NH Health Care Quality
Assurance Commission

Annual Report of the
New Hampshire Health Care Quality Assurance Commission

June 1, 2012
RSA 151-G

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) and the designee of the Commissioner of the Department of Health and Human Services.

Members of the Executive Committee include:

Chair	**Jean Corvinus**, Director, Performance Improvement, Frisbie Memorial Hospital, Rochester
Vice-Chair	**Scott Goodwin**, Executive Director of Improvement, Catholic Medical Center, Manchester
Immediate Past Chairs	**Stephanie Wolf-Rosenblum, MD, FCCP, MMM,** Chief Medical Officer, Southern New Hampshire Medical Center, Nashua
At Large	**Peter Walkley, MD,** Chief Medical Officer, Lakes Region General Hospital, Laconia
	Sue Majewski, Chief Operating Officer, Bedford Ambulatory Surgery Center, Bedford
	Terry LeBlanc, Chief Operating Officer, New London Hospital, New London

The officers serve one year terms.

During its seventh year, the Commission met five times on the following dates: August 5, 2011, October 28, 2011, January 13, 2012, March 9, 2012, and May 11, 2012.

Executive Summary

The members of the New Hampshire Health Care Quality Assurance Commission adopted the following principles to promote high quality and safe care to all patients seeking services in our organizations:

- ***Promote High Reliability Organizations***
- ***Adopt Evidence-Based Best Practices to Improve Outcomes***
- ***Establish 'Just Cultures'* within our Organizations***

These principles informed our priorities for the year and created a framework for our discussions. All 26 acute care hospitals and 17 ambulatory surgery centers voluntarily participated in the Commission meetings and actively engaged in the initiatives adopted by its members.

Promoting High Reliability Organizations

- Focused on implementation and spread of the Patient Safety Checklist to all procedural areas; shared results from a survey of staff in procedural areas with regard to awareness of and adherence to the checklist which helped determine areas of vulnerability and target further policy development and education.
- Continued sharing of reports of the state mandated serious reportable events in order to raise awareness of potential areas of harm for each organization and inform individual and collective priorities for eliminating harm.

Adopt Evidence-Based Best Practices to Improve Outcomes

- Continued efforts to improve hand hygiene compliance through the identification and sharing of best practices compiled by Kathy Kirkland, MD in a study to understand how culture and practice may contribute to the variation in rates among hospitals; distributed new set of laminated posters, screen savers, and hand hygiene education kits to all.
- Developed and distributed a "Live Clot Free NH – VTE Prevention" toolkit based on most recent evidence; completed initial chart audit as part of the statewide effort to eliminate preventable cases of venous thromboembolic disease from all inpatients.
- Shared and discussed organizational policies on influenza vaccination of health care workers, completed survey of practices at each organization and stressed the linkage to reducing patient harm from transmittal of influenza from staff.

Establish 'Just Cultures' within our Organizations

- Engaged in discussions about challenges in spreading these concepts to all areas with a focus on relationship between 'Just Culture' and relentless pursuit of improving quality and patient safety; distributed a 'Just Culture' Toolkit to all members and shared tips for successful spread.
- Through member "Storytelling", exchanged important information regarding facilities' own stories of medical errors and prevention strategies; stressed the application of the principles of 'Just Culture' to the activity of the Commission and the importance of fostering trust and open communications amongst members, in a safe environment.

** A 'Just Culture' fosters open communication and recognizes that individuals should not be held accountable for system failings over which they have no control.*

ACTIVITIES OF THE COMMISSION

The Commission met 5 times during Year 7. Attendance was excellent. All new members signed confidentiality agreements and minutes were recorded. In addition, orientation was provided to new members. The Executive Committee met prior to each meeting to set agendas and to suggest topics that reflected current priorities focused on eliminating harm and improving quality. Subcommittees of the Commission, i.e., Safety Checklist, Hand Hygiene, and Prevention of Venous Thromboembolic Disease 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.

High Reliability Organizations

A. Patient Safety Checklists

By the end of 2009, every hospital and ASC in NH had posted and implemented a patient safety checklist in all operating rooms and by 2011; each had begun to spread its use to other procedure areas. Quarterly compliance observational audits have been conducted and submitted ever since. In June 2010, every hospital and ASC anonymously surveyed their operating room staff to understand if the checklist was being used in the way it was intended. This survey was adapted in 2011 for use in all other procedure areas and distributed.

The Commission received over 500 responses from all clinician types involved in procedural areas, including ICU, ED, radiology, cardiac, maternity, nursery, ambulatory care, infusion centers, medical–surgical units and physician practices. Here is a summary of the results:

- 74% of respondents believe that the use of a checklist prevented an adverse event in their institution.
- 89% of respondents agreed that they felt free to express concerns throughout the timeout/checklist process.
- 93% believe that leadership supports the appropriate use of the timeout/checklist process.
- 68% of team members had suspended all other activities during the time-out/checklist process.
- 80% of the time, the room environment was quiet during the time-out/checklist process.

These survey results were compared to the 2010 survey results of OR staff. They helped to delineate areas that would benefit from further reinforcement of policies and education. Since the initial World Health Organization Safety Checklist was tested and developed for Operating Rooms, there were many robust discussions about its applicability to procedural areas. Open and honest sharing of adverse surgical events and near misses and their link to inadequacy of time-outs reinforced that this was the “right

thing to do". Members were encouraged to customize and adapt checklists to each procedural area. There was generous sharing of checklists, procedures and tips for education by members. A resource from the Institute for Clinical Systems Improvement Health Care Protocol: Non-OR Procedural Safety was distributed, and the list of procedures from this protocol was given to all members. Optimizing the appropriate use of this checklist is key to helping achieve a higher reliability process and to reduce harm.

B. Management and Prevention of Infections

The management and prevention of infections continued to be a priority for the Commission. As required by RSA 151:33, hospitals are submitting their institution's Central Line Associated Blood Stream Infection (CLABSI) data to the National Health Safety Network (NHSN). They are also submitting Central Line Insertion Practices (CLIP) and specific surgical site infection rates to NHSN, as mandated. Effective July 1, 2011, ASC's are required to report specific surgical site infection rates via NHSN and IV antimicrobial prophylaxis data to the State of NH. The Commission reviewed and discussed the 2010 Healthcare Associated Infections (HAI) report, released in August of 2011. All hospitals underwent a validation study for HAI in 2011. Results were shared at a NH HAI Reporting Program offered in November 2011, which also included additional training in detection and surveillance for staff of hospitals and ASCs.

C. Additional Hospital Data Reporting

The hospital Commission members continued to collect and report measures related to the care a patient receives during surgery. These measures, developed by the Centers for Medicare and Medicaid Services (CMS), are based in science and validated by an external agency. They represent the percentage of time hospitals have provided the necessary processes of care which have been proven to reduce the incidence of infection from surgery and to decrease the risk of venous thrombosis; each can lead to prolonged hospitalization, added complications and potential cardiovascular complications such as pulmonary embolism and stroke. These measures are clearly defined; the collection of these data has been systematized within hospitals; and the results are validated by an external agency.

Results:

Antibiotic received within 1 hour of surgery:
In 2011, out of 4458 of patients who underwent specified surgery, 4386 or **98%** received an antibiotic within 1 hour before the start of surgery. This compares to a rate of 72% in 2005, a 26% increase. The national average for this measure is 98%. This statewide rate includes data from all 26 hospitals.

Antibiotic discontinued within 24 hours after surgery:
In 2011, out of 4380 patients who underwent specified surgery, 4261patients or **97%** had their antibiotics discontinued within 24 hours after surgery ended. This compares to a rate of 57% in 2005, a 40% increase. The national average for this measure is 96%. This statewide rate includes data from all 26 hospitals.

Prophylactic Antibiotic Selection:
In 2011, out of 4544 patients had who underwent one of the specified surgeries, 4484 or **99%** had the appropriate prophylactic antibiotic ordered for their designated surgery to prevent infection. This compares to a rate of 75% in 2005, a 23% increase. The national average for this measure is 98%. This statewide rate includes data from all 26 hospitals.

Recommended venous thrombosis prophylaxis (clot prevention) ordered:
In 2011, out of 3484 patients who were eligible to receive prophylaxis, 3414 or 98% had the recommended prophylaxis ordered to prevent venous thrombosis. This compares to a rate of 89% for 2007, a 9% increase. The national average for this measure is 96%. This statewide rate includes data from 25 hospitals.

Recommended venous thrombosis prophylaxis received:
In 2011, out of 3484 who were eligible to receive prophylaxis, 3393 or **97%** actually received the recommended therapy. This compares to a rate of 87% in 2007, a 10% increase. The national average for this measure is 94%. This statewide rate includes data from 25 hospitals.

In summary, New Hampshire rates for recommended surgical care have improved over the duration of the collection period and are higher than the national average for 4 quality and patient safety measures and equal to 1 of these measures. The achievable benchmark for these measures is 100% so hospitals will continue to pursue excellence in this area.

Adopt Evidence-Based Practices to Improve Outcomes

A. Hand Hygiene Compliance

Since April 2008, hospitals and ambulatory surgical centers have voluntarily monitored hand hygiene compliance within their institutions using trained observers. It is well known that 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 their environment; hence this is a basic yet critical aspect to improving outcomes and reducing harm from infections. From April-December 2008, there were over 20,000 observations of opportunities for a caregiver or employee, with patient contact, to clean their hands using evidence based practices. Our statewide rate of compliance for that time period was approximately 83%. In 2009, hand hygiene compliance rate for all types of providers increased to 90% statewide. In 2010, hospitals and ASC's maintained this compliance rate at 90%. In 2011, the compliance rate increased to 91%.

Statewide grant funding was used to conduct site visits between 2010 and 2011 at every hospital and several ASCs. The purpose of these visits was to learn about the variation in practice and strategies for improvement. Kathy Kirkland, MD, an infectious disease specialist from Dartmouth presented the summary of these visits to focus groups and

shared general observations at a statewide meeting in December. All organizations received a copy of the final report, "A Qualitative Analysis of Facilitators and Barriers to Hand Hygiene Improvement at NH Hospitals during a Statewide Hand Hygiene Campaign". In addition, each organization received a one page summary of her observations, including strengths of their program, weaknesses / vulnerabilities and recommendations for potential next steps. An additional eight hand hygiene posters, selected from local hospital submissions, were printed and made available to all hospitals and ASC's. "Glo-Germ" products were purchased to help organizations with their hand hygiene education. The hope is that this activity and the new resources will further promote increases in hand hygiene compliance at NH hospitals and ASC's. Commission members discussed and agreed that this basic infection prevention campaign will require a continued, vigorous approach at the unit level with regular feedback to optimize results. Continued attention to fostering a safe culture, where peers can give direct feedback in a safe environment and are empowered to reinforce positive behaviors and practices, are critical.

New Hampshire continues to be the only state in the country to have every hospital and participating ambulatory surgery center committed publicly and at the leadership level to this important process improvement initiative.

N.B. It is important to understand that these Hand Hygiene compliance data are not validated by an external organization but rather, voluntarily reported by the individual institutions.

B. Serious Adverse Events

In 2009, the New Hampshire legislature passed House Bill 592, AN ACT relative to "adverse events" in hospitals and ambulatory surgical centers. In January of 2010, hospitals and ASCs began reporting adverse events to the Bureau of Health Facilities Licensing as required by RSA 151: 38. The events are based on the National Quality Forum's (NQF) original list of twenty-eight discrete adverse medical events, known as serious reportable events (SREs). NQF states that not all occurrences of adverse events may be preventable and is no longer referring to them as "never events". Despite the best efforts of our institutions, specific circumstances may render particular events unavoidable. Events are defined in the law, and fall into the following categories:

- Surgical
- Product or device
- Patient protection
- Care management
- Environmental
- Criminal

The law includes determining whether a patient has experienced a serious disability as it may apply to fifteen of the 28 adverse events. *Note: "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual or a loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health care facility, or loss of a body part.*

The Commission members agreed to send a notification of their reported events to the Administrator of the Commission, in addition to reporting these events to the Bureau of Health Facilities Licensing. When a patient is harmed in an organization, the event can have a profound impact on involved staff, and it is often an extremely sensitive matter to step forward and share this information with others. Nonetheless, the learning and exchange of information that comes from a member sharing an adverse event can be an important driver of change - not only for the organization that experiences it but also for others who may be at risk for a similar occurrence. It is a testimony to the trust that has been established and the confidential nature of the Commission that members willingly shared their experiences relative to adverse events and the associated root cause analyses. This activity clearly has helped enhance learning throughout our state. Candid and honest discussions, probing of systems failures and / or weaknesses, and corrections taken are helpful to everyone, but most importantly to the patients we serve.

Hospitals and ASCs not only shared specific events, but they also described their processes for closely monitor any serious events which cause harm or the potential for harm. Discussion also encompassed the hard work staff and physicians undertake to understand why these events happen and how they can be prevented. Typically this process involves gathering a team to closely examine the factors that led to the event. These factors can include communication, staffing levels, training, equipment malfunctions, failure to follow policies or protocols, or confusion about roles and responsibilities. Members openly discussed the details of their reported adverse events with the goal of sharing information on how adverse events are identified, the process for determining the root cause, and any strategies for improvement that are being tested

Adverse Events in New Hampshire Acute Care Hospitals
January 1, 2010-December 31, 2010

All except one of the adverse events reported by New Hampshire hospitals in 2011 were attributed to three categories: Environmental, Surgical and Care Management. Understanding this provides specific areas of focus for the hospitals and the NH Health Care Quality Assurance Commission as work continues to eliminate harm to patients. There were no events reported to the Commission by the ASCs.
What follows are the results of the statewide reporting of “adverse events” as defined by RSA 151: 38 in 2010 compared to those reported to the Commission in 2011. The 2011 State Report is anticipated to be released in August of 2012.

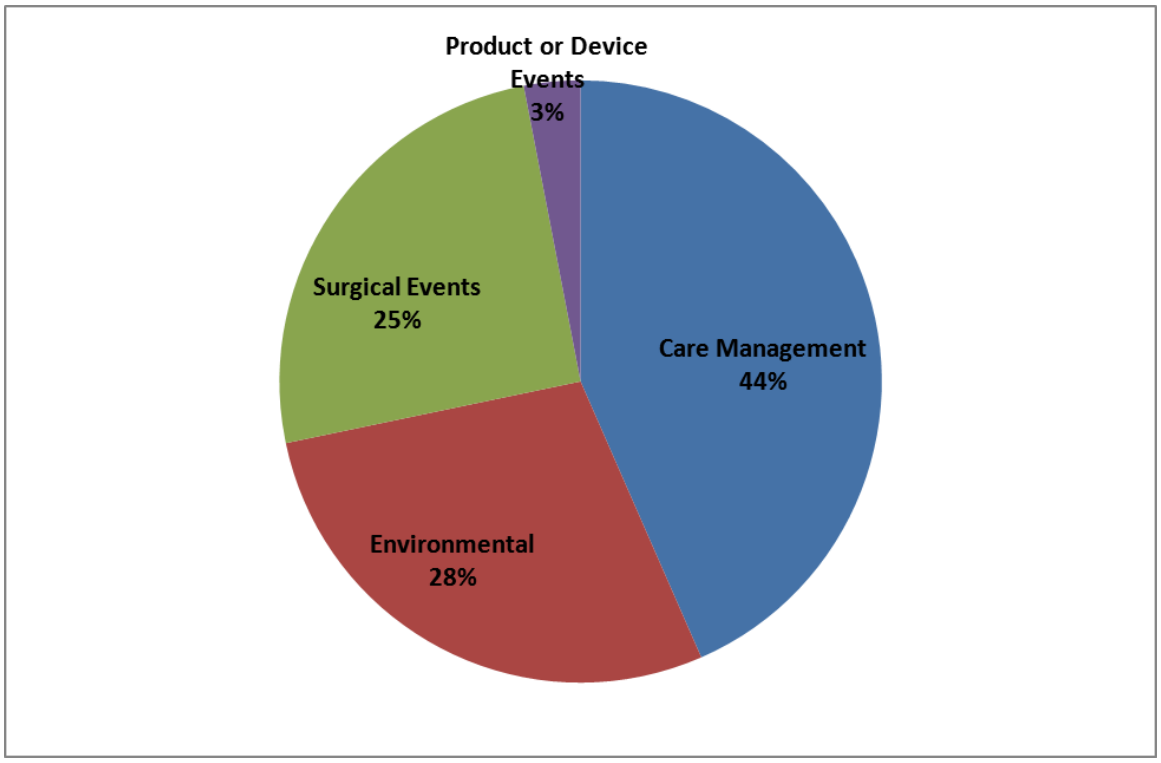
New Hampshire Hospital Adverse Events: 2010 vs. 2011*
(*Per reports to NH Healthcare QA Commission)

SURGICAL EVENTS	2010	2011*
Wrong Body Part	3	5
Wrong Patient	1	0
Wrong Procedure	1	1
Retention of a Foreign Object	9	2
Death of ASA Class 1 Patient	0	0
PRODUCT OR DEVICE EVENTS		
Use of Contaminated Drugs, Biologics or Device	0	0
Misuse/Malfunction of a Device	0	0
Air Embolism	2	1
PATIENT PROTECTION EVENTS		
Infant Discharged to the Wrong Person	0	0
Patient Elopement	0	0
Patient Suicide	0	0
CARE MANAGEMENT EVENTS		
Death or Serious Disability Due to a Medication Error	1	3
Death or Serious Disability Due to a Hemolytic Reaction	0	0
Death or Serious Disability In a Low-Risk Pregnancy, Labor or Delivery	0	0
Death or Serious Disability Associated with Hypoglycemia	0	0
Death or Serious Disability Associated with Failure to Treat Hyperbilirubinemia	0	0
Stage 3 or 4 Pressure Ulcers Acquired After Admission	11	11
Death or Serious Disability Due to Spinal Manipulative Therapy	0	0
Artificial Insemination with the Wrong Donor Sperm or Donor Egg	0	0
ENVIRONMENTAL EVENTS		
Death or Serious Disability Associated With an Electric Shock	0	0
Wrong Gas or Contamination in Patient Gas Line	0	0
Death or Serious Disability Associated With a Burn	0	1
Death or Serious Disability Associated With a Fall	14	8
Death or Serious Disability Associated With the Use of Restraints or Bedrails	0	0
CRIMINAL EVENTS		
Care Ordered by Someone Impersonating an MD, RN, or Other Provider	0	0
Abduction of a Patient	0	0
Sexual Assault of a Patient	0	0
Death or Injury of a Patient or Staff From Physical Assault	0	0
TOTAL	**42**	**32**

New Hampshire Adverse Events by Number and Percentage
January – December 2011

Event	Count	Percent
Stage 3 or 4 Pressure Ulcer	11	34%
Fall	8	25%
Wrong Site Surgery	5	16%
Medication Error	3	9%
Retained Foreign Object	2	6%
Air Embolism	1	2%
Wrong Surgical Procedure	1	3%
Burn	1	3%

Distribution of Adverse Events in New Hampshire Hospitals by Category
January – December 2011



Contributing Causes for Adverse Events

The keys to improving patient safety are the identification, reporting, and learning from potentially risky events. Hospitals and ASCs conduct a detailed analysis of the factors leading to the event which may include issues of communication, policies/procedures, and staff training. Without this information, it is difficult to prevent an event from recurring. If there is a pattern of events, there may be a broader systemic issue that may lead staff and physicians to implement patient safety improvements across departments or units. Given the rarity of these events in New Hampshire, it has been particularly important that the hospitals share information within the Commission regarding event causality to facilitate meaningful collaboration on finding solutions.

The goal of RSA 151:39 is to "facilitate quality improvement in the health care system" by increasing awareness of why events happen and how to prevent them from happening again. Individual facilities use the findings from their root cause analyses to prevent a repeat of similar events. At the same time, New Hampshire hospitals are using the New Hampshire Health Care Quality Assurance Commission to share their findings and strategies to strengthen the collaborative efforts of the group on behalf of safer care across the state.

The 2010 Report on Adverse Events was published by the NH DHHS Bureau of Health Facilities and released in August 2011. This was reviewed in detail and discussed at Commission meetings. It was noted in the report that no consumer complaints were received associated with these events. Most important is the work that has been done in responding to these events and identifying trends. Members agreed to continue to share their learning from these events, as well as to report any 2011 events to the Commission. There was also discussion of how events are reported when patients cross organizations and states. All agreed that is important to inform any organization if they become aware of an event that may have happened prior to receiving the patient. Although many types of organizations are exempt from reporting, such as nursing homes, it does not preclude the need to inform and review cases. Staffing at the State bureau changed in 2011, after the report was released. Meetings took place with the Manager of Office of Operations Support at DHHS, to offer the support of the NH Health Care Quality Assurance Commission as outlined in the State Report. Commission members are involved in many ongoing initiatives designed to reduce the occurrence of these adverse events.

Below is a summary of strategies hospitals are implementing to prevent these types of adverse events.

Care Management Events – Pressure Ulcers

Assessment/Documentation/Communication

- Revising skin assessment documentation to make assessment easier and more accurate.
- Establishing pressure ulcer prevention work group to review all cases and look for common causes.
- Consistently assess & document for skin breakdown. Communicate skin issues to clinical leaders.

- Add prompts to preop and surgical checklist and change nursing hand-off tool.
- Automatic trigger to notify wound nurse when an ulcer is documented; who then reviews the data.
- Event report hot line – considering adding skin integrity issues to events to be called in.
- Electronic medical record redesign.
- Creation of a high risk rating tool that includes history of previous ulcer.
- Modifying electronic tools to be refined and more specific.
- Developing triggers for an "almost" ulcer.
- Nurses can request consult via EMR.
- Nurse led documentation efforts "anyone can stage" tool (Medline) with staging language and use of cameras.
- Daily dashboard on wounds, pressure ulcers, catheters, etc.

Education

- Increasing the use of visual aids and pictures to assist nursing staff in correctly staging pressure ulcers and in communicating skin issues upon shift transfer.
- Providing additional training to staff on working with patients or family members who are reluctant to cooperate with skin care practices.
- Attention to urine and fecal incontinence and staff education about this concern.
- Creation of an incontinence algorithm.
- Quarterly "road shows" on all shifts including demos / posters / presentations; wound fairs.
- Orientation focus on charting; stage 3 or 4 should not be documented if not 1st reviewed by the wound care nurse.
- Education about progress notes with MD's – stickers in chart.

Patient/Family

- Encourage hydration and good nutrition.

Policy/Procedures

- Focus on best practices, mobility / nutrition, and product review.
- Developing new decision-making algorithms to assist nursing staff in implementing appropriate interventions for at-risk patients.

Staff Related

- Creation of a multidisciplinary skin and wound task force.
- MD and RN involvement in documentation of ulcers; Staging of wounds by a specific MD.
- Developing wound "super user" / skin resource role on each unit.
- Increasing use of wound, ostomy and continence nurses as consultants.

Equipment

- Purchasing special equipment to use for patients at risk for pressure ulcers.
- Change color (white) of transfer boards to bright color.
- When patients are in chairs they will be provided pressure-relieving padding.
- Pressure relieving mattresses to be used.
- ED focus on stretchers / mattresses; identifying high risk patients.
- Analysis of beds / mattresses; identifying vendor; focus on ED stretchers; algorithm for what type of bed / mattress to use.

Surgical Events – Wrong site/patient/procedure

Assessment/Documentation/Communication

- Developing scripting for pre-operative procedures and clarifying who is responsible for calling time-out.
- Include details of the wound packing materials product, size and amount inserted and extracted in Clinical Wound Care Nurse Worksheet.
- Importance of speaking up.
- Communication with transition of staff in & out of the OR.
- Confirmation/verification of messages amongst team members.

Patient/Family

- Implement physician – nurse rounding with patients.

Policy/Procedures

- Conducting a second time-out and site marking when patient is repositioned or marking isn't visible.
- Creating mandatory checklist for use during invasive procedures, including site marking.
- Standardizing sponge counting processes across units and departments.
- Increasing the use of x-rays in the operating room to identify the correct surgery site and/or to identify retained objects.
- Expanding the list of objects to be counted after a surgery or invasive procedure.
- Policy on Time-out process revised. All physicians and team members educated on revised policies.
- Change count policy and procedures. Include sheaths and other pieces of surgical supplies on count list. If count is not accurate take action, use radiographic imaging when appropriate.
- Count all sponges, sharps after infant delivery. Verify count.
- Defining what constitutes a foreign body.

Staff Related

- Assigning one individual to be accountable for implementation of time-out.
- Team members empowered to use the Time-out procedure.

Equipment

- Ensuring that all site marking materials are indelible and designed to be clearly visible on all skin types.
- Improving labeling on equipment carts so that left/right implants and/or implant sizes are clearer.
- Replacing sponges with radio-opaque or tailed sponges.
- Use of whiteboards used for communication reminders during surgery.
- Bilateral procedures – use of visual body charts.

Environmental Events – Falls

Assessment/Documentation/Communication

- Implementing new fall risk assessment policies and standardized assessment tools.
- Using high-visibility indicators of patient's fall risk (stars, bands, colored slippers, etc.).
- Posting fall prevention actions prominently in each patient's room, visible to staff, patient, and family.
- Establishing and/or clarifying existing fall risk assessments.

- Patient's status and risks are clearly communicated during handoff or at shift changes or when transferred to a different unit.
- Posters on each unit indicating the time/days since last fall.
- EHR to be made more intuitive for creating care plans based on assessments.
- Modify EHR to allow staff to document more frequent nurse rounding.

Policy/Procedures

- Modifying standard order sets so that a patient's fall risk status is consistently considered when ordering medications.
- Developing post-fall intervention protocol with clear assignment of roles.
- Implementing rounding at least every two hours to address patient's toileting and other needs.

Education

- Retraining of staff.
- Fall prevention material and pop quiz on hospital's online nursing education tool.
- Providing additional staff training on best practices in fall risk assessment.

Equipment

- Re-arrangement of furniture in patient rooms.

Patient/Family

- Patient educational material added to pre-operative discussion with patient.

New Hampshire hospitals are committed to preserving the sacred trust we have with our patients and our community to ensure that they are helped, not harmed when they seek care. Hospitals in New Hampshire measure safety in many different ways to guarantee the best outcomes including the absence of preventable harm to patients, the presence of a safe and transparent culture, implementation of evidence-based practices, ratings of patients relative to their observation that they are receiving safe and high-quality care, and performance relative to state and national goals.

C. Eliminate Harm: Live Clot Free NH

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 Commission became a project implementation partner in this effort. The Eliminate Harm initiative began with a focus on VTE (venous thromboembolism) prevention and included the development and distribution of a VTE Toolkit, "Live Clot Free NH"; to assist providers and hospitals in implementing evidence based protocols for VTE prophylaxis. Initial data was collected during quarter 4 of 2011. Of the 5757 patients reviewed, 5164 or 90% were provided with VTE prophylaxis or had appropriate documentation of a contraindication. A total of 40 patients experienced a VTE during this quarter. Seven of these patients (17.50%) received no VTE prophylaxis, which represents potentially avoidable patient "harm". Members discussed the value of learning more about the patients who experienced a VTE event and agreed to review all cases of deep vein thrombosis (DVT) and pulmonary embolism (PE) that occurred in their hospitals for Q4 (total of 40), using an ARHQ review tool designed for this type of review. Future review of these results will help determine further areas of focus.

D. Influenza Vaccinations of Health Care Workers

There was great interest in learning about policies that hospitals and ASCs had created and implemented with regard to influenza vaccination of health care workers. There were a variety of policies, definitions of "mandatory", approaches to educating and to holding staff accountable. Organizations were very creative in promoting the importance of influenza vaccination as a patient safety imperative. A Survey Monkey tool was developed to assess current influenza policies focused on the mandatory aspect, consequences, definitions of eligible staff and general approaches. 36 organizations responded, and 18 (50%) indicated they have a "mandatory" policy requiring staff to receive the influenza vaccine or to seek a waiver on religious or medical grounds. Results of the Survey Monkey were shared around policies/practices at hospitals and ASC's, focused on influenza vaccinations of staff.

Establish a 'Just Culture'

Over the last decade, David Marx, largely recognized as the "father of Just Culture", has been working with organizations to improve operational safety and performance by helping them to recognize that individuals should not be held accountable for system failings over which they have no control. Rather, a 'Just Culture' fosters open communication and recognizes that competent professionals make mistakes. In fact, Marx's work has shown that when an institution has a 'Just Culture', frontline personnel feel comfortable disclosing errors – even their own – while being held accountable professionally. A 'Just Culture' does not however, tolerate reckless behavior.

Given the intent of the legislation that created the Commission, "to share information about adverse outcomes and prevention strategies in learning environments which foster candor and self-critical analysis…" the members agreed that understanding how to create 'Just Cultures' in their institutions is not only relevant, but essential to reducing harm to patients. Therefore, at all 5 meetings, the Commission members engaged in important dialogue about the concepts of a 'Just Culture', and where each of them are working to educate staff and to adopt the principles. As a way to illustrate the benefits of a 'Just Culture' in improving patient safety, members routinely shared actual stories of adverse events or "near hits" incorporating the concepts of a 'Just Culture'. This exercise stimulated important questions, meaningful dialogue, and valuable learning.

Considering turnover in positions at hospitals and ASCs as well as Commission members, a 'Just Culture' Toolkit was distributed to all and the importance of ongoing education was reinforced. Past educational tools were also made available to members.

Summary

Year 7 has brought NH hospitals and ASC's along the continued journey of improving the safety and quality of care we provide to our patients. It is a journey that includes a depth and breadth of dialogue that promotes best practices as well as intense scrutiny of failures. The members continued to share best practices and improvement strategies as well as agree to adopt several evidence-based practices that have been proven to improve

care and decrease adverse events. All public documents as well as educational materials related to the Commission and its improvement activities can be found at *www.healthynh.com*

Hand hygiene initiatives were re-energized through the reports published by Dr. Kirkland and members agreed to maintain an aggressive campaign to maintain our gains and improve our rates. This goal will help reduce harm that occurs through transmission of health care associated infections.

The rates for all 5 measures related to how often hospitals carry out the evidence based recommended processes to prevent surgical infections remain equal to or above the national average on a scale where 100% is best practice.

The Commission collected information regarding the serious adverse events that occurred in hospitals during 2011. This information was used to identify common causal factors and strategies for ensuring that they do not recur. Honest and open sharing by those who experienced adverse events continued to reinforce the importance of the culture of the Commission in fostering safe and reflective dialogue.

One of the major accomplishments of the Commission in year 7 was the expanded focus on promoting the science of high reliability at all organizations using another anonymous survey to understand how effectively the patient safety checklist is being utilized in procedural areas of New Hampshire hospitals and ASCs. New Hampshire is the only state in the country to have every hospital and participating ambulatory surgery center committed publicly and at the leadership level to adopting a patient safety checklist in all surgical and procedure areas.

There was also the successful launch of the Eliminate Harm focus on VTE Prevention, with the roll out of a toolkit and initial chart audit. In pursuit of learning and seeking further delineation of promoting best practices, members agreed to complete a detailed review of all cases of VTE and PE that occurred during the last quarter of 2011. The work of eliminating harm will now transition to work being done through the Partnership for Patients initiative.

The practices of how organizations implemented mandatory influenza vaccination policies of health care workers were openly discussed. Policies and implementation strategies were shared, as well as challenges and barriers. Discussions of this activity at the state level and peer sharing were felt to be more helpful for hospitals addressing this issue than the regulatory mandates. There was also discussion of the unintended consequences when implementing new technology, and the potential impact on quality and safety.

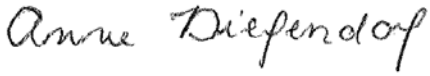
The Commission will begin Year 8 in July 2012 with a continuing focus on decreasing preventable harm by promoting high reliability organizations, adopting evidence-based best practices, and continuing work to establish ‘Just Cultures’ within each institution.

The Commission voted to adopt this seventh year report of the New Hampshire Health Care Quality Assurance Commission.

Details regarding the establishment and activities of the Commission can be found on www.healthynh.com

For questions, please call: Jean Corvinus, RN, Commission Chair: 335-8479 or Anne Diefendorf, Administrator, 415-4271.

Respectfully submitted,



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