NH Health Care Quality
Assurance Commission

Annual Report of the
New Hampshire Health Care Quality Assurance Commission

June 1, 2013
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), an "at large" public member and the designee of the Commissioner of the Department of Health and Human Services.

Members of the Executive Committee include:

Chair	**Scott Goodwin,** D.A., RN, CPHQ, LSSBB Vice President/Chief Quality Officer Catholic Medical Center, Manchester
Vice-Chair	**Terry LeBlanc**, RN, MBA, FACHE Chief Operating Officer, New London Hospital, New London
Immediate Past Chairs	**Stephanie Wolf-Rosenblum,** MD, FCCP, MMM, Chief Medical Officer, Southern New Hampshire Medical Center, Nashua
	Jean Corvinus, RN, BSN, MS, CPHQ Director, Quality & Performance Improvement, Frisbie Memorial Hospital, Rochester
At Large	**Peter Walkley,** MD, Chief Medical Officer, Lakes Region General Hospital, Laconia
	Sue Majewski, Chief Operating Officer, Bedford Ambulatory Surgery Center, Bedford
	Valerie Neill, MBA, CPHQ Manager Clinical Analysts Elliot Hospital, Manchester
	Marge Kerns, RPh,VP Clinical Support Services, LRGHealthcare, Laconia
	Lori Key, RN, MBA, Director QA & Safety, DHMC, Lebanon

The officers serve one year terms.
During its eighth year, the Commission met four times on the following dates:
August 10, 2012; October 12, 2012; January 11, 2013; and May 10, 2013.

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 22 ambulatory surgery centers voluntarily participated in the Commission meetings and actively engaged in the initiatives adopted by its members. Thomas Bunnell was appointed by Governor Lynch in October and accepted the request to serve as the member at large for the Commission. Tom offered an overview of his background and members welcomed him at the January meeting.

Promoting High Reliability Organizations

- Focused on implementation and effectiveness of the Patient Safety Checklist in all surgery and procedural areas; shared results from a survey of staff in surgery and procedural areas with regard to awareness of and adherence to the checklist which helped determine ongoing areas of vulnerability and discussed potential strategies for 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 hosted a question and answer session with staff from Licensing & Regulation Services, worked with Legislators to develop revised language for Adverse Event reporting statute.
- Presented findings from investigations of the Hepatitis C and Fungal Meningitis outbreaks, which fostered discussions about safe medication delivery systems and ensuring best practices; invited all members to attend a statewide conference featuring speakers from hospitals in other states who had experienced similar outbreaks and shared their lessons learned.

Adopt Evidence-Based Best Practices to Improve Outcomes

- Shared resources and invited members to all local events offered as part of the national initiative Partnership for Patients, with goal to reduce harm from hospital acquired conditions and readmissions by 2013; linked all activity of the Partnership to the foundation that had been established for the NH Eliminate Harm initiative.
- Continued focus on hand hygiene compliance through the identification and sharing of audit results and innovative practices being tried by some organizations; distributed new sets of laminated posters and hand hygiene education videos to all.
- Provided results from chart audit as part of the statewide effort to eliminate preventable cases of venous thromboembolic (VTE) disease from all inpatients, invited all members to participate in VTE workshop with a subject matter expert presentation and peer to peer coaching panel; shared challenges and successful approaches to risk reduction of VTE in the hospital setting.

Establish 'Just Cultures'* within our Organizations

- Engaged in discussions about the challenges in spreading these concepts to all areas with a focus on relationship between 'Just Culture' and the relentless pursuit of improving quality and patient safety (especially relative to the Surgical Safety Checklist), Commission Chair offered a brief tutorial on the meaning of Just Culture to the Health & Human Services oversight Committee.
- Through member "Storytelling", exchanged important information regarding facilities' own stories of medical errors and prevention strategies; reinforced the application of the principles of 'Just Culture' to the activity of the Commission and stressed the importance of fostering trust and open communications amongst members, in a safe environment, as part of the introduction at every meeting.
- Invited Tanya Lord to present the story of Noah, her 4 1/2 year old son whose tragic death (in another State) revealed lessons in poor communication and highlighted the importance of partnering with patients and their families after an error or adverse event occurs.

** 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 4 times during Year 8. For the 1st time in the history of the Commission, a meeting was canceled. The March 8th meeting was canceled due to a snowstorm that brought up to a foot of snow to southern NH. Attendance at meetings was excellent. All new members signed confidentiality agreements and minutes were recorded. Orientation was provided to any new members, at their organization. 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., Safety Checklist 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 had begun to spread its use to other procedure areas as a method to improve surgical safety. The goal of the checklist is to promotes safe and correct site surgery. 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 the reliability and impact of the checklist on surgical safety. This survey was adapted in 2011 for use in all other procedure areas and distributed.

In May of 2012 another survey was revised and sent to both surgery and procedural staff. There were 623 responses, from 20 hospitals and 15 ASCs.

Points of interest include:

- 99% were aware of their institutions policy on surgical checklist
- 91% said all staff were present in room at timeout
- 75% said all members had suspended activities at timeout
- 78% said the room was quiet
- 78% of the time, the checklist incorporated staff concerns
- 53% said a timeout is done again when a new member joins the surgery / procedure after it has begun
- 95% felt free to express concerns
- 80% felt use of the checklist had prevented an adverse event in their organization
- 98% believe leadership supports use of a checklist

Compared to past surveys there were no remarkable differences in the results which was disappointing. The final question of the survey provided some interesting insights. The question was: "Ongoing audits indicate continued lapses in adherence to all components of the checklist. Please share any concerns or ideas for improvement regarding the safety of patients in the operating room or procedural areas." Results of this open ended question were distributed to all members for their review and follow up discussion focused on how the Commission should re-invigorate this initiative. In consideration of the culture of safety, changing the checklist approach from "tell me what to do" to "what actions can we, as a team, take to ensure the safest environment for the patient"' may be more appropriate and effective. This approach is aimed at moving away from "checking the boxes" to a meaningful team briefing on the specific needs of the patient.

Despite adoption of the Surgical Safety Checklist, surgical errors persist. The results of ongoing quarterly checklist audits were regularly reviewed by the membership to gain better understanding of the issues. Members shared current practices and policies. Audit practices were also discussed, as a means to "coach" surgical teams to adopt best practices associated with use of the surgical checklist. Additionally, checklist protocols from RI and Minnesota were distributed to members and reviewed for their input. Members who had work experience in RI shared their insights.

An educational video, Just a Routine Operation, was distributed for use in staff education and reinforcement. It draws a parallel to the airline industry, and highlights the risk of when team members fear speaking up.

A subcommittee met in April and will meet again over the summer. They will consider how to make the existing audit a more meaningful coaching tool. They also will develop a library of references after completing a literature review and explore evidence that supports adoption of certain checklist behaviors that might be endorsed by the Commission.

B. Management and Prevention of Infections

The management and prevention of infections continue 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) and Catheter Associated Urinary Tract Infections (CAUTI)

data for selected intensive care units, 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 were required to report specific surgical site infection rates via NHSN and IV antimicrobial prophylaxis data to the State of NH. The release of the 2011 Healthcare Associated Infections (HAI) report was delayed until March due to staffing priorities and involvement in multiple, prolonged outbreak investigations. Overall, statewide infection rates were lower than expected based on national data. A total of 110 HAIs were reported, representing 85 surgical site infections and 25 central line-associated bloodstream infections. The overall observed number of HAIs in NH hospitals was 40% fewer than expected based on national data. There were 42% fewer central line-associated bloodstream infections and 40% fewer surgical site infections. Statewide HAIs in 2011 decreased compared to 2010, however this difference was not statistically significant (114 HAIs reported in 2010, representing 94 surgical site infections and 20 central line-associated bloodstream infections). Overall these results show that New Hampshire is on the right track to reducing HAIs in the state. Members were also provided many references, resources, webinars and workshops on HAI related topics via the Partnership for Patients initiative.

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. The most recent results available for 2012 are noted below.

Results:

Antibiotic received within 1 hour of surgery:
In 2012, out of 4396 of patients who underwent specified surgery, 4343 or **99%** received an antibiotic within 1 hour before the start of surgery. This compares to a rate of 72% in 2005, a 27% 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 2012, out of 4293 patients who underwent specified surgery, 4186 patients or **98%** had their antibiotics discontinued within 24 hours after surgery ended. This compares to a rate of 57% in 2005, a 41% increase. The national average for this measure is **98%**. This statewide rate includes data from all 26 hospitals.

Prophylactic Antibiotic Selection:
In 2012, out of 4435 patients had who underwent one of the specified surgeries, 4382 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 2012, out of 4685 surgical patients who were eligible to receive prophylaxis, 4618 or **99%** had the recommended prophylaxis ordered to prevent venous thrombosis. This compares to a rate of 89% for 2007, a 10% increase. The national average for this measure is **98%**. This statewide rate includes data from 26 hospitals.

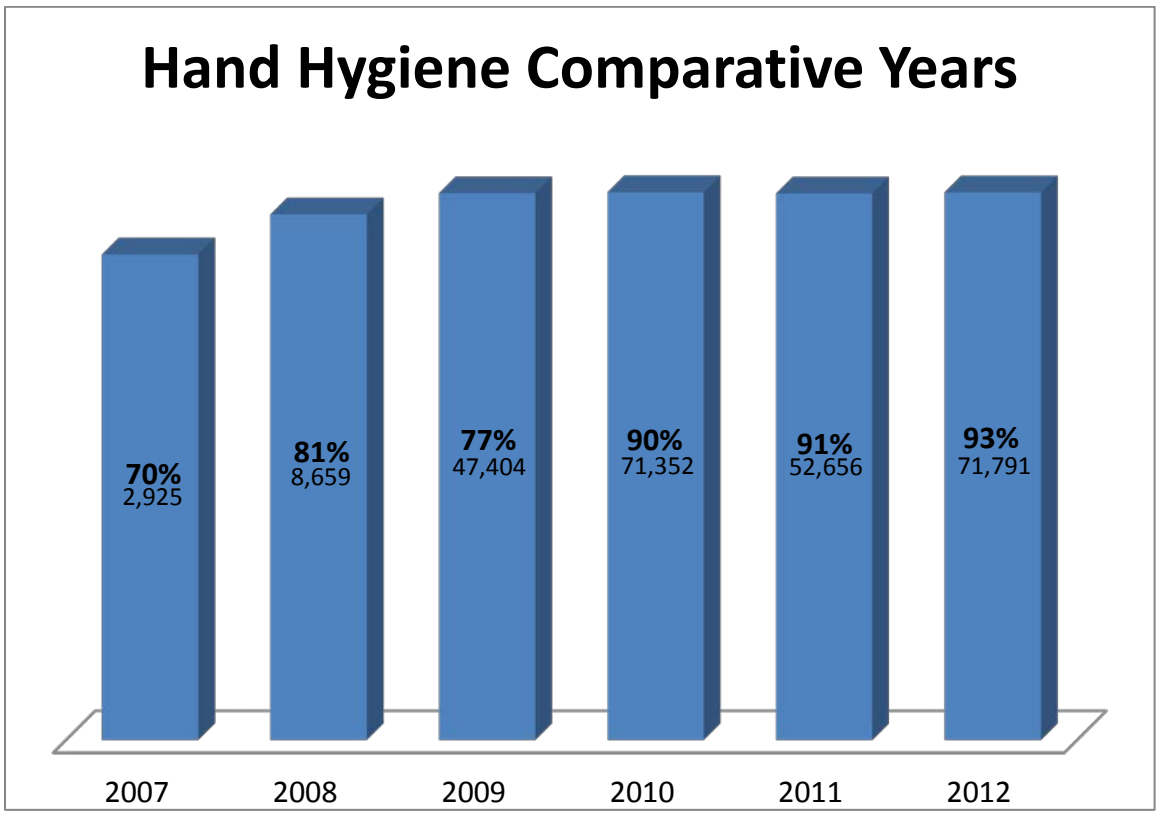
Recommended venous thrombosis prophylaxis received:
In 2012, out of 4685 surgical patients who were eligible to receive prophylaxis, 4589 or **98%** actually received the recommended therapy. This compares to a rate of 87% in 2007, a 11% increase. The national average for this measure is **94%**. This 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 3 quality and patient safety measures and equal to 2 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%. In 2012, the rate increased to 93% based on almost 72,000 observations.



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.

Members shared activities at their organizations and ways they used various resources to further promote increases in hand hygiene compliance. Commission members have an acute appreciation of the fact that this basic infection prevention campaign requires a continued, vigorous approach at the unit level with regular feedback to optimize results. A subcommittee will be formed this summer to include Commission members, infection prevention & control practitioners, and others in the community, to look at new ways to approach this campaign. Members offered strategies they have used to reinvigorate their organization's approach. They include posting unit specific results for all staff, using their infection control staff to conduct focused audits, defining hand hygiene moments in a clearer way, bringing data to medical executive committee, creating new hand hygiene teams and standardizing definitions for auditors. Fostering a safe culture, where peers can give direct feedback in a safe environment and are empowered to reinforce positive behaviors and practices, are a cornerstone to a successful campaign.

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.

B. Serious Reportable Events / 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 were 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

This year, the Commission worked with Representative Cindy Rosenwald who introduced legislation to update the NH law with the most current NQF list of Serious Reportable Events. Members were provided with a list of SREs (NQF 2011 Update), with new events or definitions of events highlighted. There is one new category of events (Radiologic Events) and the Surgical Events category has been expanded to include "Surgical or Invasive Procedure Events".

Rep. Rosenwald also requested adding a unique event, outside of NQF parameters, that would capture what happened in the recent Hepatitis C outbreak, due to presumed drug diversion of a staff member. Members agreed that the need to restore public trust in health care is critical at this time, considering the events of the past year. Reporting an event of this nature via the Adverse Event reporting system would only be one approach of many that should occur. These events should also be reported to the Public Health department as well as law enforcement, if there is potential criminal activity. The hospital licensing rules will also need to be changed. HB 293 passed both the Senate and the House of Representatives, and was signed into law by the Governor in May. The final version of HB 293 that passed is as follows:

RSA 151:38, I is repealed and reenacted 1 to read as follows:
Events to be reported under this subdivision include:
(a) Serious reportable events and specifications published and periodically amended by the National Quality Forum, which are incorporated in this subdivision by reference. The department shall provide a link from its Internet website to the serious reportable events and specifications on the National Quality Forum Internet website and shall provide a printed copy upon request.
(b) The exposure of a patient to a non-aerosolized blood borne pathogen by a health care worker's intentional, unsafe act. An act by hospital or ambulatory surgery center staff resulting in an infection or disease shall be considered to be purposefully unsafe if it meets all of the following criteria:
(1) There was an intentional act or reckless behavior;
(2) No reasonable person with similar qualifications, training and experience would have acted the same way under similar circumstances; and
(3) There were no extenuating circumstances that could justify the act.
2 Adverse Events Reporting System; Commissioner's Duties and Responsibilities. Amend RSA 151:39, VI to read as follows:
VI. ***The commissioner shall notify each hospital and ambulatory surgery center***

when the National Quality Forum publishes an amendment to the serious reportable events and specifications and immediately upon such notification, the amended serious reportable events and specifications shall be the reportable adverse events pursuant to this subdivision.

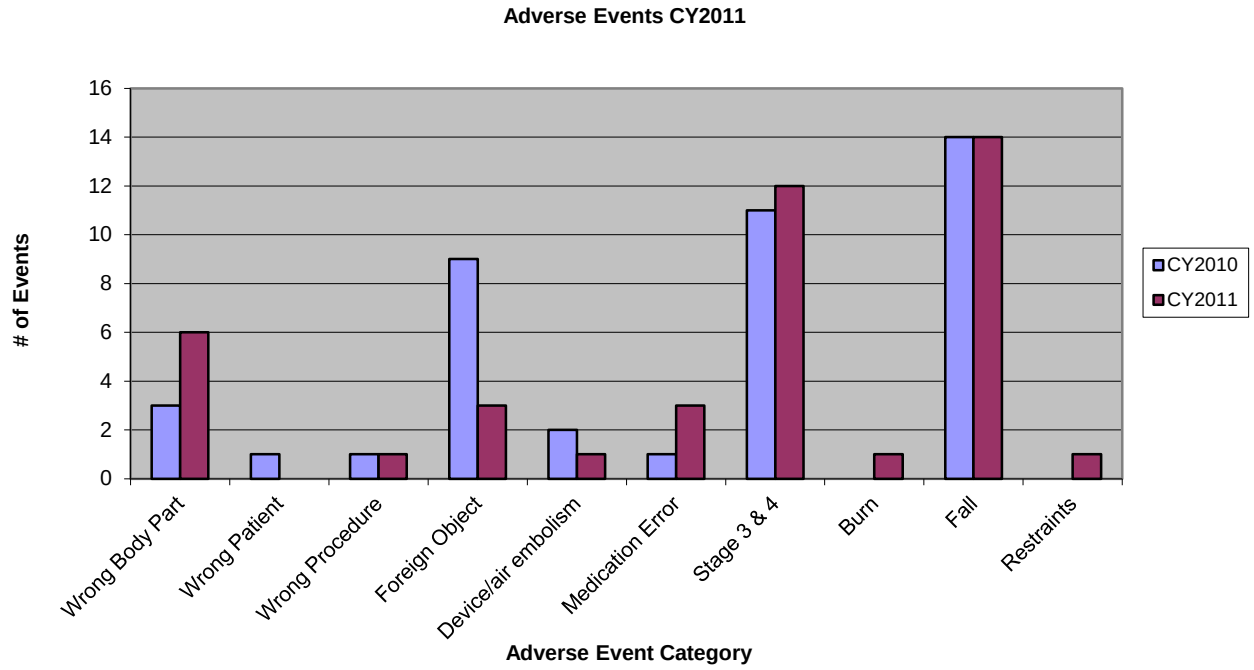
The Commission members agreed to continue to send a notification of their reported events to the Administrator of the Commission, in addition to reporting these events to the Bureau of Health Facilities Licensing. When a patient is harmed in an organization, the event can have a profound impact on involved 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 monitoring 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 and ASCs
January 1, 2011-December 31, 2011

All except one of the adverse events reported by New Hampshire hospitals in 2011 were attributed to three categories: Environmental, Surgical and Care Management. There were no events reported by an ASC. 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.

Distribution of Adverse Events in New Hampshire Hospitals
CY 2010 compared to CY 2012



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 2011 Report on Adverse Events was published by the NH DHHS Bureau of Health Facilities and released in August 2012. Mike Fleming, Pat Brett and Dr. John Lambrukos, from the Licensing & Regulation Services of Health & Human Services, attended the October meeting of the Commission. They provided an overview of the Adverse Event Report for 2011, which was comparable to the previous year. They indicated they would like to see a more in depth Root Cause Analysis (RCA) with a deeper and wider breadth of analysis in future reports. They also hope the corrective action plans (CAP) will be more in alliance with Quality Assurance Performance Improvement (QAPI) activities at the organizations, and help look at other things beyond the single event. A general question and answer session about reporting took place. The applicability of the Adverse Event law to outpatient practices/departments was clarified for

members. They stated if services are billed thru a hospital provider number, they would follow the CMS Conditions of participation so would be included for reporting.

Commission members are involved in many ongoing initiatives designed to reduce the occurrence of these adverse events. This year, through the Partnership for Patients, state wide workshops were held with a focus on Adverse Events/Hospital Acquired Conditions (HACs) including VTE, Falls, Adverse Drug Events, CAUTI, Pressure Ulcers and Readmissions. The workshops served as a forum for bringing all elements of a successful HAC prevention program to participating hospitals and their prevention teams. Agendas included presentations on the state of the science by national subject matter experts, who readily shared evidence based protocol and practical tips for implementation. Participants learned about strategic implementation of interventions and sustaining and spreading the improvements across the hospital and with community partners. New Hampshire champions from local hospitals and community settings, also served as faculty to provide supportive information relevant to all facets of a successful programs through peer to peer/coaching panel sessions. The agendas offered time for consideration of individual hospital challenges associated with each topic. Workshops were open to all members of the Commission.

Adverse Events for 2012

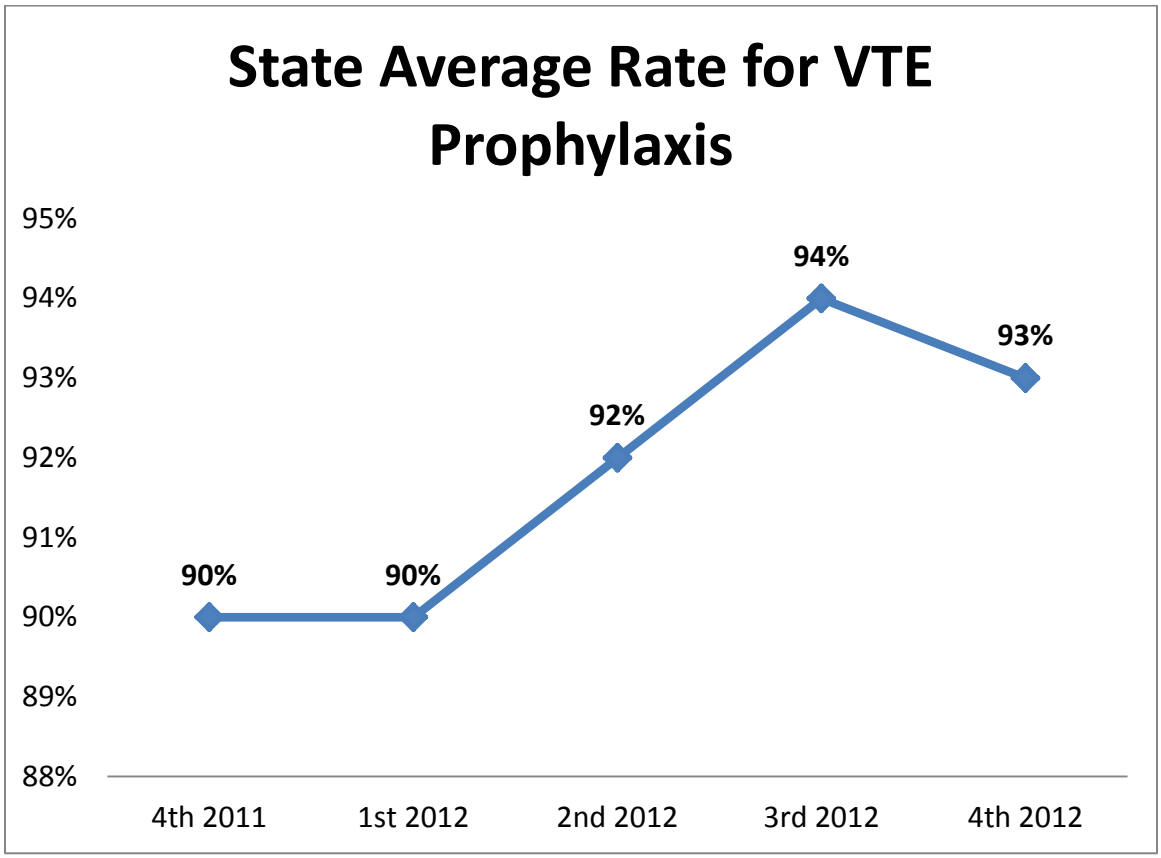
An updated report of Adverse Events for 2012, compared to 2011 and 2010 was provided to members and reviewed. This chart is on the following page. It is important to note that the total reported by the Commission underestimates the total for NH, as rehab hospitals are also required to report to the State but are not represented on the Commission. In 2012, rehab hospitals accounted for 6 of the total 42 events. Surgical events continue to be a high occurrence event, with 13 events reported, ranging from minor errors such as placing an intravenous device in the wrong arm to performing an incorrect invasive procedure. The safety checklist subgroup will review the RCAs involved in these events to determine whether there is shared learning the membership will all benefit from. It would be informative to understand if there are common root causes and how effective the corrective action plans are.

New Hampshire Hospital Adverse Events
2010 vs. 2011 vs. 2012*
***as reported to Commission (does not include rehab hospitals)**

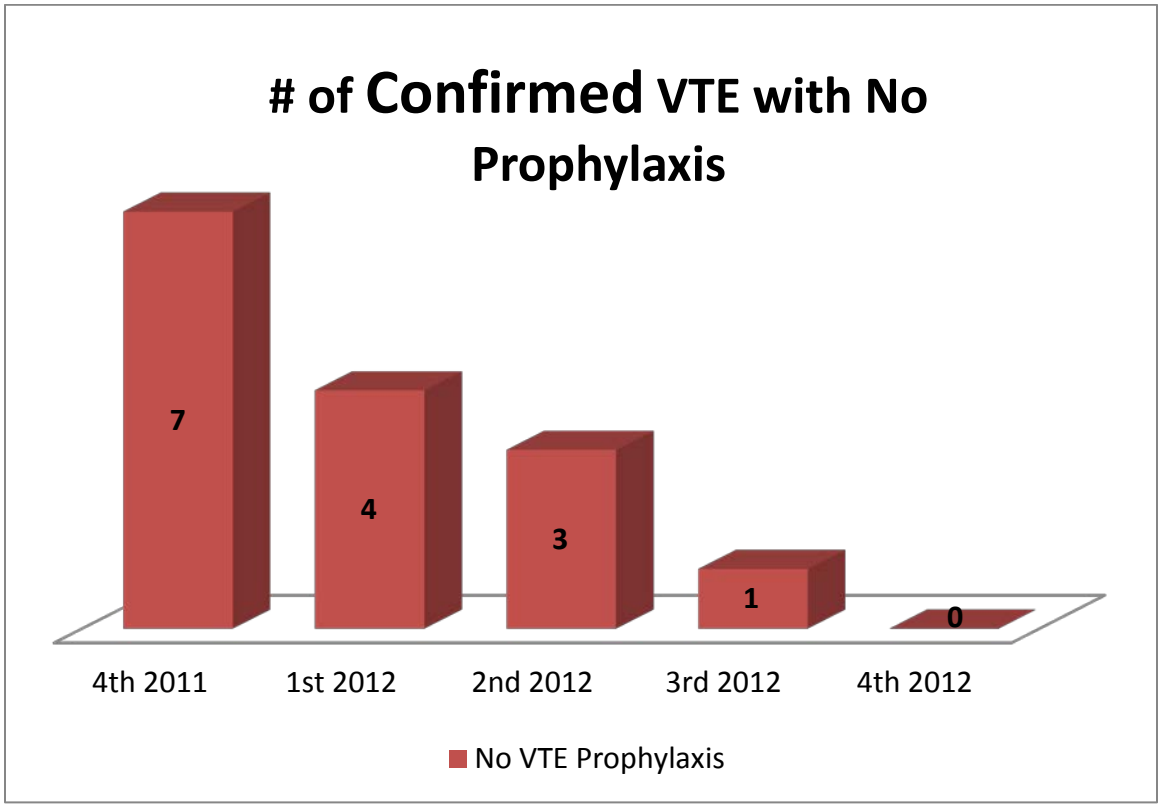
SURGICAL EVENTS	2010	2011	2012*
Wrong Body Part	3	6	6
Wrong Patient	1	0	0
Wrong Procedure	1	1	2
Retention of a Foreign Object	9	3	5
Death of ASA Class 1 Patient	0	0	0
PRODUCT OR DEVICE EVENTS			
Use of Contaminated Drugs, Biologics or Device	0	0	0
Misuse/Malfunction of a Device	0	0	0
Air Embolism	2	1	0
PATIENT PROTECTION EVENTS			
Infant Discharged to the Wrong Person	0	0	0
Patient Elopement	0	0	0
Patient Suicide	0	0	0
CARE MANAGEMENT EVENTS			
Death or Serious Disability Due to a Medication Error	1	3	1
Death or Serious Disability Due to a Hemolytic Reaction	0	0	0
Death or Serious Disability In a Low-Risk Pregnancy, Labor or Delivery	0	0	0
Death or Serious Disability Associated with Hypoglycemia	0	0	0
Death or Serious Disability Associated with Failure to Treat Hyperbilirubinemia	0	0	0
Stage 3 or 4 Pressure Ulcers Acquired After Admission	11	12	11
Death or Serious Disability Due to Spinal Manipulative Therapy	0	0	0
Artificial Insemination with the Wrong Donor Sperm or Donor Egg	0	0	0
ENVIRONMENTAL EVENTS			
Death or Serious Disability Associated With an Electric Shock	0	0	0
Wrong Gas or Contamination in Patient Gas Line	0	0	0
Death or Serious Disability Associated With a Burn	0	1	1
Death or Serious Disability Associated With a Fall	14	14	11
Death or Serious Disability Associated With the Use of Restraints or Bedrails	0	1	0
CRIMINAL EVENTS			
Care Ordered by Someone Impersonating an MD, RN, or Other Provider	0	0	0
Abduction of a Patient	0	0	0
Sexual Assault of a Patient	0	0	0
Death or Injury of a Patient or Staff From Physical Assault	0	0	0
TOTAL	**42**	**42**	**37**

C. Eliminate Harm: Live Clot Free NH / 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 Commission became a project implementation partner in this effort. The Eliminate Harm initiative began with a focus on venous thromboembolism (VTE) 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. Data has been collected beginning with quarter 4 of 2011. Patients who were provided with VTE prophylaxis or had appropriate documentation of a contraindication, has increased from a baseline of 90% to 94% in Quarter 3 and 93% in Quarter 4, as noted in chart below.



Patients who experienced a VTE during this same time frame, who received no VTE prophylaxis, dropped from 7 in Quarter 4 2011 to zero in Quarter 4 of 2012. This figure represents potentially avoidable patient "harm", so achieving zero is excellent. The following chart depicts this trend.



The Partnership for Patients, a nationwide public-private collaboration sponsored by the U.S. Department of Health and Human Services (HHS), is designed to keep patients from being harmed while in the hospital and heal without complication once they are discharged. Every hospital in NH has pledged to be part of the Partnership. Instead of having duplicative efforts, we are building upon the Eliminate Harm platform to extend the efforts and are working to reduce healthcare acquired conditions and hospital readmissions through the activities of the Partnership for Patients. The two goals of the Partnership for Patients are in alignment with eliminate harm:

- *Keep patients from getting injured or sicker*. By the end of 2013, **preventable hospital-acquired conditions would decrease by 40 percent** compared to 2010.
- *Help patients heal without complication*. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that **hospital readmissions would be reduced by 20 percent** compared to 2010.

D. Hepatitis Outbreak/Drug Diversion amongst Health Care Workers

In 2012, NH experienced a significant hepatitis C outbreak which caused immeasurable harm to our patients and a community hospital. At our August meeting, Dr. Sharon Alroy-Preis presented an in depth overview of the recent epidemiologic investigation undertaken by the staff of the NH Division of Public Health Services, in response to the recent outbreak of hepatitis C.

Her presentation included the following:

- Hepatitis C background – virology, epidemiology, testing recommendations, clinical symptoms, natural history of HCV infection, HCV diagnosis and treatment
- HCV investigation - initial steps and findings
- Nosocomial HCV transmission – 3 main mechanisms – contaminated equipment, use of single dose vial for multiple patients, and drug diversion
- Results of Literature review of previous outbreaks of hepatitis B&C in health care settings
- Public health investigation role & approach
- HCV testing approach of potential exposed patients
- Investigation findings – preliminary results, as investigation is ongoing

After the presentation members were encouraged to ask questions, share activities they have undertaken in their organizations, and delineate how we should move forward as state in prioritizing changes we may need to make in our systems.

Discussion points included the need to focus on narcotic control, distribution process and audits. The plan was to convene all appropriate stakeholders to proactively address the concerns raised as a result of the investigation. All members were in full support of a statewide effort, to include both hospitals and ASC's with a focus on narcotic process controls and getting out in front of drug testing proposals. A steering committee was formed to look at a state wide approach to reducing risk of a similar event from occurring again in NH. Regular updates of the activities of the steering committee were provided at commission meetings. Members agreed the role of the Commission was to ensure there was a disciplined focus on best practices to prevent narcotic diversion and incorporating concepts of high reliability organizations with whatever is built.

Details of legislative proposals were shared as they were available. Resources were offered about current drug testing practices and reliability. A template for organizations to use to assess their organizations practices was handed out. Resources for staff education were provided, including references to the One and Only campaign which recently released a video that links drug diversion and infection control practices to outbreaks. Members shared updates of activities that hospitals and ASCs are under taking in response to the outbreak, especially as they were assessing practices using the template. Members reinforced the importance of prioritizing staff education both in the areas of detecting possible diversion as well as preventing the risk of this occurring.

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. 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. There was intentional selection of stories that reflected our most frequent Adverse Events, in the categories of Falls and Surgery.

Transparency is an essential component of creating a Just Culture, especially when mistakes happen or harm occurs. How and when to communicate the occurrence of such an event to a patient or family members is not readily understood or comfortably done by clinicians in these situations. At our May meeting we had the unique privilege of having Tanya Lord as our guest and she was able to truly put a face to the storytelling segment of our meeting. Tanya shared her story of her son Noah, who died 13 years ago at the age of 4½ years, after a routine operation at a hospital in another State. She explained how poor communication contributed to his death. The heartfelt message she conveyed was that communication in healthcare - provider to patient, patient to provider, and provider to provider - is at the heart of improving quality and patient safety. His death has inspired her to work toward making positive changes in healthcare. Noah's story is inspirational to providers to communicate as effectively as possible. As told through Tanya, she also emphasizes the importance of effective communication with patients before and after an error. Having Tanya attend our meeting and share her story, helped reinforce the true meaning of Partnership for Patients.

Summary

Year 8 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 learning from 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*.

- 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 2012. 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. The Commission actively partnered with a Legislator to craft language for revising the Adverse Events statute, which was just signed by the Governor.
- Another major activity was the continued focus on promoting the science of high reliability at all organizations repeating another anonymous survey to understand how effectively the patient safety checklist is being utilized in both surgical and 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 continued attention to the Eliminate Harm focus on VTE Prevention, with review and analysis of the chart audits. The work of eliminating harm transitioned successfully to work being done through the Partnership for Patients initiative.
- Due to the circumstances of an outbreak of hepatitis C due to presumed drug diversion, much attention was placed by the Commission on developing high reliability approaches to a secure and safe medication delivery system, with particular focus on narcotics.

Putting a face and a person, in the name of 4½ year old Noah Lord, to a storytelling segment was an emotional and inspirational way to end the 8th year of the Commission. The story of his death, which can be attributed to a series of communication missteps, as told by his mother Tanya Lord, helped remind everyone of the importance of the work we do, for every patient, at every encounter.

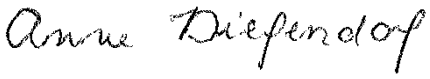
The Commission will begin Year 9 in July 2013 with a continuing focus on decreasing preventable harm by promoting high reliability organizations, adopting evidence-based best practices, and continuing work to establish 'Just Cultures' within each institution.

The Commission voted to adopt this eighth 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: Scott Goodwin, Commission Chair: 663-6509 or Anne Diefendorf, Administrator, 415-4271.

Respectfully submitted,



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