Quality Improvement: Engaging the Team

Susan Moffatt-Bruce, MD, PhD
Chief Quality and Patient Safety Officer

Agenda

• Leadership Quality & Patient Safety Goals
• Just Culture
• Quality Processes and Ongoing Evaluation
• Importance of Checklists
• Using data to improve performance
## Leadership Council for Clinical Quality, Safety and Service Goals

<table>
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<tr>
<th>Quality &amp; Safety</th>
<th>Reduce Potential Preventable Quality &amp; Safety Events</th>
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<tr>
<td></td>
<td>Achieve top decile status for health system risk-adjusted inpatient mortality rate (0.67).</td>
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<td>Enhance educational programs for Quality &amp; Safety</td>
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<td>Expand performance transparency and accountability as it related to quality, safety &amp; service outcomes across the Health System</td>
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<tr>
<td>Productivity &amp; Efficiency</td>
<td>Reduce Health System ALOS to 6.03 days.</td>
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<tr>
<td>Service &amp; Reputation</td>
<td>Achieve top decile status by 2012 for patient satisfaction (2009 Health System target 87.9)</td>
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## Quality and Safety Scorecard

<table>
<thead>
<tr>
<th>Type of Event</th>
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<tbody>
<tr>
<td>Retained Foreign Bodies</td>
</tr>
<tr>
<td>Wrong Site Events</td>
</tr>
<tr>
<td>Medication Events with Harm (Severity E-I)</td>
</tr>
<tr>
<td>Medication Events with Intervention to Prevent Harm (Severity D)</td>
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<tr>
<td>Severe Injury Falls (Resulting in change in patient outcome)</td>
</tr>
<tr>
<td>Hospital Acquired Decubitus Ulcer</td>
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<tr>
<td>Hospital Acquired MRSA</td>
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<tr>
<td>Hospital Acquired VRE</td>
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<tr>
<td>Hospital Acquired Central Line Blood Stream Infections</td>
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<tr>
<td>Ventilator Associated Pneumonia</td>
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<tr>
<td>Hospital Acquired Surgical Site Infections</td>
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<tr>
<td>Hospital Acquired Clostridium difficile Infection</td>
</tr>
<tr>
<td>Other Sentinel Events</td>
</tr>
<tr>
<td>Death in Low Mortality DRG</td>
</tr>
<tr>
<td>Codes Outside of ICU</td>
</tr>
</tbody>
</table>
Accountability

“Just Culture” – Balance system and process issues with accountability for expected behaviors

- The just culture is not a blame-free culture. It merely tries to provide a consistent guide to determine:
  1) When a person is truly at fault for a specific act
  2) Reasonable consequences that will best serve the individual’s and the organization’s interests

<table>
<thead>
<tr>
<th>Just Culture</th>
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</thead>
<tbody>
<tr>
<td>The four key categories of fault in a just culture are:</td>
</tr>
<tr>
<td>- <strong>Human error</strong>: Unintended slips, lapses, and mistakes</td>
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<tr>
<td>- <strong>Negligent conduct</strong>: Failure to exercise care expected of a prudent worker</td>
</tr>
<tr>
<td>- <strong>Reckless conduct</strong>: Conscious disregard for a known risk</td>
</tr>
<tr>
<td>- <strong>Knowing violations</strong>: Conscious disregard for known rules</td>
</tr>
</tbody>
</table>
To guide organizations when making fair decisions, decision algorithms have been developed. These algorithms typically ask a series of questions:

- Were the actions intended?
- Was the person under the influence of unauthorized substances?
- Did the person knowingly violate existing policies, procedures, or expectations?
- Would another person in the same situation perform in the same manner?
- Does this person have a history of unsafe acts?
Quality Processes and Ongoing Review

- Partnership between
  - Department Chairs
  - Quality Department
  - Credentialing Department
  - Chief Quality and Patient Safety Officer
  - Chief Medical Officer

**Quality Review Process**

1. **PEC Chair** reviews Quality Review Processes
2. **PEC Chair** notifies Depart Chair, that case going to PEC
3. PEC Chair notifies Practitioner of any preliminary issues/concerns & request input prior to final disposition
4. Final disposition to DMA/CMO as appropriate
5. **No** to PEC
   - Notify practitioner & Depart Chair of findings
   - Requires recommendation to CMO/DMA/Chair
6. **Yes**
   - CMO initiates formal peer review process as outlined in Bylaws

**PEC Potential Recommendations**

- No action - continue OPPE
- Dept Chair - process improvement plan
- Dept Chair - observation
- Dept Chair - simulation
- Notify practitioner & Dept Chair of findings
- Committee for LIHP Health

**Quality Review Process**

- OPPE (Profile, Standard & EE audit or trends)
- Morbidity & Mortality Review outcome(s)
- Mortality Review (single egregious, sentinel or trends)
- Professional Council
- PEC (new practitioner or trends)
- Service Referral (single episode or trends)
- Insurance/Managed Care Quality Notice

**Terry Zeng, RN**
Quality & Operations 06.11.10
Contact: Susan Moffatt-Bruce
Practitioner Performance Evaluation

• To evaluate the competency and professional performance of an individual practitioner
  ✓ Initial applicant - FPPE
  ✓ New privilege request - FPPE
  ✓ Concern has been identified - FPPE
  ✓ Ongoing basis - OPPE

Practitioner Performance Evaluation

• Six core competencies that were originally developed for the Graduate Medical Education:
  1) Patient care
  2) Medical knowledge
  3) Practice-based learning and improvement
  4) Interpersonal and communication skills
  5) Systems-based practice
## FPPE – Initial Privilege
(New Applicant)

- Initial privilege request – new Applicant
- Requires evidence of competency in 10 clinical encounters (outpatient or inpatient; office visit)
- Initial period of FPPE is 6 months (provisional period)
- Must be pertinent to the privileges requested
- Evidence is reviewed by the Chief Quality & Safety Officer and Credentials Committee prior to moving to full active appointment

## FPPE – New Privilege

- Current members of the medical staff or licensed healthcare professional staff with specifically delineated clinical privileges who are requesting a new privilege will be granted the new privilege on a Provisional basis.
- The review criteria may vary, but the review must be specifically relevant to the privilege granted
- Evidence is reviewed by the Chief Quality & Safety Officer and Credentials Committee prior to approving new privilege
FPPE – For Cause

- Appropriate when questions arise regarding a currently privileged practitioner's ability to provide safe, high quality patient care
- Triggers include but are not limited to:
  - Event Reporting trends or single egregious case
  - Patient/Family complaint
  - Referral from the Department Chair
  - Unprofessional behavior
  - Outliers identified in FPPE for applicant or privilege
  - Outliers identified during OPPE

Ongoing Practitioner Performance Evaluation

- Biannual evaluation of each Department member with the Department Chair
- Aligns with reappointment and data are used to determine:
  - Maintenance of privileges
  - Modification of privileges
  - Termination of privileges
- Global indicators (mortality, LOS, readmission)
- Service-specific indicators as approved by the Division and Department
- Low volume faculty- 23 / 2 years
Quality Review Process

1. Review determinations from prior levels of review, including OPPE & FPPE.
2. Obtain additional clinical expertise from internal/external physician.
3. Notify practitioner of any preliminary issues/concerns & request input prior to final disposition.
4. Final disposition to DMA/CMO as appropriate.

Mortality & Mortality Review outcomes:
- Single egregious or trends in high severity outcome
- Mortality Review
- Event Report (single egregious or trends)
- Professionalism Council
- FPPE (new privilege/new practitioner)
- Depts Chair referral

PEC Chair notifies Dept Chair, that case going to PEC

PEC Chair reviews

Case reviewed at PEC

Mortality Review outcome (s) OPPE (Profile)
Global/SSI outlier or trends
Practitioner notified

Trigger cases follow determined processes & are peer reviewed prior to forwarding to Chief Quality & Pt. Safety Officer

Check Lists:
Achieving “Zero Defects”

- Commitment to improving the process.
- Using “source check” and “sequential check” to eliminate defects.
  - “Source check” is where the operator immediately checks his or her work to see if there is an error.
  - “Sequential check” is a redundant check where every worker checks to see that the previous step has been performed correctly.
- Using systems that do not rely on memory. Checklists, prompts or forcing functions are needed.
“Check lists help achieve that balance...they supply a set of checks to ensure the stupid but critical stuff is not overlooked, and they supply another set of checks to ensure people talk and coordinate and accept responsibility while nonetheless being left the power to manage the nuances and unpredictabilities the best they know how.”

Gawande “The Checklist Manifesto”

OSUMC’s Safe Surgical Checklist
### Surgical Safety is a Serious Public Health Issue

- About 234 million operations are done globally each year.
- A rate of 0.4-0.8% deaths and 3-16% complications means that at least 1 million deaths and 7 million disabling complications occur each year worldwide.

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### World Health Organization (WHO) Surgical Safe Checklist

![World Health Organization (WHO) Surgical Safe Checklist](image)
## OSU Surgical Team Safety Checklist

### Sign In (Before Induction)
- Performed by Nursing and Anesthesia
- Team Members Introduce Themselves
- Patient Identification
  - Procedure
  - Site
  - Consent
  - Blood Bank
  - Allergies
- Confirmation of Site Marking, when applicable
- Anesthesia Assessment
  - Machine Check
  - Monitors functional?
  - Airway?
  - Suction available?
- Blood Available
  - Anticipated Blood Loss Risk
- Equipment Available

### Time Out (Before Skin Incision)
- Initiated/Led by Surgeon
- Team Members Introduce Themselves if Different Team
- Operation to be Performed
  - Anticipated Operative Course
- Site of Procedure
- Patient Positioning
- Allergies
- Antibiotics Given
- Time
- Imaging Displayed

### Sign Out (Procedure Completed)
- Performed by OR Team
- Completed Procedure Recorded
- Body Cavity Search Performed
- Uninterrupted Search Performed
- Counts Correct
  - Sponges
  - Sharps
  - Instruments
- Specimens Labeled
- Team Debriefing
- Event Report Filed

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**SCIP Measure:**
**Prophylactic Antibiotic within 1 Hour of Incision:**
* A surrogate for compliance

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Thank You
WHO Safe Surgical Checklist was found to reduce the rate of postoperative complications and death by more than one-third.


OSUMC’s Video:

mms://media.twomd.ohio-state.edu/medical_center/Safety_Checklist.wmv

Universal Protocol – Three Step Checklist
**Bedside Procedures**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
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<tbody>
<tr>
<td>All other deep, percutaneous procedures (e.g. biopsies, drainage)</td>
<td>Infusion of drugs to middle ear</td>
</tr>
<tr>
<td>Arthrocentesis</td>
<td>Lumbar puncture</td>
</tr>
<tr>
<td>Bone marrow aspiration or biopsy</td>
<td>Pacenthesis</td>
</tr>
<tr>
<td>Brachytherapy</td>
<td>All procedures in the Radiation Oncology Department</td>
</tr>
<tr>
<td>Central venous catheter insertion</td>
<td>Peripheral arterial lines (A-line) insertion</td>
</tr>
<tr>
<td>Chest tube placement</td>
<td>Placement of regional anesthesia blocks</td>
</tr>
<tr>
<td>Circumcisions (Neonatal)</td>
<td>Regional and local nerve block placement</td>
</tr>
<tr>
<td>Electro-convulsive therapy (ECT)</td>
<td>Swan-Ganz introducer/catheter placement</td>
</tr>
<tr>
<td>Epidural</td>
<td>Thoracentesis</td>
</tr>
<tr>
<td>Gamma knife</td>
<td>Traction pin placement</td>
</tr>
<tr>
<td>ICP drains and pressure monitor placement</td>
<td>Wound debridement as a planned procedure, does not include minor debridement during a routine dressing change</td>
</tr>
</tbody>
</table>

**Three Steps**

1. Conduct a Pre-Procedure Verification
2. Mark the Procedure Site
3. Perform a “Time Out”
### Step 1: Pre-Procedure Verification

Pre-procedure verification involves, with participation of the patient, confirming the correct procedure and site against the following:

- H&P,
- Signed consent containing procedure, side & site,
- Consult or order,
- Diagnostic images & tests, and
- Surgery/procedure schedule
- Ensure all documents are consistent.

### Step 2: Site Marking

- Mark all cases involving laterality, bilateral procedures, multiple structures or levels:
  - Mark at or near the incision site,
  - Visible after the patient is prepped and draped,
  - Permanent marker (initials),
  - Practitioner or representative performing the procedure should do the site marking, and
  - Marking must take place when the patient is involved, awake and aware
Step 3 – “Time Out”

• Call “Time Out” before starting the procedure:
  
  ✓ State patient’s name, procedure and side/site.
  
  ✓ Final verification of the site marking must take place during the “time out”.
  
  ✓ All members of the team must stop and participate in the “time out”.
  
  ✓ Procedure cannot start until discrepancies are resolved.
Document

Three Steps:

- Essentris
- IBEX
- UP/Time Out Form

CVC Insertion Checklist
OSUMC Total* CLA-BSIs Count by Month

Number of CLA-BSIs

Jan 09
Feb 09
Mar 09
Apr 09
May 09
Jun 09
Jul 09
Aug 09
Sep 09
Oct 09
Nov 09
Dec 09
Jan 10
Feb 10
Mar 10
Apr 10

*Includes data from: MICU, RICU, SICU, NICU, EICU, J10, JBMT, H2, H4, H5, H6, H7.

How Can I Prevent a Central Line Associated Bloodstream Infection?
(CL-BSI)

Perform Head Hygiene
- before catheter insertion
- dressing changes
- at any time the catheter is to be accessed

Wear Cap, Mask or Face Shield, Sterile Gloves, Sterile Gown (on the sterile barrier kit)
- when inserting the line
- when removing the line
- when handling sites

Insertion Key Points
- Vigorously scrub insertion site for at least 30 seconds with Chloraprep® (2 minutes if the forearm site)
- Cover patient with large sterile drape
- Avoid the femoral vein, if possible

Key Points about Tubing
- Do not contaminate previously used tubing to a new central line
- Do not loop tubing into itself; instead use a sterile cap

Dressing Maintenance
- Dressings should be clean, dry, intact and occlusive
- Sterile dressing
- Change dressings whenever loose or soiled
- Change transparent dressings every 7 days
- Change gauze/tape every 48 hours

Replacing the Line
- Vigorously scrub IV caps prior to use
- Prior to drawing any blood cultures, clean external surface of Folems, remove and replace with new cap
- Do not draw a discard prior to drawing blood for blood cultures
- Blood cultures must be hand drawn, do not use a Vacutainer

EVALUATE LINE NECESSITY DAILY. REMOVE IF NO LONGER NECESSARY.

1 Focus: Patient Safety
The Ohio State University Medical Center
Central Venous Catheter Insertion Checklist
PLEASE Fax to Epidemiology # (614) 293-4261 when completed

Date/Time: ___________________ Unit: ___________________

Catheter Type: _______________ Insertion Site: ________________ Side: R L

If line was inserted in internal jugular vein, was ultrasound used? Yes No

Was the line placed emergently (e.g., during Code Blue or trauma)? Yes No

If "No," STOP the procedure

Before the procedure, did the operator:
- Document informed consent
- Perform timeout

Assistant: If enters sterile field, uses sterile gown and gloves, cap, mask / eye protection
- Prep site with ChloraPrep for 30sec minimum (if femoral site, 120sec minimum)
- Allow site to dry
- Sterile technique to drape patient from head to toe

During the procedure, did the operator:
- Maintain a sterile field
- Obtain a qualified second operator IF 3 unsuccessful sticks (except if emergent); document the number of attempts
- Change gloves: if a catheter was exchanged over a guide wire before handling the new sterile catheter
- Account for the guidewire at all times

After the procedure, did the operator:
- Apply a sterile dressing immediately after insertion
- Document date and time on the dressing
- Perform hand hygiene
- All staff wore a mask until sterile dressing placed

Assistant: ______________

Operator: ___________________
Signature: ___________________

Dispose sharps immediately after the procedure N/A

Attach patient label here

1 Focus: Patient Safety

Coming Soon!
Chest Tube Insertion Checklist
# Chest Tube Insertion Checklist

**UWET ***

- Universal Precautions (achieved by using sterile cap, mask, gown, and gloves);
- Wider skin prep;
- Extensive draping; and
- Tray positioning.

U.S. Agency for Healthcare Research and Quality (AHRQ)

## The Ohio State University Medical Center
Chest Tube Insertion Checklist

<table>
<thead>
<tr>
<th>Step</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document informed consent</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Perform hand hygiene</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Operator(s): Wears cap, mask / eye protection, sterile gown and sterile gloves</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Assistant: If enters sterile field, uses sterile gown and gloves, cap, mask / eye protection</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Prep site with ChloraPrep for 30 sec minimum (if femoral site, 120 sec minimum)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Allow site to dry</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Sterile technique to drape patient from head to toe</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Position tray close to operator’s dominant hand</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Maintain a sterile field</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>After the procedure: Apply a sterile dressing immediately after insertion</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Document date and time on the dressing</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Perform hand hygiene</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>All staff wore a mask until sterile dressing placed</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Dispose sharps immediately after the procedure</td>
<td>✓</td>
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</table>

**UWET **

*Universal Precautions (achieved by using sterile cap, mask, gown, and gloves); Wider skin prep; Extensive draping; and Tray positioning.*

*U.S. Agency for Healthcare Research and Quality (AHRQ) by Dr. Colin F. Mackenzie and colleagues at the University of Maryland in Baltimore.*

**Focus: Patient Safety**
Using Data to Improve Performance

- Quality and Safety Scorecard
- Signature program score card
- Physician specific scorecards

Health System Mortality

Source: UHC
Factors Impacting Outcomes

<table>
<thead>
<tr>
<th>Uncontrollable</th>
<th>Controllable</th>
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<tr>
<td>• Age, Race, Gender</td>
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<td>• Socioeconomic Status</td>
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<tr>
<td>• Co-morbid conditions</td>
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<td>• Acuity &amp; severity of Illness</td>
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<td>• Use of evidence based practice: complications avoidance</td>
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<td>• Staffing levels</td>
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<td>• Competency and experience</td>
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<tr>
<td>• Transfers</td>
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<td>• Patient Selection</td>
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Source: UHC

Accountability for Quality and Service Metrics

- Length of Stay
- Mortality
- Readmissions
- Patient Satisfaction
Physician Performance Reporting

- Chair Report
  - Department Performance
  - Division Performance
  - Individual physician performance

- Division Director Report  *NEW – Mid July*
  - Division Performance
  - Individual physician performance

- Physician Portal  *NEW – Mid July*
  - Every physician will have access to their data

Dept/Div Chair/Director Reports

![Graphs and tables showing performance metrics for Department of Surgery and Inpatient Satisfaction with Physicians]
Summary

- Leadership Quality & Patient Safety Goals
- Just Culture
- Quality Processes and Ongoing Evaluation
- Importance of Checklists
- Using data to improve performance

What can you do?

- Accountability, ownership and integrity
- Create a work environment that is open, honest and transparent
- Speak Up if you see something wrong
### 1 Focus: Patient Safety

What does it mean?

- We are 1 team focused on patient safety.
- We’ll focus on 1 person at a time.
- 1 time makes a difference.
- Each 1 of us has to be accountable for our actions.
- Each 1 of us should professionally remind our colleagues to do the right thing for patient safety.