NH Health Care Quality
Assurance Commission

Annual Report of the
New Hampshire Health Care Quality Assurance Commission

June 1, 2016

RSA 151-G: 1 established the New Hampshire Health Care Quality Assurance Commission. Its intent is *to enable health care providers to share information about adverse outcomes and prevention strategies in learning environments which foster candor and self-critical analysis while maintaining the confidentiality of the information submitted to the Commission, the proceedings of the Commission, and the results of the Commission's deliberations.*

Members of the Commission include one representative from each acute care hospital and free standing ambulatory surgical center (ASC), a designee of the Commissioner of the Department of Health and Human Services and an "at large" public member. During the past year Thomas Bunnell served as the public representative, appointed by Governor Lynch in 2012.

Members of the Executive Committee include:

Chair	**Marge Kerns,** RPh VP Clinical Services, LRGHealthcare, Laconia
Vice-Chair	**Lori Key**, RN, MBA Director QA & Safety, Dartmouth Hitchcock Medical Center, Lebanon
Past Chair	**Jean Corvinus**, RN, BSN, MS, CPHQ, CPPS Director Quality & Performance Improvement, Frisbie Memorial Hospital, Rochester
At Large	**Erin Collins**, RN, BSN Director of Quality Performance and Patient Safety, Infection Prevention and Nursing Informatics Concord Hospital, Concord
	Natalie Gosselin, MS, RN, CPHQ, CSSGB Director Center for Quality& Safety, Southern New Hampshire Medical Center, Nashua
	Martha Leighton, MS, RN, CPPS Patient Safety Officer Elliot Health System, Manchester
	Sue Majewski, Chief Operating Officer, Bedford Ambulatory Surgery Center, Bedford
	Christopher Tkal Director of Quality Improvement & Risk Cheshire Medical Center/Dartmouth-Hitchcock Keene, Keene

During its eleventh year, the Commission met four times on the following dates:

- October 9, 2015
- January 8, 2016
- March 11, 2016
- May 13, 2016

Executive Summary

The following principles were reviewed and updated. They are used as a guide by the Commission in our efforts to promote high quality and safe care to all patients seeking services in our organizations. Agenda planning incorporated these principles, including topics that are timely and would support them.

Guiding Principles:

☑ Promote High Reliability Organizations

Improving systems and standardizing processes to yield best outcomes and avoid harmful choices.

- Safety Huddle
- Serious Safety Event Classification
- Top Ten List
- Culture of Safety Survey
- Advancing Transparency

☑ Adopt Evidence-Based Best Practices to Improve Outcomes

Using scientific studies to select interventions that are proven to improve outcomes and avoid harm.

- Barriers to Transmission (i.e. Hand Hygiene, Personal Protective Equipment Compliance)
- Diversion Detection Programs
- Acute Pain Management (managing opioids)
- Hospital Information Technology; Exchange of patient information across continuum
- Use of Checklists

☑ Establish 'Just Cultures' within our Organizations

Creating cultures of safety where staff and providers involved in an error are treated fairly in the investigation process and we clearly understand contributing factors that involves differentiating system failures from human failures.

☑ Patient Experience

Creating a forum for patients to have open conversations about their experiences and discuss common assumptions will be invaluable in improving care on many levels.

- Compassion Fatigue
- Always Events
- Hospital violence
- Engagement in RCAs/ Proactive Risk Assessment

Prevention of Harm topics the Commission focused on this year included:

- ☑ Learning about the new CDC protocol: Interim Protocol for Healthcare Facilities Regarding Surveillance for Bacterial Contamination to be used for duodenoscopes
- ☑ Creation of a hand hygiene program that was patient-centered and utilized the patient and / or family observation in the audit methodology
- ☑ Shared discussions and understanding of how to apply the definitions of serious harm and the serious reportable events required to be reported to the state
- ☑ Significant contribution to the content of the 2014 NH Adverse Event Report, outlining activities in healthcare organizations that are taking place to reduce risk of harm
- ☑ New approaches to learning from adverse event investigations and creation of a root cause analysis team, to prevent future harm
- ☑ Shared learning, resources and best practices from the National Partnership for Patients initiative
- ☑ Continued encouragement of Just Culture adoption in healthcare organizations and ongoing education using practical examples of its application through a comprehensive presentation by a hospital and educational approaches used
- ☑ Presentations by four hospitals on their approach to daily safety huddles / leadership rounds that foster a culture of excellence and helps prioritize activities to improve quality & safety
- ☑ Acceptance of recommendations from the hand hygiene task force to utilize expanded methods of measuring adherence and creation of a repository of resources for education
- ☑ Sharing ways to engage patients and families in root cause analysis teams after an adverse event
- ☑ Learning about approaches to pain management through revised pain management protocols and alternative treatments being offered by organizations
- ☑ Reducing incidence of drug diversion by various methods of detection and drug testing of employees
- ☑ Introduction of concept of workplace safety and its role in promoting a culture of safety through presentations on a patient search policy and the experience of a hospital in responding to a tragic act of violence in a patient setting

Organizational Structure and Activities

The Commission is working under the protection of RSA 151:13a and RSA 329.29A. All new members received an orientation and signed confidentiality agreements, to allow for free exchange of sensitive information from members. All meetings were coordinated and meeting minutes were recorded by an administrative representative of the Foundation for Healthy Communities.

The Commission was repealed effective July 1, 2015 due to an oversight of the legislation from 2010 that listed the sunset. The authority of the Commission was extended for another year, with an amendment that was included with the budget passage and signed by the Governor on September 17, 2015. As a result, we were not able to begin our Commission Year 11 until October. A bill was introduced reauthorizing the Commission for another five years, which was passed by both the House and Senate. It included amendments that added two more public members-at-large: one member appointed by the Speaker of the House of Representatives, one member appointed by the President of the Senate, and one appointed by the Governor. Commission members offered support for this action. Having greater public participation may guide us to develop more meaningful ways to encourage patients to partner with their clinicians to assure optimal health benefits. Their presence may also help us to relay our message of what we are trying to accomplish. Mr. Bunnell continues to add value by bringing the voice of the public to our discussions.

The Executive Committee met or held conference calls prior to meetings to set agendas and to suggest topics that reflected current priorities focused on eliminating harm and improving quality. Subcommittees of the Commission, i.e., Adverse Event Reporting met as needed to propose options for collaboration or recommendations for the statewide adoption of best practices. The group is highly committed to learning from one another through data gathering and the sharing of best practices about how to provide better and safer care to patients.

Representatives from the Commission also participated in SB56: A study Commission to review oversight, regulation, and reporting of patient safety and infection disease prevention and control issues in healthcare settings. This study commission was created in response to concerns of infection control breaches in an orthodontic office, which surfaced concerns about other settings that may not fall under any oversight / regulatory bodies.

Adopt Evidence-Based Practices to Improve Outcomes

Management and Prevention of Healthcare Associated Infections

NH healthcare organizations continue to work hard to reduce and eliminate opportunities for exposure to infection. As required by law, all Hospitals and ASCs are submitting infection data to the National Healthcare Safety Network (NHSN) or the NH Healthcare Associated Infection program. The 2014 Healthcare Associated Infection (HAI) Reports for Hospitals and ASCs were distributed to all members and results reviewed.

Overall results for NH include:

Hospitals:

- A total of 219 HAIs were reported by hospitals in 2014, compared with 183 in 2013, 198 in 2012, 110 in 2011, 114 in 2010, and 134 in 2009. Due to an expansion of hospital reporting requirements, there were more infections reported in 2014.
- The observed number of HAIs in New Hampshire hospitals was 15% lower than predicted based on national data; there were also 39% fewer central line-associated bloodstream infections and 22% fewer surgical site infections than predicted. There were 26% more catheter-associated urinary tract infections than predicted, but this difference is not statistically significant and the number of infections observed is considered similar to national data.
- Statewide hospital adherence to four infection prevention practices during central line insertions was 98.3%, (compared to 98.4% in 2013).
- Healthcare personnel influenza vaccination rate in hospitals was 93.5%, which has shown continuous improvement since 2008, when it was 59.9%.

The overall observed number of HAIs was 15% lower in NH hospitals and 64% fewer in ASCs than expected based on national data.

Ambulatory Surgery Centers:

- Statewide infection rates in ASCs are similar in comparison to national data. A total of four surgical site infections were reported by ASCs for 2014, compared with six in 2013.
- The observed number of surgical site infections in New Hampshire ASCs was 64% fewer than predicted based on national data; however, this difference is not significant and considered similar to national data.
- Statewide ASC adherence to intravenous antibiotic prophylaxis timing guidelines to prevent surgical site infection was 98.4% (compared to 98.3% in 2013) and the overall staff influenza vaccination rate was 85.7% (compared to 88.7% in 2014).

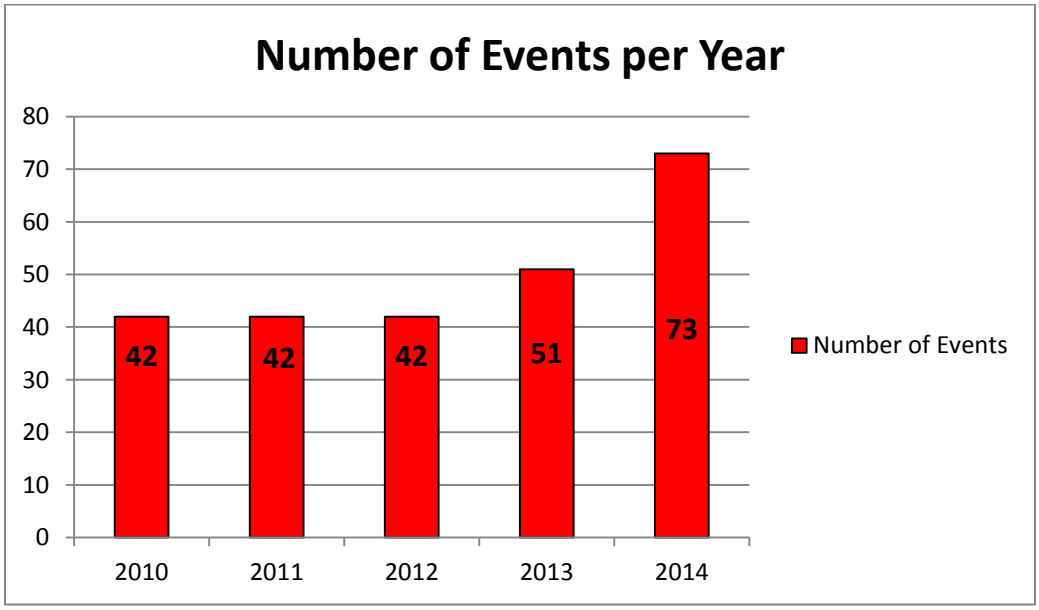
Source: 2014 Healthcare Associated Infection Report http://www.dhhs.nh.gov/dphs/cdcs/hai/publications.htm

Duodenoscopes & CDC Protocol

In March 2015, the CDC released an Interim Protocol for Healthcare Facilities Regarding Surveillance for Bacterial Contamination of Duodenoscopes after Reprocessing. In the past the outbreaks of infections associated with these types of instruments were due to defective equipment or failure to follow guidelines. A recent outbreak, not involving NH facilities, was attributed to issues of actual cleaning practices. Staff training, determining competence and audits of both are critical components of a solid program. Five professional societies came together and agreed on Guidelines, which were distributed and reviewed with members at a Commission meeting and each organization agreed to review their practices to assure they were consistent with the national guidelines. Members agreed that a "Just Culture" would also foster staff willingness to report deviations from expected practices.

Serious Reportable Events / Adverse Events

Since January 2010, NH hospitals and ASCs have been reporting adverse events (which were revised in 2013) to the Bureau of Health Facilities Licensing as required by RSA 151: 38. The list of events are based on the National Quality Forum's (NQF) revised list of twenty-nine discrete adverse medical events, known as **serious reportable events (SREs).** In NH, there is an additional event related to the transmission of blood borne pathogens that is required to report. The NQF definitions were broadened and additional event types were added to the list of SREs which resulted in an increased number of NH reports. This is particularly evident in the category of pressure ulcers, whose definition was expanded to include "unstageable", which resulted in a doubling of pressure ulcer reports between 2013 and 2014, from 11 to 22. Organizations also believe the increase in reporting is an indicator of their culture of safety that promotes the importance of detecting errors and adverse events, learning from them, and taking positive actions to improve systems of care to prevent them from happening again.



Discussion about experiences with Adverse Events and adherence to the reporting requirements of the State of NH were regular agenda topics. An Adverse Event advisory subgroup was available to members to review potentially reportable events that members could submit for consideration. Their focus is assisting members in determining whether an event meets the criteria and threshold of reporting, based on review of NQF definitions and using their implementation guidance. This promotes consistency in reporting and ensures all organizations apply NQF definitions accurately to events that may occur in their organizations.

A Commission subgroup worked on writing the majority of content for the State of NH 2014 Adverse Event Report. It included an outline of major activities in response to events as well as addressing how safety is being given priority. We recognize the need to increase the public's trust in NH hospitals and ASCs and the Commission is committed to improve processes

and systems that contribute to healthcare associated preventable adverse events. The focus of the report was on what is being done, not just what we have learned. Members shared activities their organizations have been involved in, as part of their root cause analysis (RCA) and corrective action plan (CAP) associated with individual events as well as overall patient safety activities, all of which was included in the Adverse Event report for 2014.

Hospitals contributed data on their total beds, ICU beds, admissions, patient days, inpatient and outpatient surgical volumes to enhance the report to more accurately describe the level of acuity and the relative size of NH organizations. ASC volumes were not included since they reported zero events.

Another focus was on educating the public on the importance of having a high level of engagement in their care and working together with their healthcare team. How we partner with patients and family was included as a key part of the report.

The report was presented on October 9, 2015 to the Health & Human Services Oversight Committee by the Bureau Chief of Health Facilities-Certification. In March 2016 we received notice that the chart of events for hospitals had incorrect adverse event data listed for some hospitals. We provided suggestions to the Bureau to improve the process, including having hospitals validate the data before the report is finalized. We will continue to work closely with the department and invite their participation in Commission meetings on an annual basis.

The creation and use of a permanent RCA team was shared by one hospital. A description of its members, their process, their approach to interviewing involved staff and how follow up is determined and tracked was presented. The concept of a permanent team ensures that they follow a consistent process, develop a high skill level, and receive extensive education about sentinel events. A permanent team also reduces subjectivity, bias and the temptation to leap to quick and early solutions. They focus on systems, using references from professional journals, The Joint Commission Sentinel Event Alerts and other resources to educate team members in an effort to focus solutions on the highest impact system issues.

Adverse event reporting often intersects with other patient safety efforts, making partnership and collaboration across agencies and organizations an effective way to improve patient safety.

(2014 Guide to State Adverse Event Reporting Systems - National Academy for State Health Policy)

The concept of unavoidable / unpreventable harm was also addressed as it relates to pressure injuries of the skin, based on current evidence based research and literature. A letter was sent to the Bureau Chief of Health Facilities-Certification offering recommendations on how this current knowledge (including supportive literature) could be incorporated into the State AE report to better inform the public.

High Reliability Organizations

Adherence to Hand Hygiene Practices

One of the primary ways to decrease infections is by using evidence based practices for cleaning hands before and after contact with patients and with the environment. Although basic, it is a critical aspect to improving outcomes and reducing harm from healthcare associated infections.

The NH Hand Hygiene Improvement Task Force has been meeting since June 2014. Representatives include members from the Commission and the NH Infection Control & Epidemiology Professionals. Although the submission of hand hygiene (HH) audit data to the Commission was suspended due to concerns of data reliability, all organizations were encouraged to continue to audit HH practices based on their experience, access to information, and abilities.

New models for audits were extensively reviewed which can be adopted and incorporated as new approaches for use by hospitals and ASCs. A significant focus of the group was on the importance of training staff and ensuring competency for anyone completing observation audits. Audit tools were disseminated as well as training materials. HH is a surrogate measure of the culture of an organization. Many aspects of a "just culture" can enhance HH programs.

One hospital shared their campaign for HH titled "Be Seen and ***Heard*** Being Clean!" It is a great example of including patients in HH improvement efforts and in doing so, makes it a patient-centered and patient safety priority. Staff members are instructed to say "I am cleaning my hands" as they clean their hands in front of their patients. Patients are asked if they saw or heard staff cleaning their hands. Patient comments suggested they really appreciated being told and not left to wonder if the provider had clean hands. The methodology and approach to education about the campaign was shared as well as resources. The patient engagement aspects of this effort are notable.

The NH Hand Hygiene Improvement Task Force made the following recommendations which were accepted and approved by the Commission:

- Each facility will have an established Hand Hygiene program.
- Each HH program will collect valid and reliable HH adherence data.
- Designated HH observers will be trained to observe HH compliance by staff members.
    - Competency of observers will be assessed to help maintain valid and reliable data.
    - Refresher trainings should be provided on a routine basis and as needed.
    - If possible, the identity of observers should remain anonymous.
    - If possible, the role of HH observers should be rotated amongst staff to help reduce "burn out".
    - Consider providing incentives to observers as it may increase participation.
- HH data will be presented to leadership in a meaningful format, on a quarterly basis at minimum.
- The methods for collecting HH data can vary, but should be based on reliable sources.

Pain Management

The opioid crisis in NH has focused attention on many aspects of health care, one of which is how our hospitals, ASCs and providers approach pain management of patients. This topic was addressed at a Commission meeting and included sharing of best practices, policies and procedures.

Members were provided with examples of:

- Alternatives to pain medication including a menu of Pain Management Options to help patients who experience pain to consider alternative modalities.
- Acute Pain Management Opioid Orders and guidelines including an opioid conversion, and established parameters for dosing.
- A pain management initiative which includes setting goals and expectations with patients as well as complementary and non-narcotic options for pain management.

A letter to the US Secretary of Health and Human Services, that was written by a number of Senators including the NH delegates, that raises concerns about the financial incentive to improve patient satisfaction scores that includes a question on the survey about pain control, (which can be a conflict in the current environment of opioid abuse / overuse) was distributed to members.

Establish a 'Just Culture'

The concepts of a Just Culture offer our organizations a means to fairly evaluate systems issues while ensuring personal accountability. As a continuance to a model we began two years ago, we used presentations by members who shared their approaches on how they engage leadership and staff in their ongoing patient safety efforts.

One organization gave a very comprehensive overview of their journey as they have made the establishment of Just Culture a strategic priority. The presentation included:

- Discussion of the background and problems addressed with Just Culture
- Introduction to basic principles of a Just Culture
- A comprehensive approach to patient safety in a community hospital

Members learned about a survey tool for employees - the Just Culture Assessment Tool (JCAT) – used to investigate the impact of a just culture program implemented at the organization.

> *"There has been a lot of focus on improvement processes and technology in healthcare, and those are all well and good, but culture is the No. 1 system contributor to safety."*
>
> *Healthcare Executive, March April 2015*

Leadership / Safety Huddles

Four hospitals shared their Leadership / Safety Huddle models, as another way to incorporate aspects of a Just Culture with the goal of improving patient safety and quality. Presentations included:

- The *Daily Leadership Huddle/Safety Brief* brings together all inpatient and ancillary departments to report on events and concerns over the previous 24 hours and anticipated problems/risks for the next 24 hours. It has helped diminish the 'silo" tendency and helps everyone appreciate what is going on in each other's areas, fostering empathy when there are issues. The meeting facilitates an immediate huddle amongst affected areas and problem solving, helping to increase sense of collegiality and supports real time performance improvement. There is huge board that lists issues, resolution and pending actions that are tracked.
- *Daily Leadership rounds* which includes rounding to clinical areas by senior management, including the CEO, helps increase accountability for actions needing to be taken for issues that have surfaced.
- *Operational Excellence* model that espouses the core components of a strong management system and supports the cultural aspect of ongoing performance improvement. The CEO leads the huddle and each department provides metrics of daily activity / staffing issues / safety concerns which are posted on the Huddle Board. The CEO and a few others then make rounds on up to 5 departments. They spend two minutes in each department, where a staff person reviews their key performance indicators, which are aligned with a safety, quality and experience metrics. Visibility, transparency and accountability all can improve with this model.
- *Bed Huddle* which takes a pure operations approach, with a focus on the here and now. It helps instill the sense of team, with staff walking out with more energy and more information than other meetings. It helps communicate the status of departments and what pressures they may be facing that day.

Another presentation focused on the use of a *Top Ten List* and overall development of a "Culture Plan". Emphasis was made that the leader's role is to address problems that affects staff member's ability to do their work effectively and to establish accountability of performance expectations. Main avenues that leaders use to learn about safety issues are the daily safety huddle and the organizational safety brief. Problems that are identified thru these venues are prioritized and placed on a Top 10 Problem List. On a weekly basis, key leaders meet to determine how to prioritize issues onto a grid. This work builds upon the High Reliability Organization concepts but is very concrete, has actionable items, and is a good addition to the quality tool box.

Employee Drug Testing

Balancing components of a Just Culture with the need to ensure a safe, drug free workplace was another topic that was discussed this year. Based on recent experiences of drug diversion that brought attention to this subject as well as regulatory responses, members shared various approaches to drug testing of employees and described their policies. Examples of organization policies included:

- Upon Hire / Fitness for Duty drug testing for employees, which involves a Fitness for Duty evaluation that occurs when there is a reasonable suspicion of substance use. An important component is educating staff about behaviors to look for that could be potentially related to drug use.
- Random Testing in addition to performing tests at time of hire, with 10% of the entire staff population tested every quarter and 50% of high risk staff (based on access and literature indicating risk of higher diversion activity). Staff education has taken place with emphasis on "if you see something, say something".
- For Cause / Transfer of Positions which considers any staff transfer to a new department as falling under the "new hire" policy application for drug testing. Refusal of a 'for cause' test is treated as a positive and action may be taken, up to termination.

Workplace Safety

Workplace safety is a new topic the Commission agreed to address. It is defined as having an environment that is free of physical and psychological harm. Cultivating a culture of safety should integrate both patient safety and worker safety. A number of healthcare organizations in NH have experienced acts of violence resulting in employee harm over the past few years.

The powerful and emotional story of an act of violence that occurred in a community hospital was shared at a Commission meeting. The role of the Incident Command Center and the impact of law enforcement and media were described. Critical to the event was the need of the hospital to provide support to the staff, patients and families. Counseling was offered to all hospital staff, with particular attention paid to those directly involved in the event, since they would have greater potential for emotional and psychological harm. The hospital reviewed the findings from their RCA and outlined the actions that took place following the event. They also shared additional references from the Veterans Administration Safety Program.

Another hospital presented their Patient Search Policy. The Director of Security shared their perspective that they were shocked to see the behavior of some patients when interacting with staff. They found it unacceptable that staff members were being put at risk and felt that nurses should not have to search patient belongings since it could create the wrong therapeutic environment of caring. The process now requires that Security Officers do any necessary patient or visitor searches. Their focus is on patients who have been identified as high risk – such as an overdose or medical condition related to drug use. This is helping to contribute to a safer work environment.

Eliminate Harm: Partnership for Patients

In 2010 the CEOs and Board of Trustees at every acute care hospital in NH agreed to support the goal of eliminating harm by 2015**.** The Eliminate Harm Initiative work was aligned with the efforts of the Partnership for Patients, a national initiative that took place from 2012-2014. This initiative was renewed in September 2015, with all 26 acute care hospitals committed to this work.

The Partnership for Patients' focus on making hospital care safer, more reliable, and less costly is through the achievement of two goals:

- Making Care Safer: Preventable hospital-acquired conditions would decrease by 40%
- Improving Care Transitions: All hospital readmissions to be reduced by 20%

The goals of the Partnership for Patients are aligned with the Commission's principles of high reliability, adoption of evidence based practices, patient experience and encouragement of a Just Culture in our organizations. Patient and family engagement is an essential component.

Resources including evidence based guidelines, change packages, webinars and presentations to assist in implementation are shared with hospitals, ASCs and all partners along the continuum of care.

The Partnership for Patients include the following areas of focus:

1) Adverse Drug Events
2) Catheter Associated Urinary Tract Infections
3) Central Line Blood Stream Infections
4) Injuries from Falls and Immobility
5) Obstetrical Adverse Events
6) Surgical Site Infections
7) Venous Thromboembolism
8) Ventilator Associated Events
9) Pressure Ulcers
10) Readmissions

Additional topics that NH hospitals are focused on include Sepsis, Clostridium difficile, and the Culture of Safety, especially as it relates to workplace safety.

Data collection requirements allow us to compare performance nationally as well as statewide, in a timely manner. Since data is being collected for the Partnership for Patients, data submission to the Commission was suspended to reduce redundancy and burden to the hospitals.

Patient Experience

Incorporating the Patient Voice / Experience as part of an RCA

RCA teams should be composed of 4 to 6 people. The team should include process experts as well as other individuals drawn from all levels of the organization, and inclusion of a patient representative unrelated to the event should be considered.

The National Patient Safety Foundation

How organizations respond after an adverse event or serious mistake happens can be a reflection of their culture. Transparency is an essential component of creating a Just Culture, yet how and when to communicate the occurrence of such an event to a patient or their family members is not always readily understood or easily done. Tanya Lord, Director of Patient & Family Engagement at the Foundation for Healthy Communities, provided an overview of who patient and family advisors are and the roles that they are serving in NH hospitals. She reviewed the pros and cons of having a patient who may have been harmed (or their family member) participate on a root cause analysis of the event. The contrast of the hospital's response to an event and the time frame compared to the patient / family awareness reinforced the challenge of this scenario.

Tanya suggested ways that the patient voice could be represented through a Patient Family Advisor (PFA). Their role and training / preparation requirements were reviewed. Equally important is the preparation of the RCA team to understand and welcome the role of a PFA. Tanya's final message was asking Commission members to reflect and consider taking this next step forward in embracing the culture of patient safety.

Summary

Year 11 has continued to bring NH hospitals and ASCs together to focus on the prevention of harm and continuous learning. Hospitals and ASCs are clearly supporting the efforts of the Commission as a primary lead in promoting the best patient safety practices.

The Commission will begin Year 12 in July 2016 with a continued focus on decreasing preventable harm by promoting high reliability organizations, adopting evidence-based best practices, embedding the patient experience and continuing work to establish 'Just Cultures' within each institution. All public documents related to the Commission can be found at www.healthynh.com. For questions, please call:

Marge Kerns, Commission Chair: 630-3044 or Anne Diefendorf, Administrator: 415-4271.

Respectfully submitted,

Anne Diefendorf

Anne Diefendorf
Administrator,
NH Health Care Quality Assurance Commission

Foundation *for* Healthy Communities