NH Health Care Quality
Assurance Commission

Annual Report of the New Hampshire Health Care Quality Assurance Commission

June 1, 2011
HB 514, RSA 157:2, Laws of 2005

RSA 157:2, of the Laws of 2005, 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	**Ross Ramey, MD** Monadnock Community Hospital, Peterborough
Vice-Chair	**Jean Corvinus**, Director, Performance Improvement, Frisbie Memorial Hospital, Rochester
Immediate Past Chairs	**Stephanie Wolf-Rosenblum, MD, MMM** Chief Medical Officer, Southern New Hampshire Medical Center, Nashua
At Large	**Sue Majewski**, Chief Operating Officer, Bedford Ambulatory Surgery Center, Bedford
	Anne Diefendorf, Director of Quality Performance, Concord Hospital, Concord
	Scott Goodwin, Director Performance Improvement, Catholic Medical Center, Manchester

The officers serve two year terms.

During its sixth year, the Commission met five times on the following dates: August 6, 2010, October 29, 2010, January 14, 2011, March 11, 2011, and May 13, 2011.

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:

- Institutional implementation of the Patient Safety Checklist in all procedure areas
- Voluntary reporting of the state mandated serious reportable events in order to inform our individual and collective priorities for eliminating harm going forward and be accountable and transparent to the public regarding the harm, contributing causes, and strategies for improvement.

Adopt Evidence-Based Best Practices to Improve Outcomes

- Continued efforts to improve hand hygiene compliance using laminated posters, screen savers and the identification and sharing of best practices and strategies
- Hand Hygiene site visits by Kathy Kirkland, MD to understand how culture and practice may contribute to the variation in rates among hospitals and between provider groups
- Developed a provider toolkit and metrics to launch a statewide effort to eliminate preventable cases of venous thromboembolic disease from all inpatients

Establish 'Just Cultures' within our Organizations

- Establishment of a learning collaborative to gain a deeper understanding of the concept of a 'Just Culture' and the benefit it brings throughout an organization
- Exchange of important information regarding facilities' own stories of medical errors and prevention strategies

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

** 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 6. Attendance was excellent. All new members signed confidentiality agreements and minutes were recorded. There were several subcommittees of the Commission, i.e., Adverse Events, Prevention of Venous Thromboembolic Disease which 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 was conducting quarterly compliance audits. 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. Use of the checklist involves both changes in processes and changes in the behavior of individual procedural teams at these institutions. To implement the checklist, all sites have to introduce a formal pause in care prior to induction of anesthesia, prior to incision, and just before closure of the incision. We received over 600 responses from all clinician types involved in the operating room. Here is a summary of the results:

- Results showed that over 75% of respondents believe that the use of a checklist has prevented an adverse event in their institution
- Over 95% of respondents agreed that they felt free to express concerns throughout the timeout/checklist process
- Over 96% believe that leadership supports the appropriate use of the timeout/checklist process
- 68% of OR team members had suspended all other activities during the time-out/checklist process
- 76% of the time the room environment was quiet during the time-out/checklist process

These survey results informed our yearlong sharing of best practices by identifying high performers and learning from their improvement strategies. The survey will be repeated in 2012.

By January 2011, the Commission members had posted and implemented a patient safety checklist in other procedure areas. They adapted the anonymous questionnaire administered in the operating room for all other procedure areas and are currently surveying those staff members regarding the effectiveness with which the checklist processes are being carried out.

B. Management and Prevention of Infections

The management and prevention of infections continues to be a priority for the Commission this year although as of January 1, 2009, hospitals no longer submit data to the NH Health Care Quality Assurance Commission. As required by RSA151:33 of the New Hampshire Statute, hospitals are submitting their institution's Central Line Associated Blood Stream Infection (CLBSI) 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. The Commission closely monitors the results of this statewide reporting and uses it to inform our priorities for the coming year relative to decreasing preventable infections.

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 decrease the risk of venous thrombosis which 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:

4733 patients received an antibiotic within 1 hour of surgery of the 4856 patients who underwent the specified surgery or, **97%** of patients received an antibiotic within 1 hour of surgery for the specified procedures. This compares to a rate of 76% in Year 1, 85% in Year 2, 93% in Year 3, 95% in Year 4 and 98% in Year 5.

- This statewide rate includes data from all 26 hospitals;
- The national average for this measure is 97% which compares to the NH average of 97%.

Antibiotic discontinued within 24 hours after surgery:

4580 patients had their antibiotics discontinued within 24 hours of surgery of the 4729 patients who underwent the specified surgery or, **97%** of patients had their antibiotic discontinued within 24 hours after surgery. This compares to a rate of 74% for Year 1, 83% for Year 2, 91% for Year 3, 94% for Year 4 and 96% for Year 5.

- This statewide rate includes data from all 26 hospitals;
- The national average for this measure is 96% compared to the NH average of 97%.

Prophylactic Antibiotic Selection:
4847 patients had the appropriate prophylactic antibiotic ordered for their designated surgery of the 4936 patients who underwent one of the specified surgeries or, **98%** of patients undergoing specific surgeries received the appropriate antibiotic before the procedure to prevent infection. This compares to a rate of 99% last year.

- This statewide rate includes data from all 26 hospitals;
- The national average for this measure is 98% which compares to the NH average of 98%.

Recommended venous thrombosis prophylaxis (clot prevention) ordered:
2247 patients had the recommended prophylaxis ordered to prevent venous thrombosis following specific surgeries of the 2338 patients who were eligible to receive the prophylaxis or; **96%** of patients undergoing specific surgeries had an order for the recommended venous thrombosis prophylaxis. This compares to a rate of 96% last year.

- This statewide rate includes data from 26 hospitals;
- The national average for this measure is 95% compared to the NH average of 96%.

Recommended venous thrombosis prophylaxis received:
2226 patients received the recommended venous thrombosis prophylaxis following specific surgeries of the 2336 patients who were undergoing specific surgeries or, **95%** of patients received the recommended venous thrombosis prophylaxis for indicated surgeries. This compares to a rate of 95% last year.

- This statewide rate includes data from 26 hospitals;
- The national average for this measure is 93% compared to the NH average of 95%.

New Hampshire rates are equal to or higher for each of these 5 measures of quality and patient safety than the national average.

Adopt Evidence-Based Practices to Improve Outcomes

A. Hand Hygiene Compliance

Beginning in 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. During the 8 month period from April-December 2008, there were over 20,000 opportunities observed where a caregiver or employee who had contact with a patient should have cleaned their hands. Our statewide rate of compliance for that time period was about 83%.

In 2009, our hand hygiene compliance rate for all types of providers increased to 90% statewide. We achieved this high level of performance using a number of strategies. The Foundation for Healthy Communities sent institutions a variety of laminated posters and computer screen savers throughout the year as prompts for employees to clean their hands. The Commission also invited several hospitals and ASCs to share their strategies for encouraging hand hygiene.

In 2010, we maintained our compliance rate at 90%. We also secured statewide grant funding to conduct site visits at every hospital and several ASCs to learn about the variation in practice and strategies for improvement. Kathy Kirkland, MD, is conducting those visits which are ongoing in 2011 with a report of the findings expected in December.

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.

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 June 2009, the New Hampshire legislature passed House Bill 592, AN ACT relative to "adverse events" in hospitals and ambulatory surgical centers (ASCs). 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) 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. These events are defined in the law as follows:

(a) Surgical events including:

(1) Surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this subparagraph do not include situations requiring prompt action that occur in the course of surgery or situations where urgency precludes obtaining informed consent.

(2) Surgery performed on the wrong patient.

(3) The wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this subparagraph do not include situations requiring prompt action that occur in the course of surgery or situations where urgency precludes obtaining informed consent.

(4) Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

(5) Death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

(b) Product or device events including:

(1) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product.

(2) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. “Device” includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators.

(3) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

(c) Patient protection events including:

(1) An infant discharged to the wrong person.

(2) Patient death or serious disability associated with patient disappearance, excluding events involving adults who have decision-making capacity.

(3) Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

(d) Care management events including:

(1) Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the

wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

(2) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products.

(3) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

(4) Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility.

(5) Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

(6) Stage 3 or 4 ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission.

(7) Patient death or serious disability due to spinal manipulative therapy.

(8) Artificial insemination with the wrong donor sperm or wrong egg.

(e) Environmental events including:

(1) Patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock.

(2) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.

(3) Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility.

(4) Patient death or serious disability associated with a fall while being cared for in a facility.

(5) Patient death or serious disability associated with the use or lack of restraints or bedrails while being cared for in a facility.

(f) Criminal events including:

(1) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

(2) Abduction of a patient of any age.

(3) Sexual assault on a patient within or on the grounds of a facility.

(4) Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

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.

In addition to reporting these events to the Bureau of Health Facilities Licensing, the Commission members agreed to send a copy of their reported events to the Administrator of the Commission in order to inform our ongoing priorities as a quality and patient safety learning collaborative. The learning and sharing of information that comes from an adverse event can be an important driver of change but given that events are infrequent relative to the possible risks inherent in complex care and the fact that they don't take into account close calls, the reporting of events will always be just one aspect of a broader initiative and will require the ongoing collaboration among healthcare providers that has been well-established in the Commission.

Hospitals and ASCs closely monitor any serious events which cause harm or the potential for harm and work hard to understand why they happen and how they can be prevented. 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

All except one of the adverse events reported by New Hampshire hospitals in 2010 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.

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

What follows are the results of the statewide reporting of "adverse events" as defined by RSA 151: 38.

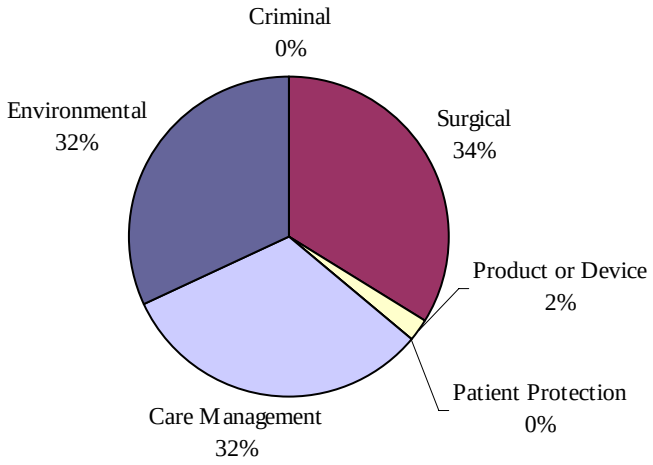
Aggregate Numbers of Events by Category
January – December 2010

SURGICAL EVENTS	**14**
Wrong Body Part	3
Wrong Patient	1
Wrong Procedure	1
Retention of a Foreign Object	9
Death of ASA Class 1 Patient	
PRODUCT OR DEVICE EVENTS	**1**
Use of Contaminated Drugs, Biologics or Device	
Misuse/Malfunction of a Device	
Air Embolism	1
PATIENT PROTECTION EVENTS	**0**
Infant Discharged to the Wrong Person	
Patient Elopement	
Patient Suicide	
CARE MANAGEMENT EVENTS	**13**
Death or Serious Disability Due to a Medication Error	2
Death or Serious Disability Due to a Hemolytic Reaction	
Death or Serious Disability In a Low-Risk Pregnancy, Labor or Delivery	
Death or Serious Disability Associated with Hypoglycemia	
Death or Serious Disability Associated with Failure to Treat Hyperbolirubinemia	
Stage 3 or 4 Pressure Ulcers Acquired After Admission	11
Death or Serious Disability Due to Spinal Manipulative Therapy	
Artificial Insemination with the Wrong Donor Sperm or Donor Egg	
ENVIRONMENTAL EVENTS	**13**
Death or Serious Disability Associated With an Electric Shock	
Wrong Gas or Contamination in Patient Gas Line	
Death or Serious Disability Associated With a Burn	
Death or Serious Disability Associated With a Fall	13
Death or Serious Disability Associated With the Use of Restraints or Bedrails	
CRIMINAL EVENTS	**0**
Care Ordered by Someone Impersonating an MD, RN, or Other Provider	
Abduction of a Patient	
Sexual Assault of a Patient	
Death or Injury of a Patient or Staff From Physical Assault	
TOTAL	**41**

New Hampshire Adverse Events by Number and Percentage
January – December 2010

Event	Count	Percent
Fall	13	32%
Stage 3 or 4 Pressure Ulcer	11	27%
Retained Foreign Object	9	22%
Wrong Site Surgery	3	7%
Medication Error	2	5%
Air Embolism	1	2%
Wrong Patient Surgery	1	2%
Wrong Surgical Procedure	1	2%

Distribution of Adverse Events in New Hampshire Hospitals by Category
January – December 2010



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 to 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.

Below is a summary of information drawn from the root cause analyses conducted by hospitals following the occurrence of adverse events. These causes are similar to the findings of other states with similar reporting systems such as Massachusetts and Minnesota.

Environmental Events – Falls:

- High-risk patient placed in room not visible from nursing station; staff could not hear bed alarm
- Standard order sets did not include flag for physicians to consider fall risk when ordering certain medications that might increase risk
- Unclear post-fall intervention protocol, or protocol not implemented as required
- Transition from paper documentation to electronic medical record, with different communication processes, led to information being inconsistently shared
- Revisions to facility-wide fall prevention protocols not adequately communicated to all staff
- Fall risk assessment and/or interventions not adjusted with change in patient's status or medications
- Bed alarm was de-activated for care and not reactivated
- Patients did not adhere to nursing and staff instructions to call for assistance when getting up

Care Management Events – Pressure ulcers:

- Failure to completely document patient's skin condition on admission
- Communication breakdown between dietitian, therapist, and nursing staff about skin abnormalities
- Dressing changes did not coincide with physician rounding; physician had to rely on verbal descriptions of ulcer progression
- Regular skin inspections not done, or not reflective of current best practice
- Care plan related to skin was not developed when new equipment began to be used with patient
- Inconsistent or incomplete documentation of skin inspections or of interventions such as turning
- Details about patient's risk factors for skin breakdown, or about needs for pressure redistributing devices, not fully communicated to new staff at shift change

- Staff unable to determine what type of bed or other pressure-redistributing devices to use for particular risk factors, or unaware how to find equipment they need
- Staff not adequately trained on ulcer progression and appropriate treatment at different stages
- High workloads or staffing shortages prevented some staff from attending training on skin safety
- Lack of defined written process for performing skin assessment or communicating potential for skin breakdown
- Patient factors: Nutrition, Skin Integrity, Patient Weight

Surgical Events – Retained Objects:

- Process relied on provider's memory to check for retained sponges
- Staff reluctant to voice questions or concerns to surgeons
- Differences in staff practice for counting lap sponges individually or in groups of five
- Staff moving in and out of operating room during procedure may miss some items placed in cavity if not verbalized by surgeon and written on white board
- Staff felt rushed to prepare for next case, so sponge count was not consistent with policy
- Radiologist doing post-op x-ray was not told to look for a potential foreign object
- Policy was not in place to do sponge counts after vaginal deliveries

Wrong site/wrong procedure/wrong patient

- Noise, interruptions, multiple competing responsibilities, or other distractions prior to surgery made if difficult to focus on the time-out or other pre-procedure verification policies
- No policy in place for verifying certain aspects of implants
- Policies or protocols that are used in the operating room to verify surgical sites may not be used in procedure rooms or during bedside procedures, or it may not be clear to staff that policies apply in other settings
- Documentation or protocols for procedures conducted in other settings may not include a trigger for a time-out to stop the procedure and verify correct patient/site/procedure
- Surgical drapes, betadyne, or equipment obscured the surgical site marking
- Hand-written surgical schedule differed from surgeon's notes about procedure
- Staff were reluctant to speak up when working with experienced surgeon
- Patient was repositioned after surgical site was marked, and second time out after repositioning was not conducted
- No policy in place for conducting second time-out in cases of internal laterality (paired organs or structures)

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.

Below is a list of strategies hospitals are implementing to prevent these types of adverse events. You will note that a section is included for what patients and their families can do to play a role in preventing these events.

Environmental Events – Falls

What hospitals are doing:

- Implementing new fall risk assessment policies and standardized assessment tools
- Using high-visibility indicators of patient's fall risk (stars, bands, colored slippers, etc)
- 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
- Providing additional staff training on best practices in fall risk assessment
- Posting fall prevention actions prominently in each patient's room, visible to staff, patient, and family

What patients/families can do:

- Ask for help when you need it
- Make sure you know how to use call lights, alarms, and safety equipment in your room
- Pay attention to how you feel
- Inform your care provider if you have a history of falls

Care Management Events – Pressure Ulcers

What hospitals are doing:

- Revising skin assessment documentation to make assessment easier and more accurate
- Developing new decision-making algorithms to assist nursing staff in implementing appropriate interventions for at-risk patients
- Purchasing special equipment to use for patients at risk for pressure ulcers
- Increasing use of wound, ostomy and continence nurses as consultants
- 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
- Establishing pressure ulcer prevention work group to review all cases and look for common causes
- Providing additional training to staff on working with patients or family members who are reluctant to cooperate with skin care practices
- Encourage hydration and good nutrition

What patients/families can do:

- Participate in your own care by inspecting your own skin and ensuring that your caregivers do so daily
- Limit pressure by moving often
- Ask questions to understand your care

Surgical Events – Wrong site/patient/procedure

What hospitals are doing:

- Conducting a second time-out and site marking when patient is repositioned or marking isn't visible
- Assigning one individual to be accountable for implementation of time-out

- Developing scripting for pre-operative procedures and clarifying who is responsible for calling time-out
- Creating mandatory checklist for use during invasive procedures, including site marking
- 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
- 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

What patients/families can do:

- If you are having surgery or other medical procedures, make sure that you, your doctor, and your surgeon all agree and are clear on exactly what will be done
- If possible, verify that your surgeon has marked the correct site with indelible ink

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.

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 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 misses incorporating the concepts of a Just Culture. This exercise stimulated important questions, meaningful dialogue, and valuable learning.

Summary

Year 6 has been another highly successful year for the New Hampshire Health Care Quality Assurance Commission. 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 as *www.healthynh.com* .

Great strides were made across hospitals and ASCs this past year in the frequency with which care providers comply with recommended hand hygiene practices. The members agreed to maintain an aggressive campaign to maintain our gains and improve our rates.

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 2010. This information was used to identify common causal factors and strategies for ensuring that they don't recur.

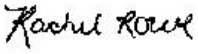
The major accomplishment of the Commission in year 6 was the expanded focus on promoting the science of high reliability at all organizations using an anonymous survey to understand how effectively the patient safety checklist is being utilized in New Hampshire hospitals and ASCs using anonymous surveys. 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 procedure areas.

The Commission will begin Year 7 in July 2011 continuing our focus on decreasing preventable harm by promoting high reliability organizations, adopting evidence-based best practices, and continuing our work to establish Just Cultures within our institutions.

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

For questions, please call: Ross Ramey, MD, Commission Chair: 924-7191 or Shawn LaFrance, Interim Administrator 415-4270.

Respectfully submitted,



Rachel Rowe
Administrator, NH Health Care Quality Assurance Commission