Welcome to Amerinet’s QualityTouch newsletter, part of the Amerinet Quality Solutions program, designed to meet the demanding and dynamic needs of patient safety officers, risk managers, quality improvement staff and nursing administration professionals. We welcome your thoughts for topics of interest.

The QualityTouch program is broken down into the following nine pillars of quality:

1. Pillar One: Patient Safety Infrastructure
2. Pillar Two: Clinical Challenges
3. Pillar Three: Clinical Repository/Benchmarking Guidelines
4. Pillar Four: Regulatory Compliance
5. Pillar Five: Process Improvement Tools
6. Pillar Six: Safety (Disaster Preparedness) / Environmental Issues (Green Initiatives)
7. Pillar Seven: Legislative Issues
8. Pillar Eight: Key Industry Issues
9. Pillar Nine: Education

Visit the QualityTouch section of the Amerinet Web site to learn more.

Pillar One: Patient Safety Infrastructure

Patient Safety Organizations (PSOs)

It has been about a year since the Agency for Healthcare Research and Quality (AHRQ) began implementing regulations for PSOs. There are now approximately 68 organizations that have been designated as AHRQ approved PSOs. According to Ronni Solomon, executive vice president and general counsel at ECRI, the organizations are in the early stages of data gathering and analysis. This may be due to the fact that involvement with PSOs is voluntary for organizations and PSOs are not required to report their work to the AHRQ’s national database. Insurers or regulatory bodies are not permitted to be PSOs but nearly any other organization can operate a separate group known as a “component PSO.” There are about 41 organizations with this distinction. Source: Modern Healthcare, October 12, 2009

Hospitals in Pursuit of Excellence

The American Hospital Association (AHA) Quality Center has identified six Principles of Performance Excellence common in all high-performing organizations. These core principles form the foundation of Hospitals in Pursuit of Excellence:

- The patient experience
- Creation of a high-reliability culture
- Managing organizational variability
- Removing waste
- Eliminating defects
- Reducing process variation

Source: AHA Quality Center, March 2009

Mission, Vision and Value Statements

Hospitals and physicians need to live and breathe their mission, vision and values. The mission statement is the anchor of the organization, stating their reason for being. The vision is the end of the journey, the perfect outcome that stretches the organization to grow. Values are the road map that directs the organization to get from the mission to the vision. In order for a hospital to be successful, the mission, vision and values need to be focused on the patient. Source: Healthcare Financial Management, October 2009

Pillar Two: Clinical Challenges

H1N1- CDC doesn’t budge on N95 respirator recommendation

The CDC continues to recommend the use of respiratory protection at least as protective as a fit-tested disposable N95 respirator for healthcare workers who come in contact with a suspected or confirmed H1N1 patient. Source: Inside the Joint Commission, October 26, 2009

Patient Safety in Physician Offices

How prepared are patients when they visit the physician’s office? According to Matthew Mireles, PhD, MPH, president and CEO of Community Medical Foundation for Patient Safety (CMFPS) in Bellaire, Tex., these patients lack preparedness. In order to improve the communication between the patient and the doctor, a small group of researchers developed a two page checklist. This checklist is filled out prior to the patient’s visit. A copy of this checklist can be found at www.communityofcompetence.com. Topics such as unused and expired medications, fall prevention basic hospital security and medication safety are addressed in the checklist. Source: Briefings on Patient Safety, August 2009

Medication Safety: A Complex Puzzle

According to Michael Cohen, RPh, MS, ScD, president of the Institute for Safe Medication Practice (ISMP), there are approximately 1.5 million people harmed each year due to medical errors in hospitals, about one medication error per patient per day. There have been some successful interventions made by hospitals and healthcare organizations such as:

- Encouraging the use of “tall man” lettering with look or sound alike medications
- Ensuring read-back of all verbal medication orders
- Communicating with pharmaceutical vendors regarding problem packaging
- Standardizing drug concentrations whenever possible
- Involving patients in the medication process as much as possible
• Involving pharmacists in the medication administration process as much as possible, including them on clinical teams
• Creating a medication safety committee
Source: Briefings on Patient Safety, August 2009

MRSA Survivors say screening is key
The first case of MRSA (Methicillin-Resistant Staphylococcus Aureus) appeared in hospitals in the late 1970s. In 2006, there were 1.2 million MRSA infections documented nationwide. The disease comes in two forms:
• Community associated MRSA
• Hospital associated MRSA
Since MRSA is resistant to many antibiotics, the treatment of this condition is very difficult. Screening is key.
Source: chicagotribune.com, October 7, 2009

Preventing the spread of MRSA
There is no evidence that MRSA is more contagious than other forms of staph. Unfortunately, there are fewer drugs to treat the disease. There has been an increase in the incidence of community acquired MRSA in patients with no previous contact with a healthcare system, from 11 percent in 2002 to 64 percent in 2006. In order to decrease the spread of MRSA, staff need to use standard precautions (personal protective equipment), proper hand hygiene, and take part in staff and patient education. Most importantly, the organization needs to create a culture that supports and promotes the behavioral change, as well as the prevention and control of disease transmission.
Source: Material Management in Health Care, August 2009

Can a Cranberry Concentrate Complex Liquid Combined with Increased Hydration Protect Elderly Residents from Urinary Tract Infections (UTIs)?
A study was conducted by Mary Ellen Posthauer, RD, CD, LD in ten long term care facilities to determine the effects of cranberry concentrate with UTIs. UTIs are the most common bacterial infections among women residents in long term care facilities. Cranberry concentrate has been found to be effective in the treatment of UTIs, reducing the need for antibiotics. Cranberries possess antibacterial activity that inhibits the adherence of bacteria to the lining of the urinary tract. The results of the study suggested that cranberry juice may decrease the number of symptomatic UTIs over 12 month period, particularly in women with recurrent UTIs. Cranberry concentrate was found to be a useful frontline intervention when combined with hydration, hygiene and judicious use of antibiotics.
Source: The Director, Fall/Winter 2008

Contrast Occurrences: Gadolinium Based Contrast
The contrast may cause nephrogenic systemic fibrosis (NSF). Be aware of the BUN creatinine when ordering Magnetic Resonance Angiography (MRA) that requires IV contrast that is usually 3 times higher than the dose use for a MRI. A patient with severe renal impairment may be at risk for NSF. With the risk being about 4 percent, information should be included on the consent form.
Source: Sue Dill Callaway, RN, Esq., Nursing and the Law 2009

Contrast Induced Nephropathy
Kidney failure caused from the iodine dye used for x-rays especially in patients with renal failure. These patients need to be informed of the risk in the consent form. Creatinine levels need to be checked prior to the exam.
Source: Sue Dill Callaway, RN, Esq., Nursing and the Law 2009

Pillar Three: Clinical Repository/Benchmarking Guidelines

Fall Rates
• Hospitals: 2.2 to 7 per 1,000 patient days
• Long Term Care Facilities: 11 to 24.9 per 1,000 patient days
• Rehab Care Units: 8 to 19.8 per 1,000 patient days
Source: Sue Dill Callaway, RN, Esq., Nursing and the Law 2009

Hand Washing Compliance
Eight participating hospitals in a recent study involving the Joint Commission found, on average, caregivers washed their hands less than 50 percent of the time. The leading causes of hand-washing failure were:
• Ineffective placement of dispensers or sinks
• Hand hygiene compliance data not collected or reported accurately or frequently
• Lack of accountability and just-in-time coaching
• Safety culture does not stress hand hygiene at all levels
• Ineffective or insufficient education
• Hands full
• Wearing gloves that interfere with process
• Perception that hand hygiene is not needed if wearing gloves
• Healthcare workers forget
• Distractions
Source: Material Management in Health Care, October 2009

Fresh approaches stem MRSA tide
Through the use of “positive deviance theory,” staff can help to identify new approaches for the treatment of MRSA. Rochester (NY) General Hospital used this theory in their cardiothoracic surgery service with a goal of eliminating all infections, specifically MRSA. Through this program, MRSA surgical site infection rate fell from 1.8 to 0 percent with CT surgery patients. Staff-recommended changes that were adopted include:
• Nasal cultures are performed on patients at entry to the CT service, weekly and at discharge
• Patients colonized with MRSA are isolated
• The antibiotic ointment mupirocin is administered to all CT patients to prevent or treat colonization
• Dedicated thermometers are used for all intensive care unit patients
• Additional alcohol gel dispensers installed in patient rooms
• Results are posted publicly on a regular basis
Through the positive deviance approach, the teams reach out to the front line staff to find out what barriers are interfering with performance and figure out who has developed a solution and is performing above the rest.
Source: Material Management in Health Care, August 2009
Problems identified with ripped mattresses or wheel on wheelchairs

EC.02.06.01: The hospital reduces the risk of infections associated with medical equipment, devices and supplies.
Problems identified with the cleaning, disinfecting and sterilizing of equipment. The surveyor will be checking for compliance with the manufacturer’s guidelines.

PC.01.02.03: The hospital assesses and reassesses the patient/condition according to the defined time frames.
Problems identified with timely compliance with history and physical and nursing assessments.

MS.08.01.01: The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner’s professional performance.
Problems identified with focus periodic performance evaluation was based on time frames instead of volumes.

RC.02.01.03: The patient’s medical record documents operative and other high-risk procedures and the use of moderate or deep sedation or anesthesia.
Problems identified with the completion of the immediate post-op note, including blood loss and specimens removed.

EC02.01.01: The hospital manages safety and security risks.
Problems identified with sensitive areas and who has access to these areas. Annual safety and security assessments need to be done.

MS.08.01.03: Ongoing professional practice evaluation (OPPE).
Problems identified with organizations that do not clearly define the process and that only conduct annual evaluations. OPPE must occur more frequently than annually.

LD.04.03.09: Care, treatment and services provided through contractual agreement are provided safely and effectively.
Problems identified with annual contract evaluation not including performance review and expectations.

Source: Inside the Joint Commission, October 12, 2009

Complaints and grievances
According to CMS, if the hospital’s patient relations staff is involved, the complaint must be treated as a grievance and must go through the formal process that includes a formal follow-up letter to the patient.

Source: Inside the Joint Commission, October 26, 2009

Joint Commission Survey Findings- Amerinet Member
During a September 2009 survey, the following findings were identified by TJC:

- Verbal orders need to be signed within 48 hours
- Pain assessment
- Disaster privileges must check a photo ID
- All entries must be dated, timed and authenticated
- High risk medications, insulin and epinephrine, different doses must be separated
- Penetrations in the fire wall
- Generators not properly tested
- Security and safety risk assessment not performed annually

TJC Scoring Changes
Under the 2009 scoring rules, surveyors will score an entire standard as noncompliant if the organization fails to meet just one direct impact element of performance (EP). If a direct impact EP is not compliant, the organization has 45 days to address all insufficiently compliant EPs under that standard in an Evidence of Standard
Four more CMS quality measures to report
According to the August 27, 2009, Federal Register, Medicare FY2010 prospective payment system for inpatient acute care and long term care hospitals is adding four more quality measures. Two new surgery related quality measures deal with urinary catheter removal on post-operative days and peri-operative temperature management (added to SCIP measurement set). Two structural measures assess the characteristics and capacity of the provider to deliver quality health care – systematic clinical database registry for stroke care and participation in a systematic clinical database registry for nursing sensitive care.
Source: Inside the Joint Commission, September 14, 2009

Recovery Audit Contractor (RAC)
According to Sg2, RACs have targeted 1 day length of stay claims in their audits. Many were denied, finding the cases would have been more appropriate to be treated on an outpatient basis. In addition, auditors have focused on three day length of stay to determine if the patient was admitted in order to qualify for Medicare skilled nursing facility coverage.
Source: Sg2 Reform Readiness Analysis, August 2009

Preventable Readmissions
On average, 20 percent of Medicare patient are readmitted within 30 days. In 2005, potentially avoidable readmissions cost Medicare an estimated $12 billion, leading the Senate Finance Committee to propose payment holds for hospitals with high readmission rates.
Source: Healthcare Financial Management, October 2009

Lean Management & Best Practices
Lean is about quality with a simple formula: Liberate the people who do the work to use a proven method to look at what they do with “new eyes,” allowing them to identify elements of the work that permit errors and delay in care/service, waste of resources and frustration in the workplace. The “ideal” of lean is to provide the customer with exactly what is needed, no more or no less, through a focus on removing defects and waste.

Pillar Six: Safety/Disaster Preparedness
Hazard Vulnerability Analysis (HVA)
Make sure the HVA is conducted annually to identify the priorities to be set by the organization. The Joint Commission (TJC) will use this document to determine the focus of the emergency preparedness interview. In preparation for your survey, make sure there is a plan to address those vulnerabilities at high risk for your organization. Common challenges and opportunities for improvement identified by TJC regarding emergency preparedness have been:
- Exercise or actual drills not conducted
- No follow through conducted after the drill/actual disaster critique
- Not being able to sustain operations for 96 hours
- HVA priorities not addressed with mitigation, preparedness, response and recovery

Pillar Seven: Legislative Issues
Visit the QualityTouch section of the Amerinet Web site to learn more.

Pillar Eight: Key Industry Issues
Scope Processing Error Incidents
A new report from the Department of Health and Human Services’ Office of Inspector General revealed widespread scope processing errors. Forty-two randomly selected VA facilities were subject to an unannounced inspection to ensure that employees were familiar with and adherent to, proper equipment cleaning and reprocessing procedures. Of those 42 sites, employees from 22 sites failed to illustrate proper knowledge and procedural compliance. There was also documentation lacking regarding staff training and competency. It was found that the mistakes were not limited to just VA facilities. Even though the incidence of scope induced infection is low, proper cleaning could bring the level of risk to 0%.
Source: Material Management in Health Care, August 2009

Pillar Nine: Education
Amerinet Information Exchange
To pose a question on quality, patient safety, risk management, compliance or nursing issues, please send your questions to holly.hampe@amerinet-gpo.com.
Would you be interested in participating in “roundtable discussions” with other quality, patient safety, risk managers or regulatory compliance coordinators? E-mail holly.hampe@amerinet-gpo.com if you would like to participate in this type of forum.

For additional information
Please visit the QualityTouch section of the Amerinet Web site which may be found by going to www.amerinet-gpo.com then sign in to Member Resources and click on QualityTouch. We hope you will find this information beneficial to you. Please contact holly.hampe@amerinet-gpo.com should you have any questions or comments.

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