Quality Improvement: Engaging the Team

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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

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

Quality and Safety Scorecard

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

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**

Just Culture

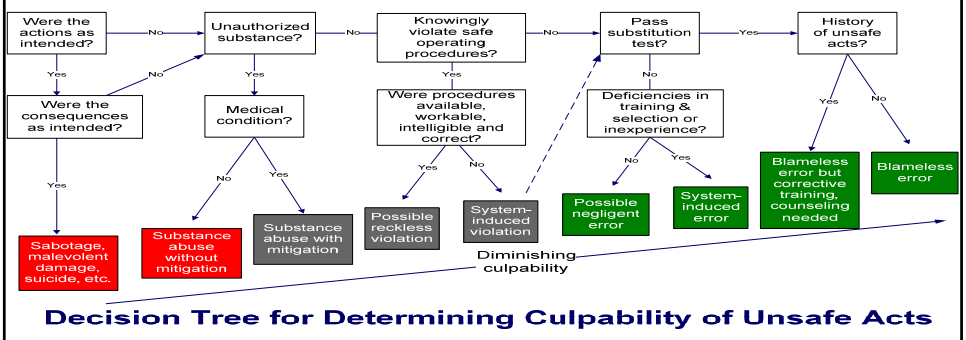
The four key categories of fault in a just culture are:

- **Human error: Unintended slips, lapses, and mistakes**
- **Negligent conduct: Failure to exercise care expected of a prudent worker**
- **Reckless conduct: Conscious disregard for a known risk**
- **Knowing violations: conscious disregard for known rules**

Just Culture

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?**

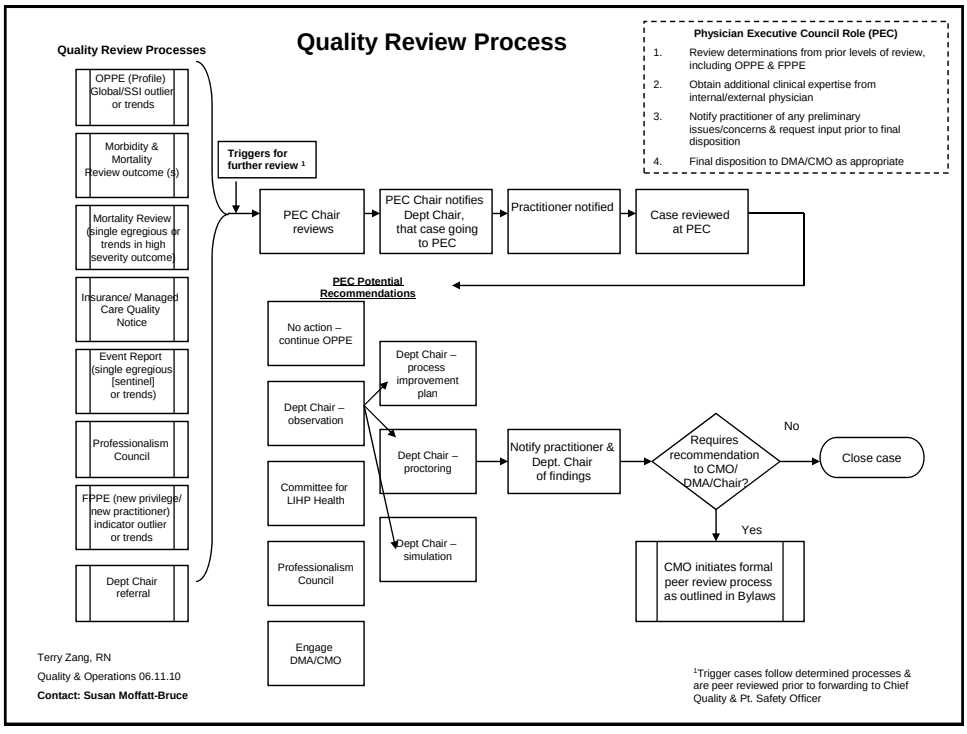


Decision Tree for Determining Culpability of Unsafe Acts

Reason, J: Managing the Risk of Organizational Accidents

Quality Processes and Ongoing Review

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



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

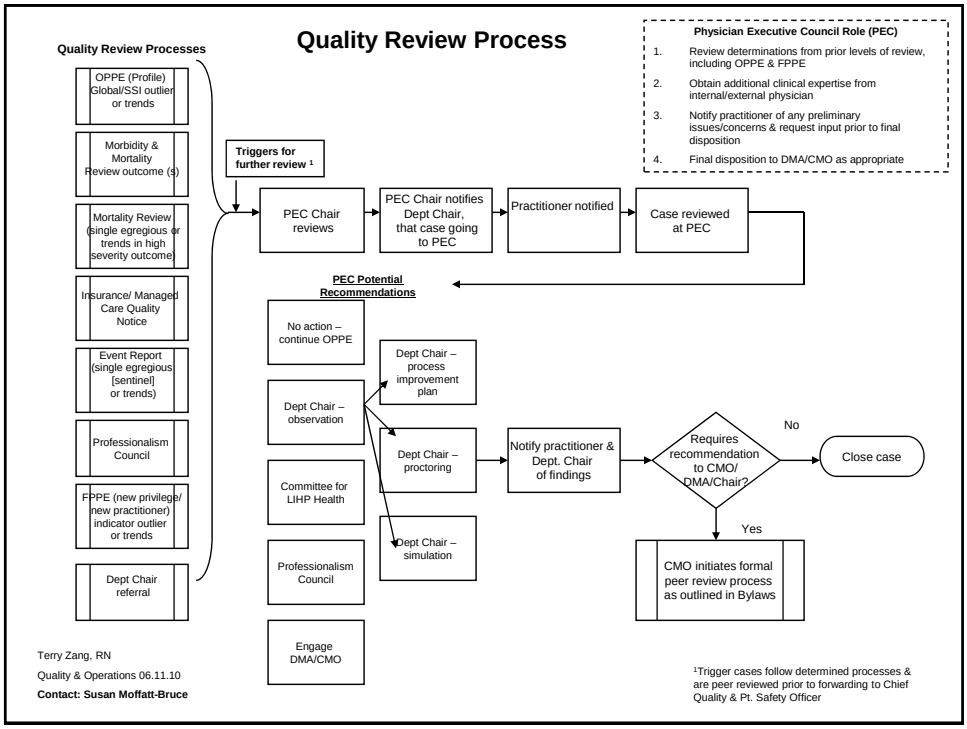
- **Current members of the medical staff or licensed healthcare professional staff with specifically delineated clinical privileges who are requesting a new privilege will be granted the new privilege on a Provisional basis.**
- **The review criteria may vary, but the review must be specifically relevant 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**



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

World Health Organization (WHO) Surgical Safe Checklist

OSU Surgical Team Safety Checklist

Sign In (Before Induction)
Performed by Nursing and Anesthesia

- ☐ **Team Members Introduce Themselves**
- ☐ **Patient Identification**
  - Procedure
  - Site
  - Confirmed Consent
  - Blood Band
  - Allergies
- ☐ **Confirmation of Site Marking, when applicable**
- ☐ **Anesthesia Assessment**
  - Anesthesia Machine Check
  - Monitors functional?
  - Difficult Airway?
  - Suction available?
  - Patient's ASA status
- ☐ **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

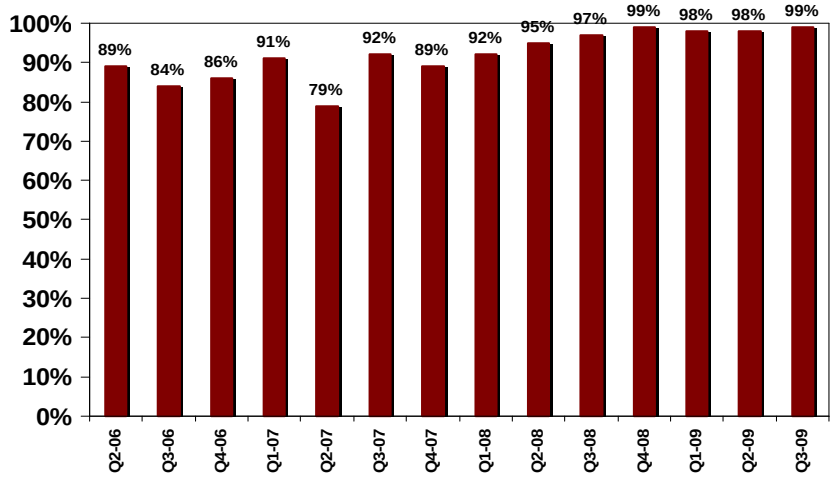
- ☐ **Performed Procedure Recorded**
- ☐ **Body Cavity Search Performed**
- ☐ **Uninterrupted Count**
  - Sponges
  - Sharps
  - Instruments
- ☐ **Counts Correct**
  - Sponges
  - Sharps
  - Instruments
- ☐ **Specimens Labeled**
- ☐ **Team Debriefing**
- ☐ **Event Report Filed**

Adapted from World Health Organization
September 2009

Thank You

Medical Center

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



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

Haynes et al. A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. New England Journal of Medicine 360:491-9. (2009)

OSUMC's Video:

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

Universal Protocol – Three Step Checklist

Bedside Procedures

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

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.**

Medical Center

Universal Protocol

Universal protocol applies to the operating room, procedure areas and bedside procedures. It helps prevent wrong-site, wrong-procedure and wrong-person surgery.

Full participation and effective communication among all members of the patient care team are important for success. A “zone of silence” should be created to minimize disruptions. Wireless devices such as pagers and mobile phones should be handed off or turned off during the procedure.

Step 1: Preoperative and Preprocedure Verification

Ensure:
- History & Physical, procedure consent, images and preoperative checklist are available and consistent.
- Pertinent images are properly displayed and reviewed.

Verification of the correct person, procedure and site should occur:
- With the patient involved, awake and aware, if possible.
- Before the patient leaves the preoperative area or enters the procedure/surgical room.
- Anytime the responsibility for care of the patient is transferred to another caregiver.

Step 2: Marking the Operative or Procedure Site

Mark all cases involving laterality, bilateral procedures, multiple structures (fingers, toes, lesions) or multiple levels (spine):
- Make the mark at or near the incision site.
- The mark must be visible after the patient is prepped and draped.
- The mark must be made using a permanent marker.
- A member of the team participating in the procedure should do the site marking. The mark must contain the initials of the person making the site.
- Marking must take place with the patient involved, awake and aware.
- Final verification of the site mark must take place during the “time out”

Exemptions to site marking:
- Single organ cases (e.g., cesarean birth, cardiac surgery, thyroid).
- Interventional cases for which the catheter/instrument insertion site is not predetermined (e.g., cardiac catheterization).
- Teeth – but indicate operative tooth names on documentation or mark the operative tooth (teeth) on the dental radiographs or dental diagram.
- Premature infants for whom the mark may cause a permanent tattoo.
- For bedside procedures when the practitioner will be continually in the presence of the patient from the time of the decision to do the procedure until it is performed.

Step 3: “Time Out”

“Time Out” Document:
- Verification of the patient’s identity through their name and either DOB or MRN.
- Correct side and site marked.
- Agreement on the procedure to be done.
- Correct patient position.
- Antibiotics or fluids to be administered.
- Allergies.
- Images and results are properly labeled and displayed.
- Any required implants, blood products, devices, special equipment and supplies are available.

“Time out” immediately before starting the procedure:
- A “time out” should be called by stating the patient’s name, procedure and side/site.
- Final verification of the site mark must take place during the “time out.”
- The “time out” must be conducted in the location where the procedure will be done and just before starting the procedure and ideally before sedation/induction.
- All members of the team must stop and participate in the “time out.”
- Procedure cannot start until discrepancies are resolved.

Universal Protocol Applies to the Following Bedside Procedures Listed Below*:

- All other deep, percutaneous procedures (e.g., biopsies, drainage)
- All Radiation Oncology department procedures
- Arthrocentesis
- Bone marrow aspiration or biopsy
- Brachytherapy
- Central venous catheter insertion
- Chest tube placement
- Circumcisions (neonatal)
- Electro-convulsive therapy
- Epidurals
- ICP drains and pressure monitor placement
- Infusion of drugs to middle ear
- Lumbar punctures
- Paracentesis
- Peripheral arterial lines (A-line) insertion
- Peripherally inserted central catheters (PICC lines)
- Placement of regional anesthesia blocks
- Regional and local nerve blocks placements
- Swan-Ganz introducer/catheter placement
- Thoracentesis
- Traction pin placement
- Wound debridement as a planned procedure; does not include minor debridement during a routine dressing change

* Site marking must be done for any procedure involving laterality, multiple structures or levels.

Cases when the individual responsible for bedside procedures is in continuous attendance with the patient (from the time of decision to perform procedure and patient consent to procedure performed) may be exempted from the site marking requirement. The preprocedure verification and “time out” final verification are still required.

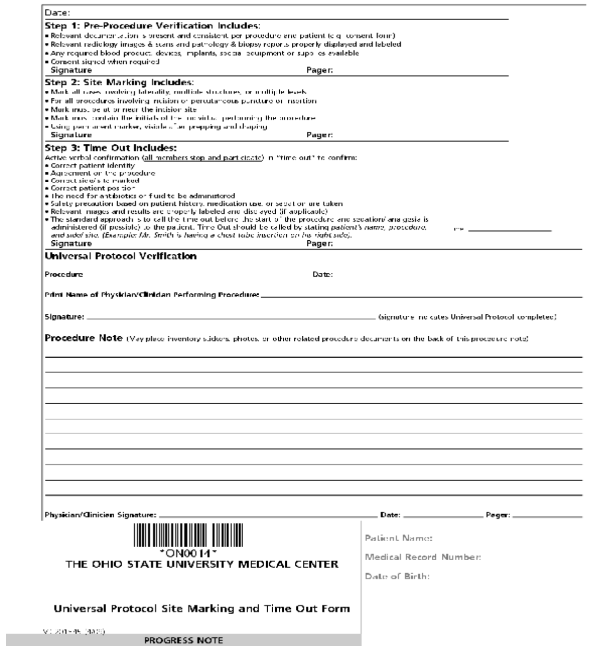
1 Focus: Patient Safety

Make sure all members of the care team are actively involved during a “time out” by reminding them if they become distracted.

April 2010

Document Three Steps:

- **- Essentris**
- **- IBEX**
- **- UP/Time Out Form**


Date:

Step 1: Pre-Procedure Verification Includes:
- Relevant documentation is present and consistent per procedure and patient (e.g. consent form)
- Relevant radiology images & scans and pathology & biopsy reports properly displayed and labeled
- Any required blood product, devices, implants, special equipment or supplies available
- Consent signed when required

Signature Pager:

Step 2: Site Marking Includes:
- Mark all cases involving laterality, multiple structures, or multiple levels
- For all procedures involving incision or percutaneous puncture or insertion
- Mark must be at or near the incision site
- Mark must contain the initials of the individual performing the procedure
- Using permanent marker, visible after prepping and draping

Signature Pager:

Step 3: Time Out Includes:

Active verbal confirmation (all members stop and participate) in "time out" to confirm:
- Correct patient identity
- Agreement on the procedure
- Correct side/site marked
- Correct patient position
- The need for antibiotics or fluid to be administered
- Safety precaution based on patient history, medication use, or sedation are taken
- Relevant images and results are properly labeled and displayed (if applicable)
- The standard approach is to call the time out before the start of the procedure and sedation/analgesia is administered (if possible) to the patient. Time Out should be called by stating *patient's name, procedure, and side/ site. (Example: Mr. Smith is having a chest tube insertion on his right side).*

Signature Pager:

Universal Protocol Verification

Procedure Date:

Print Name of Physician/Clinician Performing Procedure: ____

Signature: ____ (signature indicates Universal Protocol completed)

Procedure Note (May place inventory stickers, photos, or other related procedure documents on the back of this procedure note)

Physician/Clinician Signature: ____ Date: ____ Pager: ____

ON0014

THE OHIO STATE UNIVERSITY MEDICAL CENTER

Universal Protocol Site Marking and Time Out Form

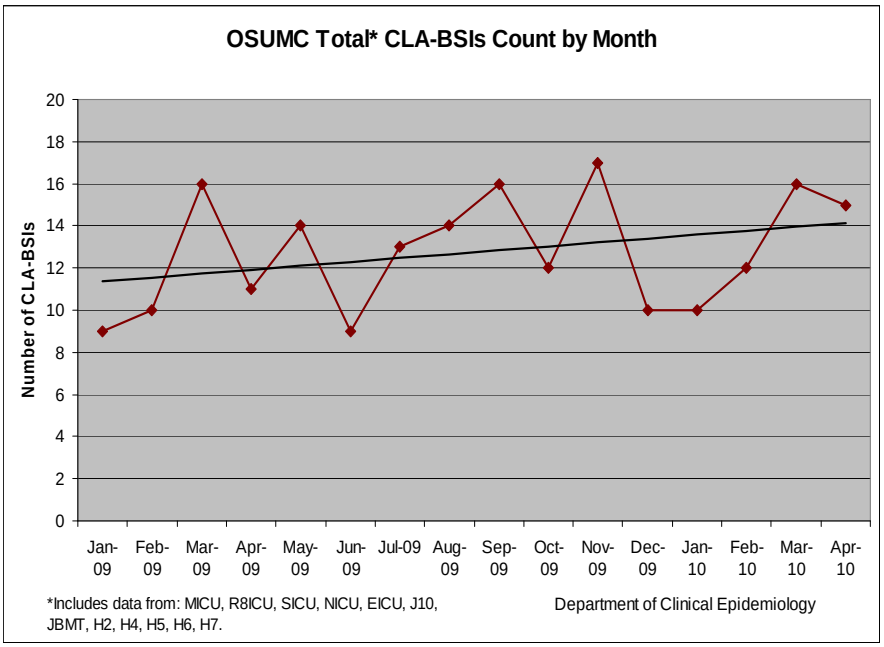
PROGRESS NOTE

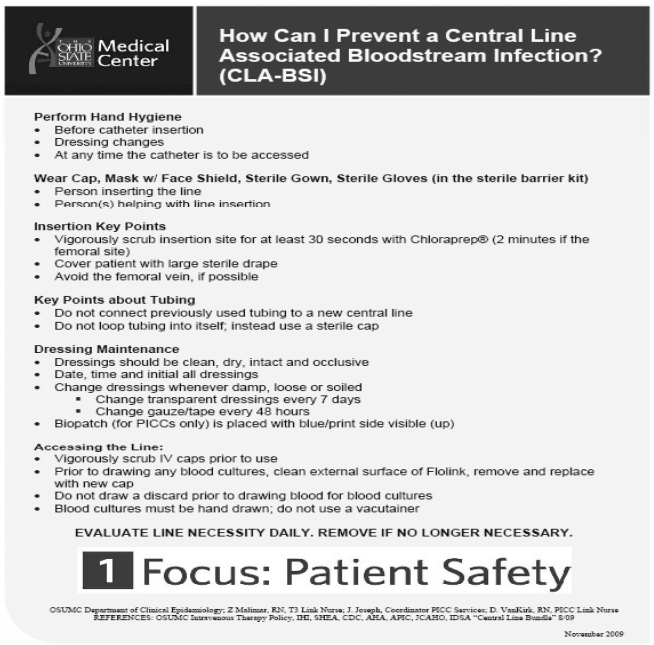
Patient Name:

Medical Record Number:

Date of Birth:

CVC Insertion Checklist


OSUMC Total* CLA-BSIs Count by Month
Number of CLA-BSIs
20
18
16
14
12
10
8
6
4
2
0
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, R8ICU, SICU, NICU, EICU, J10, JBMT, H2, H4, H5, H6, H7.
Department of Clinical Epidemiology


Medical Center
How Can I Prevent a Central Line Associated Bloodstream Infection? (CLA-BSI)
Perform Hand Hygiene
Before catheter insertion
Dressing changes
At any time the catheter is to be accessed
Wear Cap, Mask w/ Face Shield, Sterile Gown, Sterile Gloves (in the sterile barrier kit)
Person inserting the line
Person(s) helping with line insertion
Insertion Key Points
Vigorously scrub insertion site for at least 30 seconds with Chloraprep® (2 minutes if the femoral site)
Cover patient with large sterile drape
Avoid the femoral vein, if possible
Key Points about Tubing
Do not connect 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
Date, time and initial all dressings
Change dressings whenever damp, loose or soiled
Change transparent dressings every 7 days
Change gauze/tape every 48 hours
Biopatch (for PICCs only) is placed with blue/print side visible (up)
Accessing the Line:
Vigorously scrub IV caps prior to use
Prior to drawing any blood cultures, clean external surface of Flolink, 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
November 2009

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
(Temp CVC, PICC, Dialysis Catheter, Swan Ganz, Introducer, Apheresis Catheter)

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

	Yes ✓	If "No," STOP the procedure	Comments:
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			
Dispose sharps immediately after the procedure		N/A	

Assistant: _____

Operator: _____

Signature: _____

Attach patient label here

1 Focus: Patient Safety

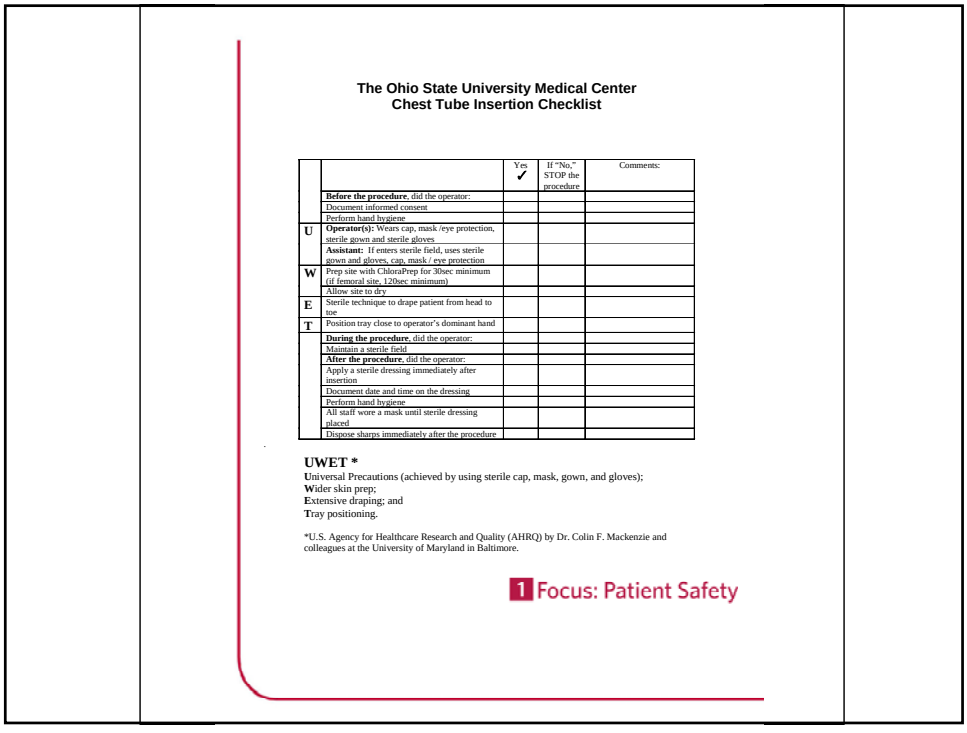
Coming Soon!
Chest Tube Insertion Checklist

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

		Yes ✓	If "No," STOP the procedure	Comments:
	Before the procedure, did the operator:			
	Document informed consent			
	Perform hand hygiene			
U	**Operator(s):** Wears cap, mask /eye protection, sterile gown and sterile gloves			
	Assistant: If enters sterile field, uses sterile gown and gloves, cap, mask / eye protection			
W	Prep site with ChloraPrep for 30sec minimum (if femoral site, 120sec minimum)			
	Allow site to dry			
E	Sterile technique to drape patient from head to toe			
T	Position tray close to operator's dominant hand			
	During the procedure, did the operator:			
	Maintain a sterile field			
	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			
	Dispose sharps immediately after the procedure			

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

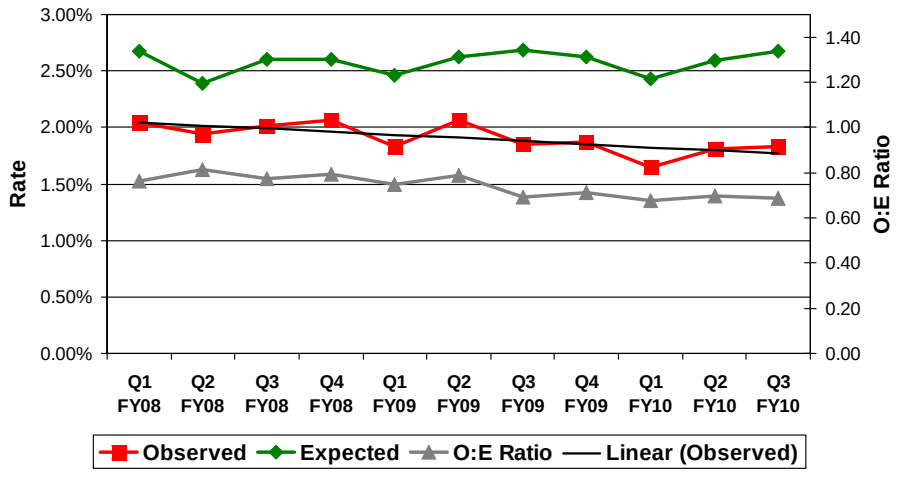
*U.S. Agency for Healthcare Research and Quality (AHRQ) by Dr. Colin F. Mackenzie and colleagues at the University of Maryland in Baltimore.

1 Focus: Patient Safety

Using Data to Improve Performance

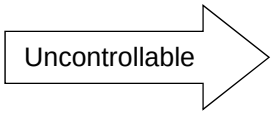
- Quality and Safety Scorecard
- Signature program score card
- Physician specific scorecards

Health System Mortality

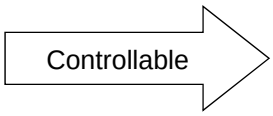


Source: UHC

Factors Impacting Outcomes



- **Age, Race, Gender**
- **Socioeconomic Status**
- **Co-morbid conditions**
- **Acuity & severity of Illness**



- **Use of evidence based practice: complications avoidance**
- **Staffing levels**
- **Competency and experience**
- **Transfers**
- **Patient Selection**

Source: UHC

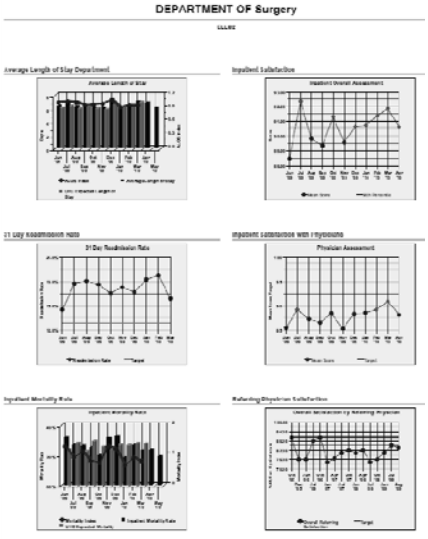
Accountability for Quality and Service Metrics

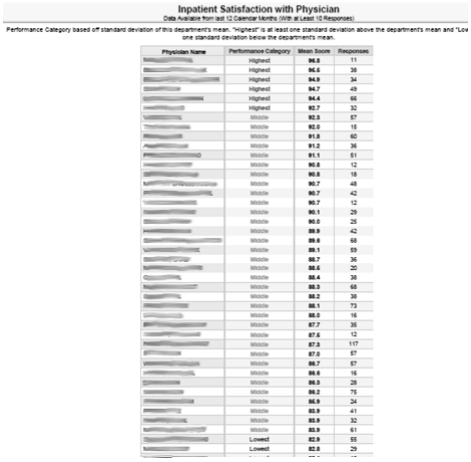
- **Length of Stay**
- **Mortality**
- **Readmissions**
- **Patient Satisfaction**

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





Physician Quality and Service Data Portal

Physician Quality and Service Data Portal

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.**