatment for staff.
3. Provide organizations with a concise, practical resource to inform their efforts when a serious adverse event occurs in the absence of a clinical crisis management plan and /or culture of quality and safety.

Several key concepts are important in the management of every event: ongoing communication, empathy, disclosure, support, assessment, resolution, learning and improvement. Clearly, not responding to a serious event in a timely and effective manner carries risks: loss of trust among patients, sending mixed messages to employees related to the commitment to safety and quality, absence of learning and improvement, absence of healing, increased risk of regulatory action or claims, and media reaction. Without a plan that is structured and tested for effectiveness, organizations tend to go into a reactive, defensive survival mode, but may choose to instead pursue a proactive, learning mode.

In a recent Australian study, patients and family members stated communication about serious incidents rarely met their expectations and actually compounded their distress(1). One key point related to respectful disclosure that enabled patients, families, and staff to move forward after a disclosure was the ongoing nature of the communications.

A key strategy of all organizations should include a standing Crisis Management Team (CMT) that has the ability to immediately assemble in response to a serious clinical event. The role of this team is to ensure that the priorities of the patients, families, staff, and organization are met and to ensure the key principles are enacted (enhanced communication, support, assessment, resolution, learning, and improvement following the event). Key team members include the CEO, COO, CMO, CNO, legal counsel, pastoral care counselor, public relations, patient representative, Risk, Management, Quality-Safety representatives, and appropriate clinical leaders (physicians, nurses, pharmacist, etc). A back-up response team is highly recommended to enable a standardized response regardless of day of week or hour of the day. Practice drills and simulations are suggested to assure common understanding and effectiveness of the process.

Many organizations have internal and external disaster plans that may serve as a model to build the CMT. Take a moment to review a previous serious event and the organization's response to learn what worked well and what could work more smoothly. The four hallmarks of a strong crisis response include immediacy, transparency, apology, and accountability. The three priorities of response are the patient and family, the staff (especially front line staff), and the organization.

When a patient has been harmed, the way the organization responds after such events can erode the trust of the patient and family. If we always keep the patient and family in the front of our minds, our actions will be guided appropriately. There is significant evidence on the effects these types of events can have on the associate and physicians involved in the care of the patient, causing significant stress, shame, disengagement and at times they choose not to continue in their chosen career. It is our job to provide an empathetic response to all involved – always offer support through Employee Assistance Programs, pastoral care, and other resources through human resources or wellness programs. Establish and practice principles of a fair and just organizational culture. This will shape the culture and response of the organization. Remember that early information is often incorrect and communication without facts is very hard to correct at a later time. Most importantly, learning from these events through interviews, document review,

Respectful Management of Serious Clinical Adverse Events...continued...

and root cause analysis is paramount to prevention of future similar events. Appropriate and timely notification to regulatory agencies based on state and other requirements is important – be prepared for external regulatory organization visits.

Internal and external communication remains a part of the ongoing process to assure accurate information is communicated in an appropriate and timely manner. Service recovery should be an immediate proactive response and discussions around disclosure, compensation and reimbursement bring about thoughtful and lively debate related to the overall impact.

Remember that executive leadership holds the responsibility to ensure that action to further understand and analyze the causes and institute plans to prevent a recurrence are accomplished in a thorough, yet timely manner. It takes a team!

1. Ledema R, Allen SA, Britton K, et al. Patients' and family members' experiences of open disclosure following adverse events. *International Journal for Quality in Health Care*. 2011;20(6):421-432.



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HOW MUCH DO YOU MAKE.....NURSE?????

Somebody asked: "You're a nurse? That's cool, I wanted to do that when I was a kid. How much do you make?" The nurse replied: "HOW MUCH DO I MAKE?" ... I can make holding your hand seem like the most important thing in the world when you're scared. ... I can make your child breathe when they stop. ... I can help your father survive a heart attack. ... I can make myself get up at 5a.m. to make sure your mother has the medicine she needs to live... I make my family wait for dinner until I know your family member is taken care of. ... I make myself skip lunch so that I can make sure that everything I did for your wife today is charted. ... Or almost pee my pants.....I make myself work weekends and holidays because people don't just get sick Monday thru Friday. ... So, how much do I make?

All I know is, I make a difference.....Author Unknown

CPHQ REVIEW COURSES SCHEDULED!

Are you interested in becoming a CPHQ? If you are already a CPHQ do you just want to get your CPHQ educational requirements completed?

OAHQ has two CPHQ re-



Become a Certified Professional in Healthcare Quality!

view classes scheduled thus far in 2012. The first of these will be held in Cincinnati at The Christ Hospital on April 23 and 24, 2012, The second will be held in Cleveland at University Hospital – Richmond Campus, on April 30 and May 1.

These classes will be taught by Linda DaMert, Linda has taught several of the CPHQ classes sponsored by OAHQ. Reviews from past participants in Linda's classes have highly rated her ability to teach and her volume of knowledge about quality.

Brochures for these classes will be sent out in March. If

you are interested, please mark you calendars and plan to attend. We do need to have a minimum of 20 participants to conduct the class.

The CPHQ review course has been approved for 15 CPHQ or 15 RN CEU hours.