NIH Clinical Center
Patient Safety and Clinical Quality Update

NIH Research Hospital Board

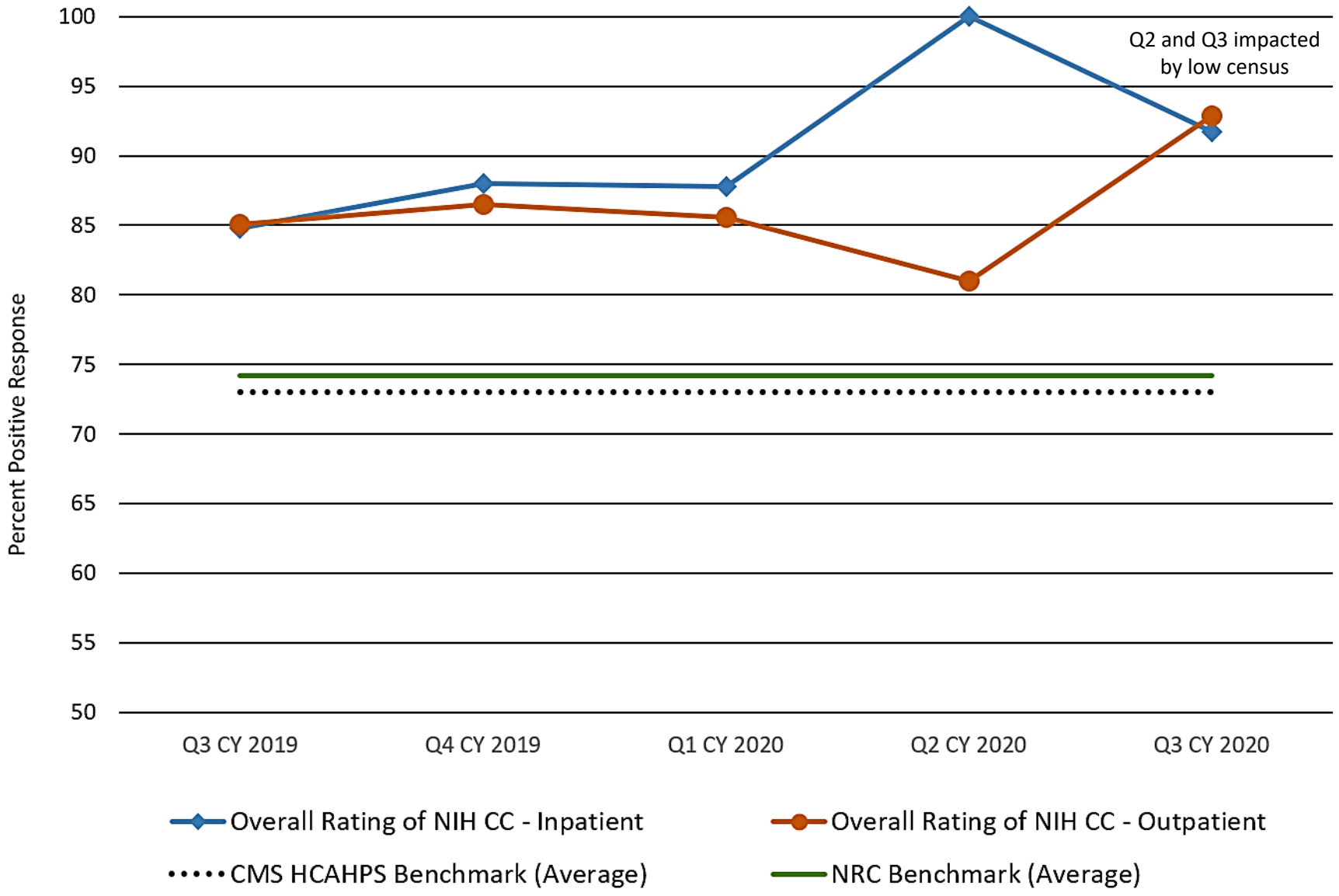
October 2020

Patient and Employee Safety Performance Metrics

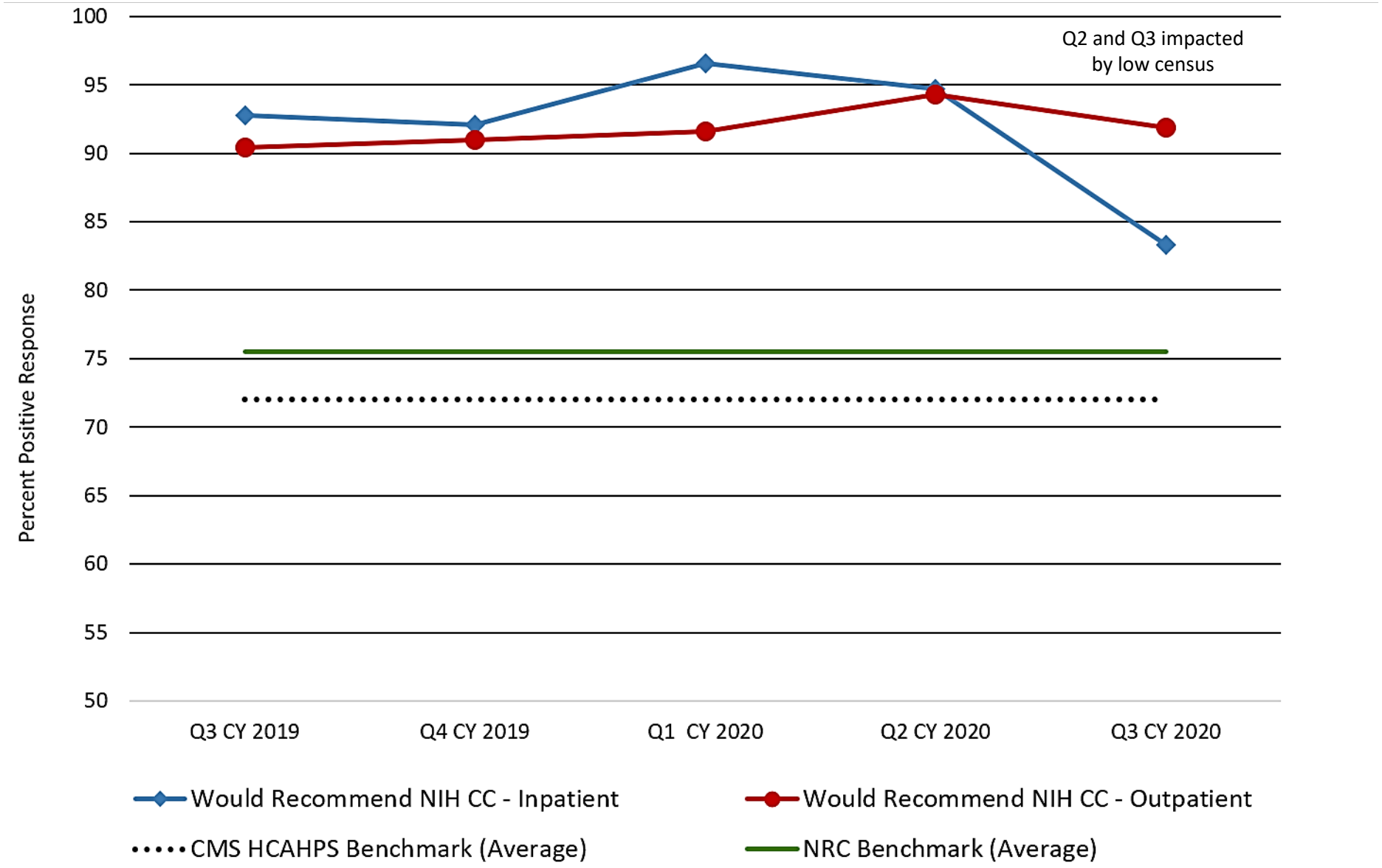
Patients' Perceptions

- Overall Hospital Rating
- Would you Recommend the NIH CC?

Overall Hospital Rating



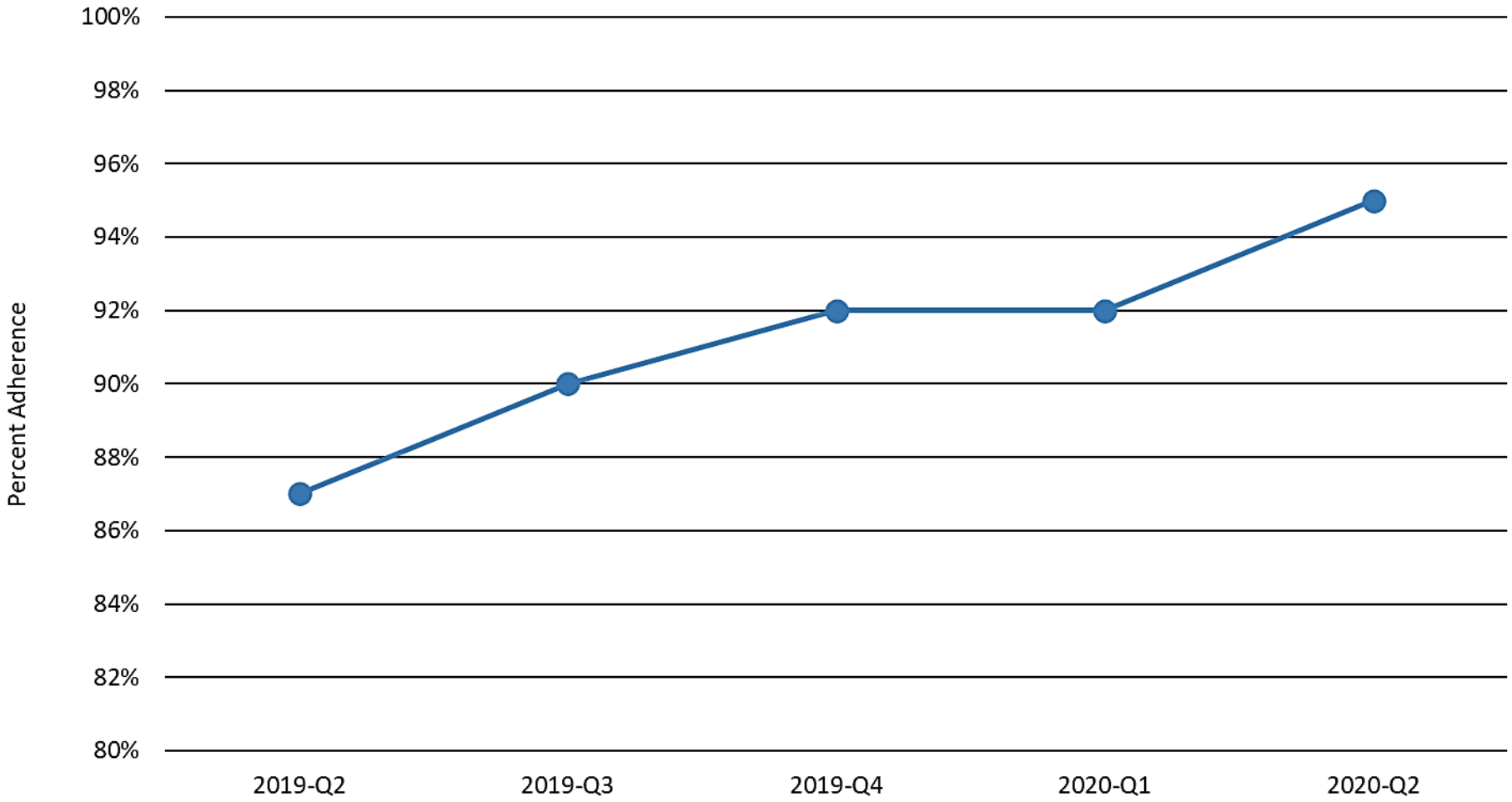
Would You Recommend the NIH CC?



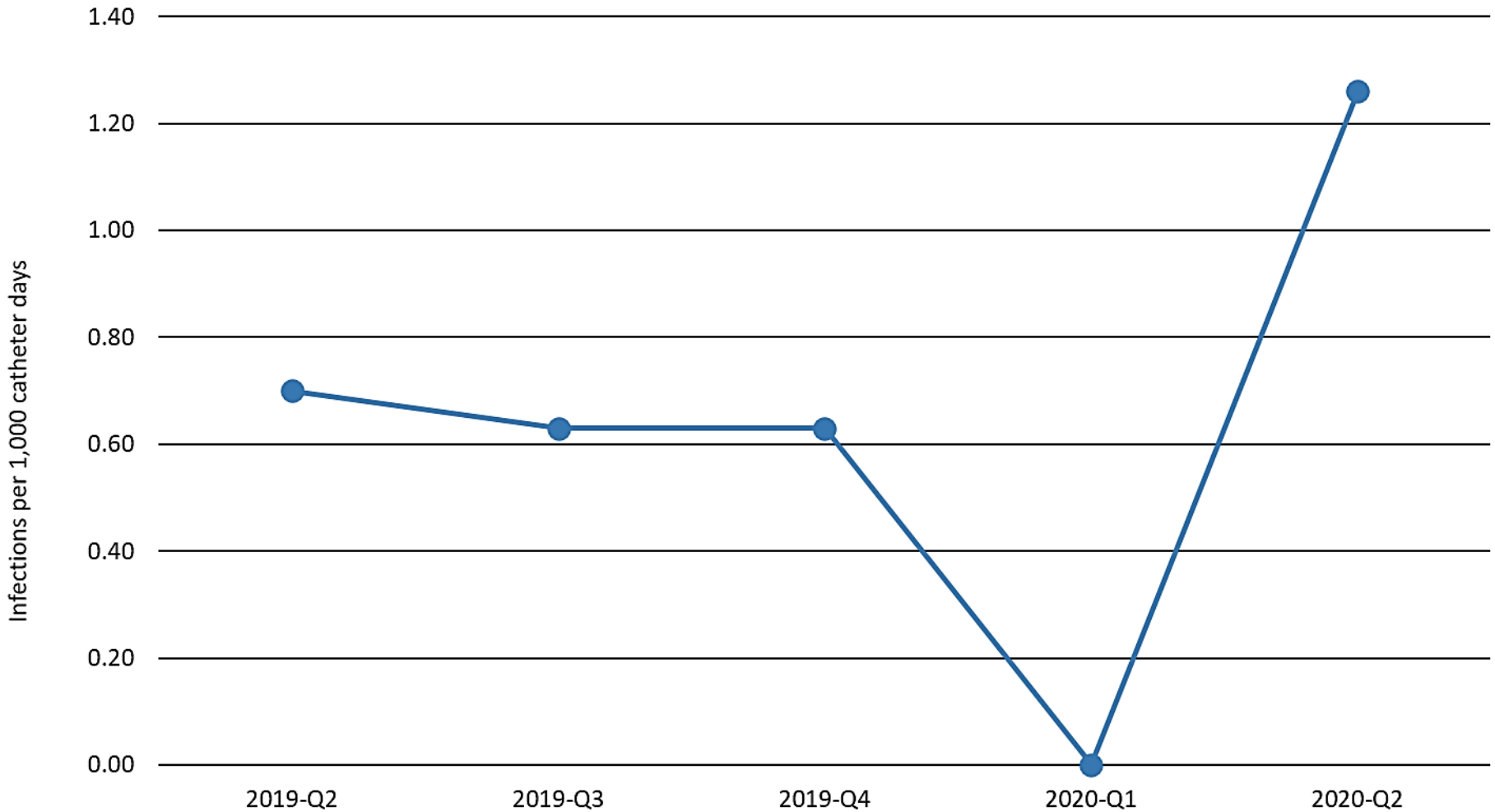
Infection Control Metrics

- Hand Hygiene
- Central-Line Associated Bloodstream Infections
  - Whole-house
  - Intensive Care Unit
- Catheter Associated Urinary Tract Infections
  - Intensive Care Unit
  - Surgical Oncology

Hand Hygiene Compliance



Wholehouse Central-Line Associated Bloodstream Infection (CLABSI) Rate



Stakeholder Review Date: _____

HA-CLABSI Review Tool

Instructions: The patient listed below has a tentative or final HA-CLABSI diagnosis.

- The Nurse Manager/ Clinical Manager or designee completes this form.
- Review CRIS documentation of clinical care, interventions, and nursing care assignments provided 48 hours prior to the infection.
- Conduct a collaborative, multidisciplinary review of this occurrence and complete this form.
- On page 2 identify any variabilities in practice that may apply to the patient being reviewed.

Patient and Blood Culture Information

Patient Name (last, first)	MRN:	Blood Culture Collection date/time:
PCU:	DOB:	Organism:

Line History

CVAD Type, Location, and # of Lumens:	
CVAD insertion date: ☐ Unknown ☐ _____	CVAD removal date: ☐ Unknown ☐ Still in ☐ _____

CVAD care and maintenance provided 48 hours before referenced blood culture

When was the last:	Due Date	Actual Date Completed
CVAD dressing change		
CVAD connector change		
CVAD tubing change		

Biopatch in place	☐ Yes ☐ No	If no, why not:
2-RN dressing change required ☐ Yes ☐ No	2-RN dressing changes documented ☐ Yes ☐ No ☐ n/a	If not documented, why not:
High Touch Surface Cleaning documented per policy	☐ Yes ☐ No	If no, why not:
CHG bath completed	☐ Yes ☐ No	If no, why not:
Room reassignment completed every 30 days	☐ Yes ☐ No	If no, why not:

Does CVAD have history of occlusion? ☐ Yes ☐ No **Date/Time rTPA last given:**

Lumen _____ ☐ Blood return obtained

Type of Infusion: ☐ Continuous ☐ Intermittent ☐ n/a

Was this patient frequently disconnected and reconnected from CVAD? ☐ Yes ☐ No

Was the patient on pass 48 hours before blood culture was collected? ☐ Yes ☐ No

If so, did the patient/family provide CVAD care while on pass? ☐ Yes ☐ No

List lessons learned and opportunities for improvement from your review:

Lessons Learned	Opportunities for Improvement

CLABSI Review Tool
5/21/2019

Stakeholder Review Date: _____

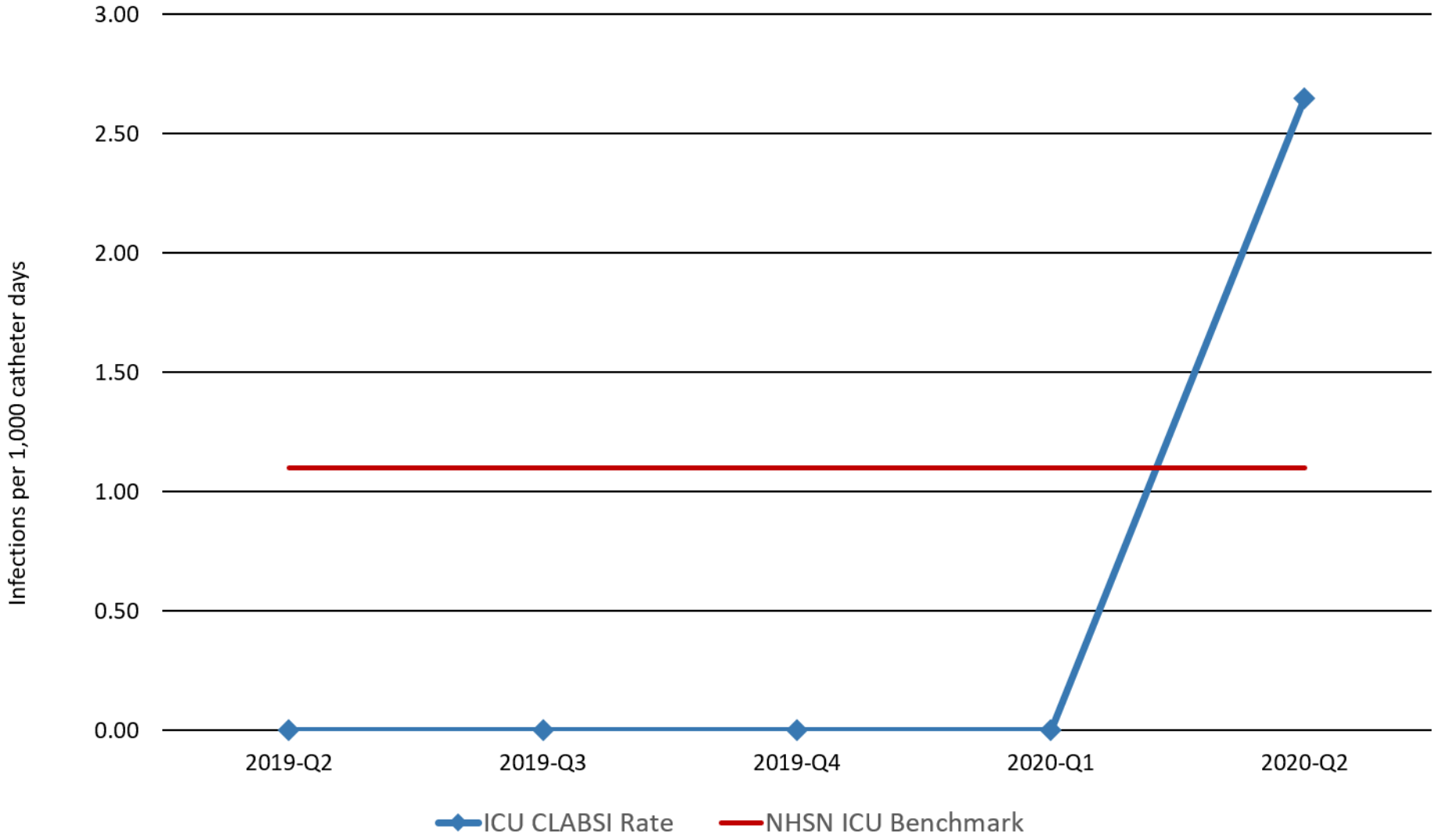
Variability in Patient and Practice

INSTRUCTIONS AND DEFINITIONS

1. Based on the HA-CLABSI discussion, review the following definitions.
2. Identify any variabilities (as many as apply) to the patient being reviewed.

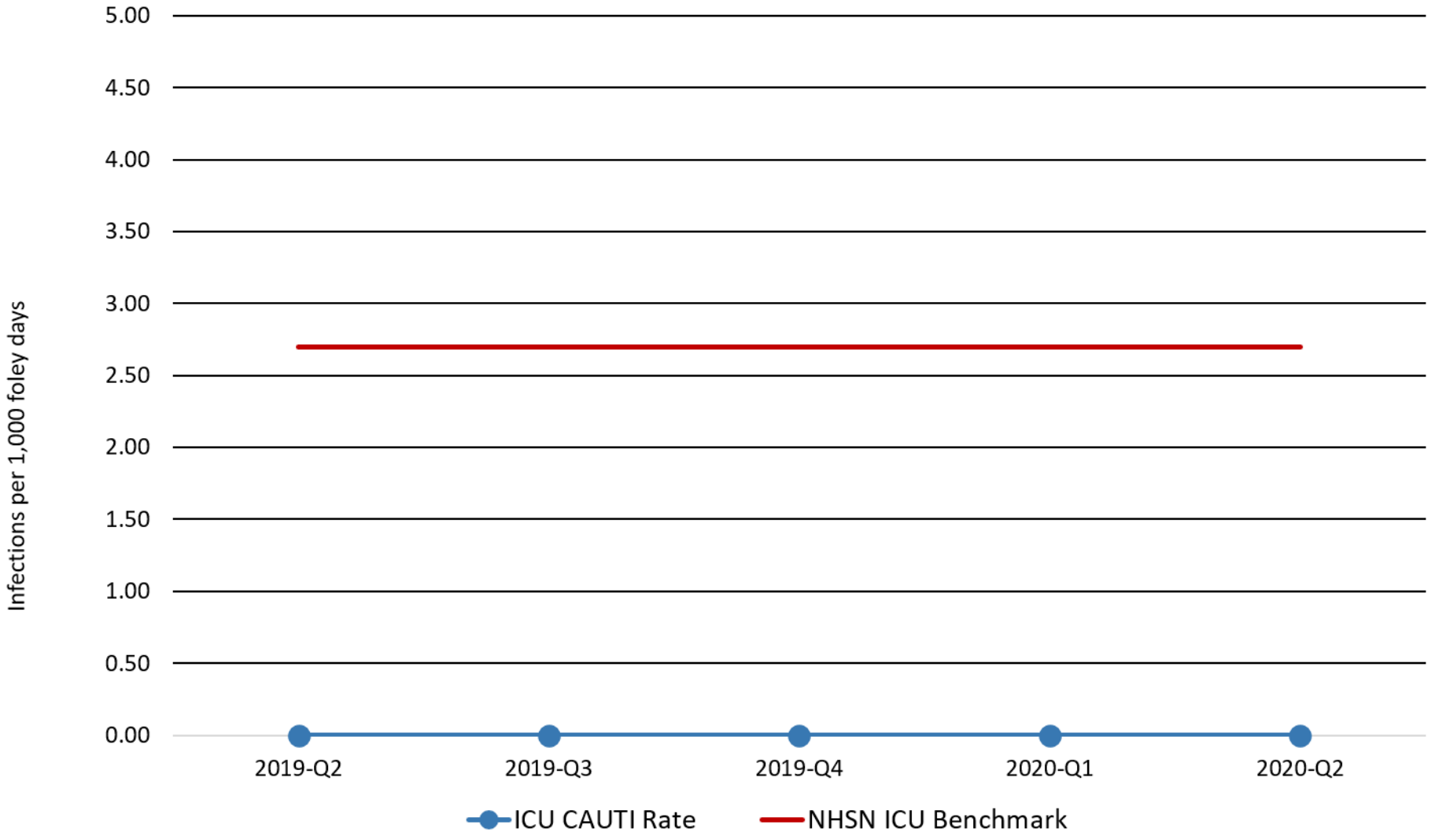
	Variability	Explanation	Examples
☐	CVAD Care & Maintenance	Variation in routine nursing care encountered in caring and maintaining CVAD	1. Line connected and disconnected multiple times 2. rTPA administered within 48 hours prior to referenced blood culture 3. Dressing changed more frequently than scheduled due to placement, skin issues, dressing not adhering well, etc. 4. Connector changes not documented 5. Dressing changes not documented per SOP/PRO
☐	Environmental	Environmental organisms or housekeeping issues identified as barriers to adequate cleaning and disinfection.	1. Organisms found in aqueous environments and can live on surfaces/equipment 2. Clutter in room made cleaning difficult 3. Variation in housekeeping practices 4. Tub cleaning procedure not followed
☐	Procedure	CVAD was used during a procedure off home unit in the preceding 48 hours before blood cultures	1. Procedure off home unit such as IR, OR, CT, MRI 2. Frequent accessing of line during the procedure
☐	Patient Hygiene	Patient experiencing general personal hygiene issues	1. Copious body secretions 2. Infrequent showering 3. Poorly maintained acrylic nails
☐	Patient & family engagement	Education provided by nursing has not resonated with patient and family. Mismatch between patient's verbal understanding and demonstration of understanding.	1. Care of CVAD while on pass 2. Patient or family disconnects patient from IV 3. Family not adhering to isolation standards 4. Patient and family not adhering to hand hygiene guidelines 5. Patient and/or family not adhering to recommendations for care and maintenance of CVAD
☐	Clinical Condition	Patient's clinical condition requires line to stay in place despite increase infection risk	1. Low platelets 2. No feasible alternate IV access 3. Unable to tolerate procedure to place or change IV line

ICU Central-Line Associated Bloodstream Infection (CLABSI) Rate



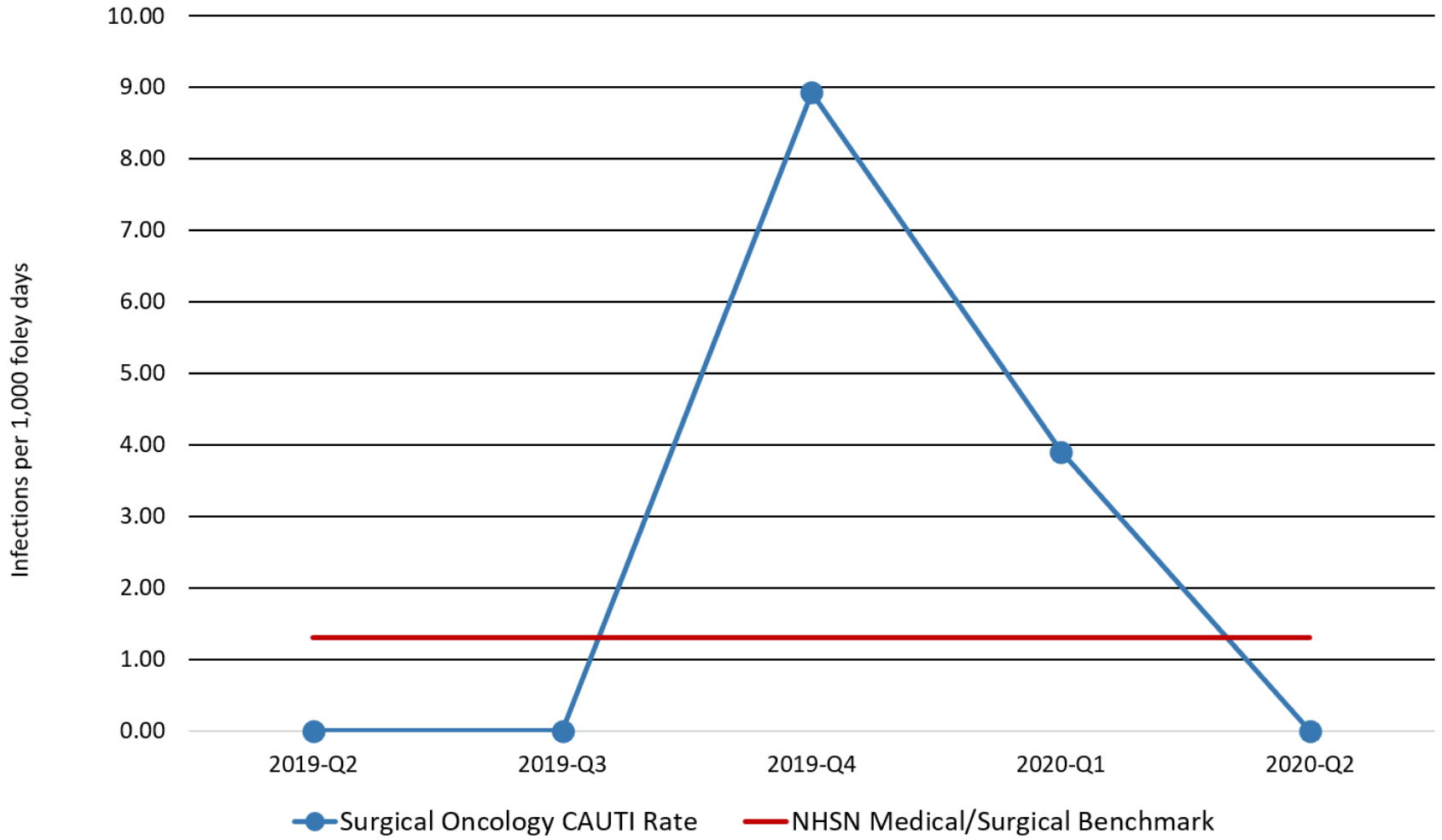
2013 CDC National Healthcare Safety Network (NHSN) Benchmark: Critical Care Units, Medical/Surgical -major teaching mean 1.1

ICU Catheter-Associated Urinary Tract Infections (CAUTI) Rate



2013 CDC National Healthcare Safety Network (NHSN) Benchmark: Critical Care Units, Medical/Surgical -major teaching mean 2.7

Surgical Oncology Catheter-Associated Urinary Tract Infections (CAUTI) Rate

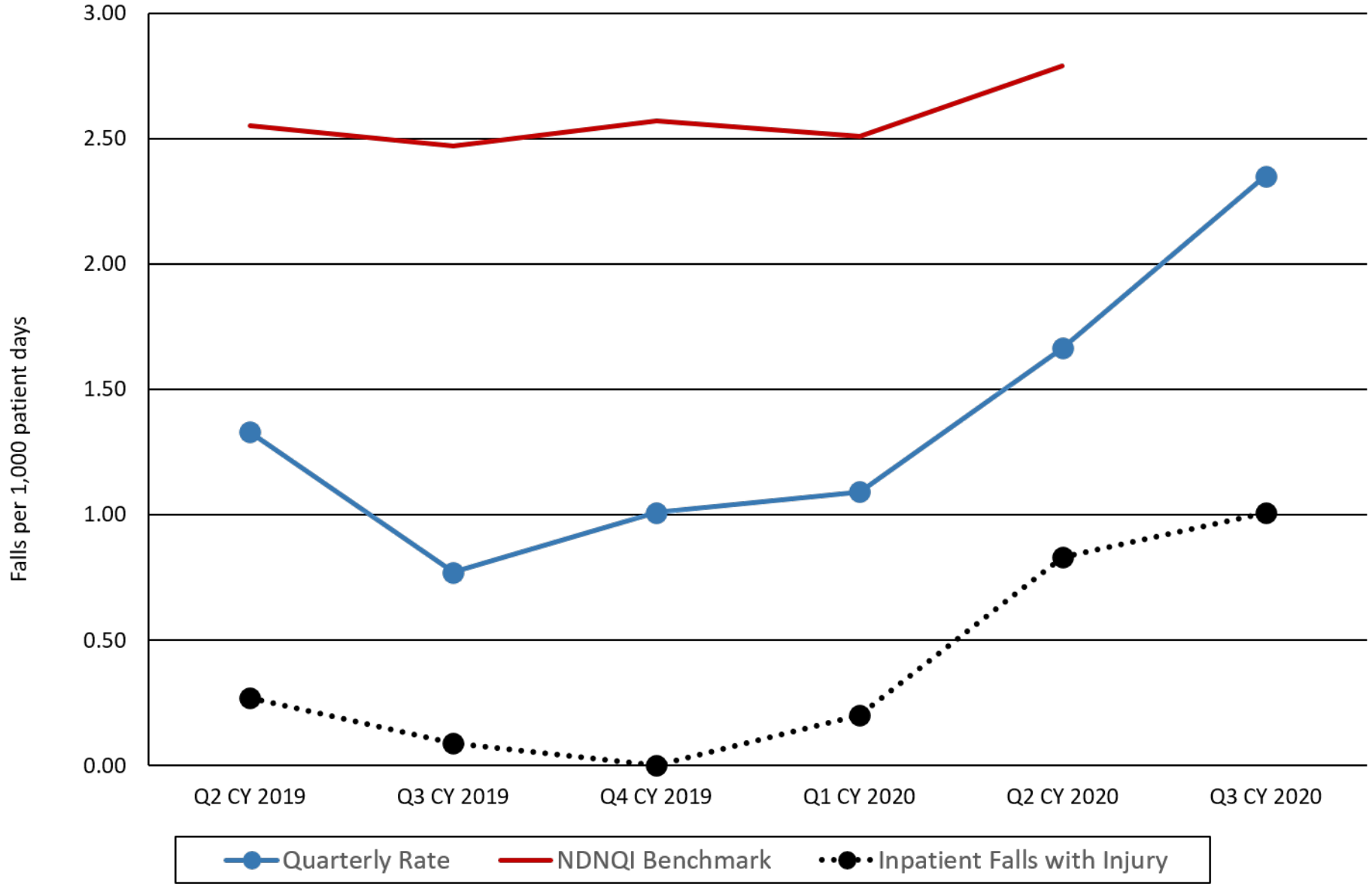


2013 CDC National Healthcare Safety Network (NHSN) Benchmark: Inpatient Wards, Medical/Surgical mean 1.3

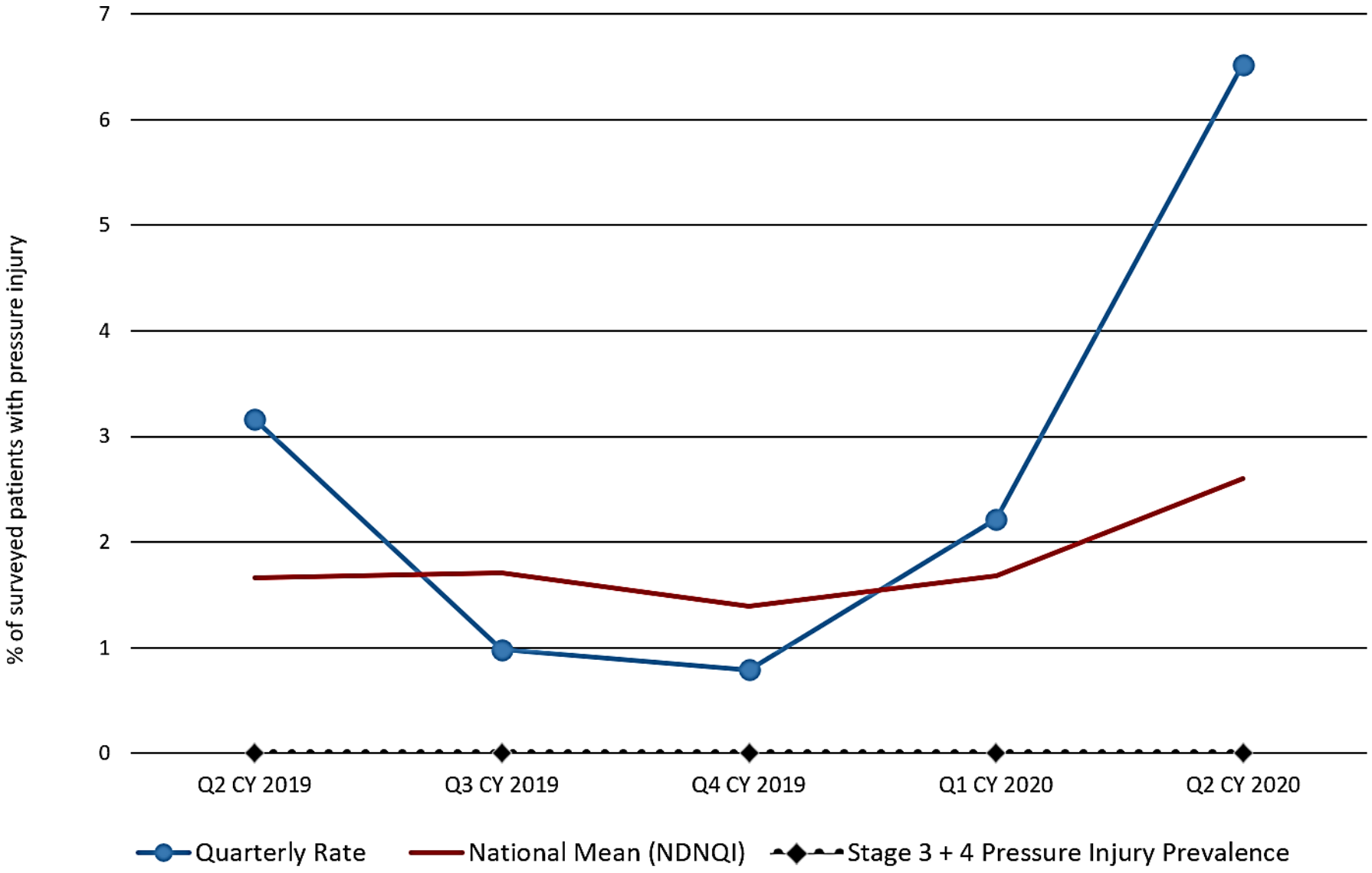
Nursing Quality Metrics

- Falls
- Pressure Injury
- Medication Administration Barcoding

Inpatient Falls Rate

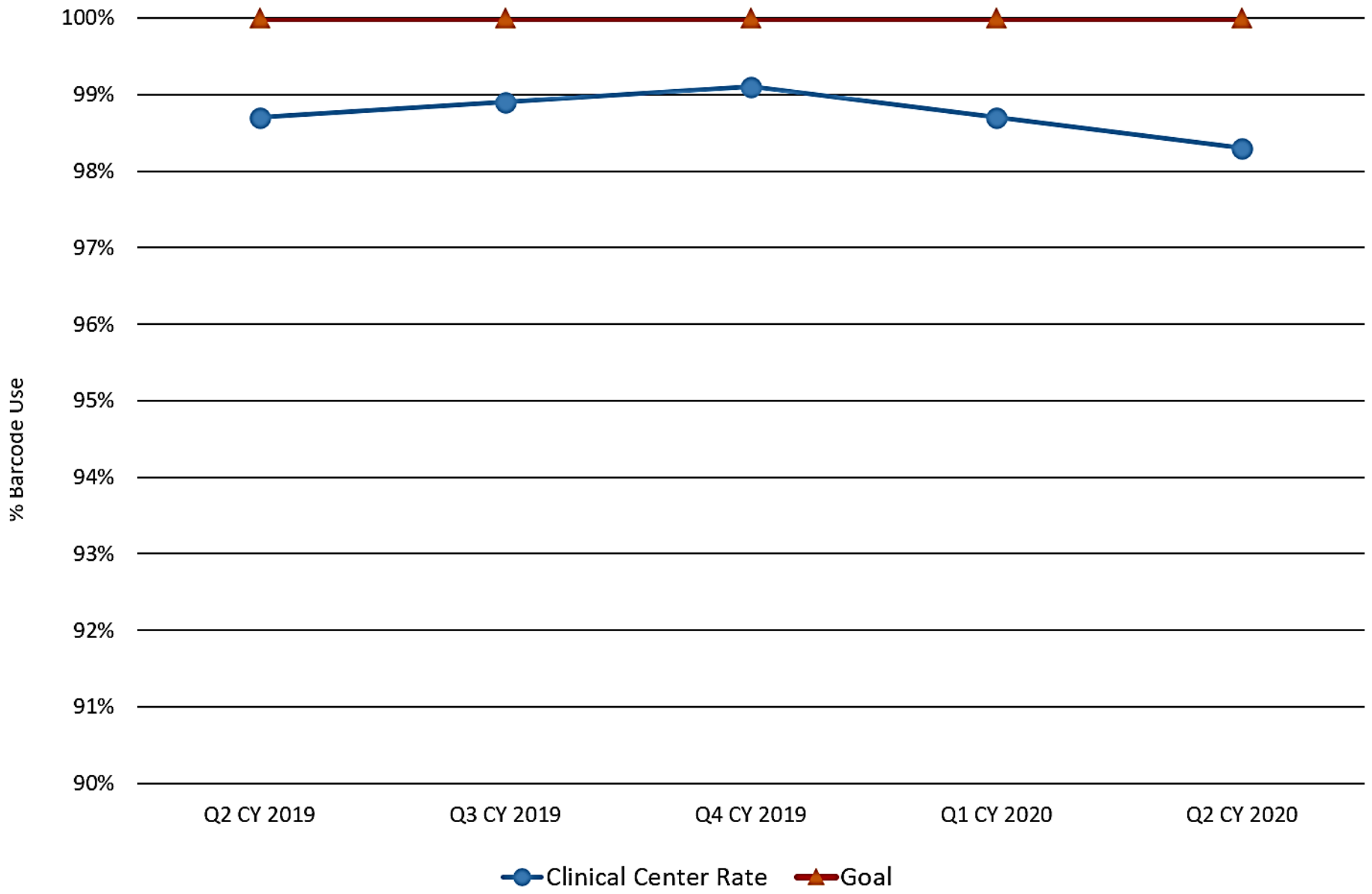


Pressure Injury Prevalence



NDNQI Benchmark for Total Pressure Injury Rate only

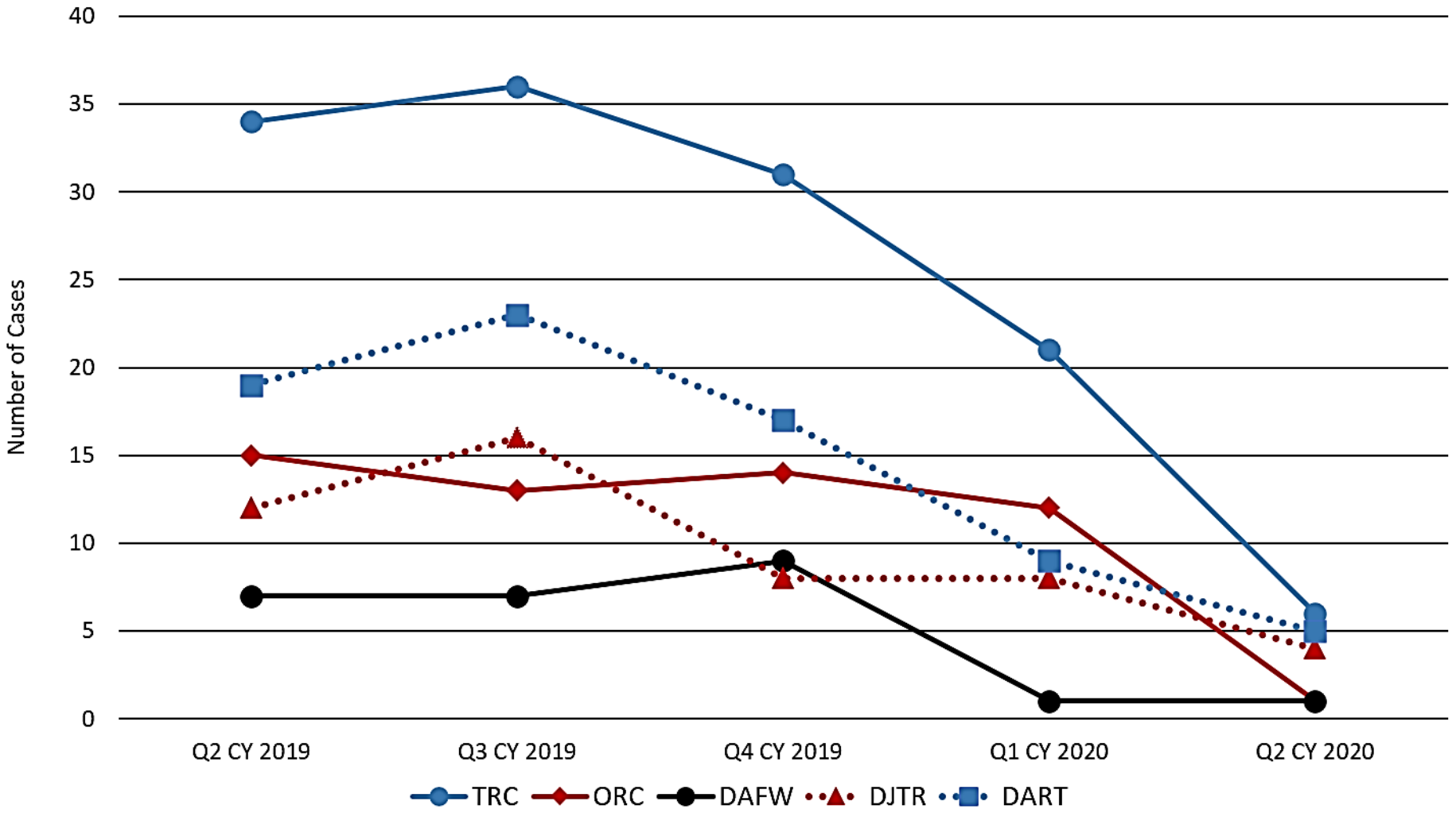
Medication Administration Barcode Use



Employee Safety

- Occupational Injury and Illness

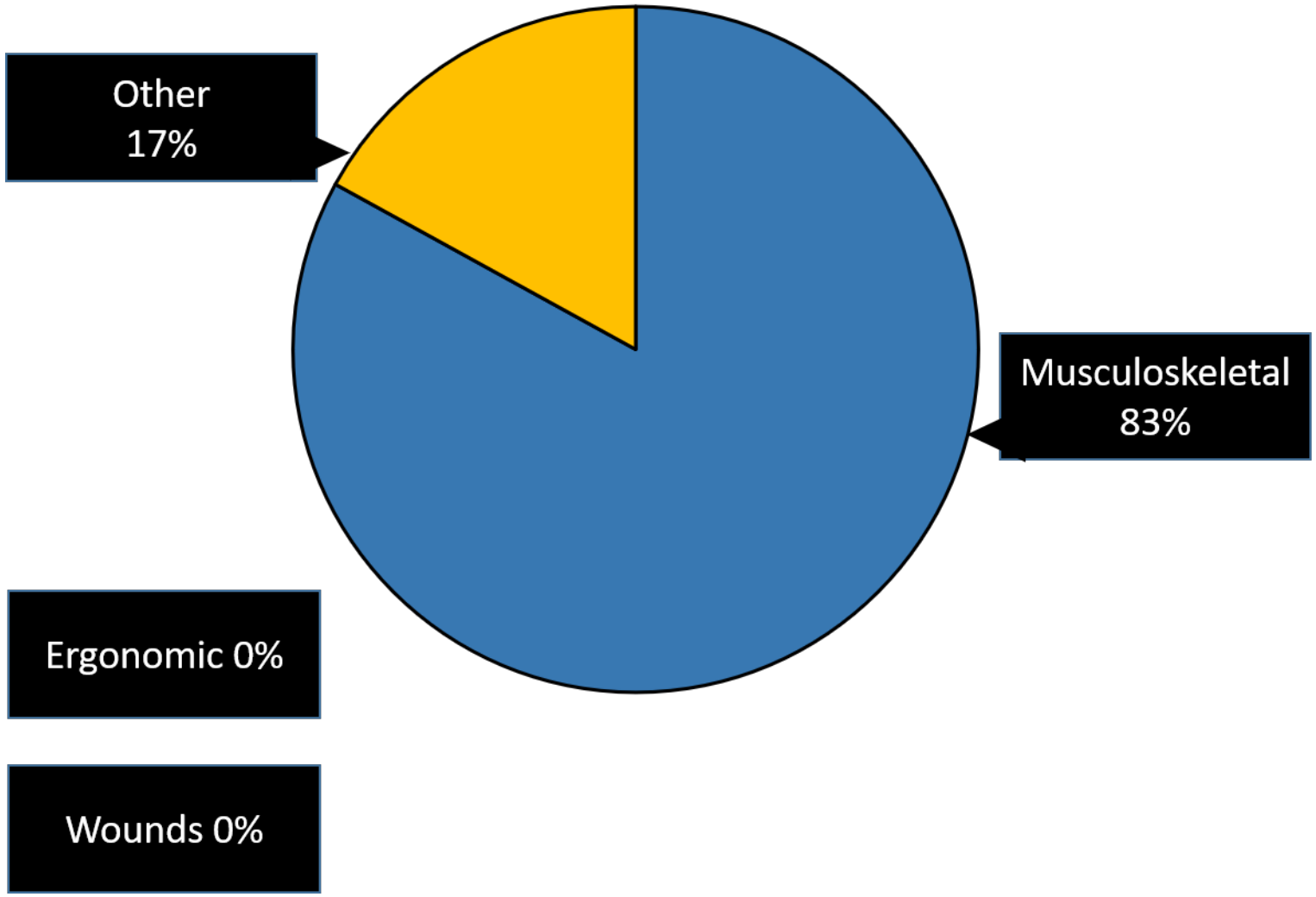
Occupational Injuries and Illnesses for CC Employees



TRC: Total Recordable Cases; **ORC**: Other Recordable Cases; **DAFW**: Days Away From Work; **DJTR**: Days Job Transfer, Restriction; **DART**: Days Away, Restricted or Transferred (DAFW + DJTR)

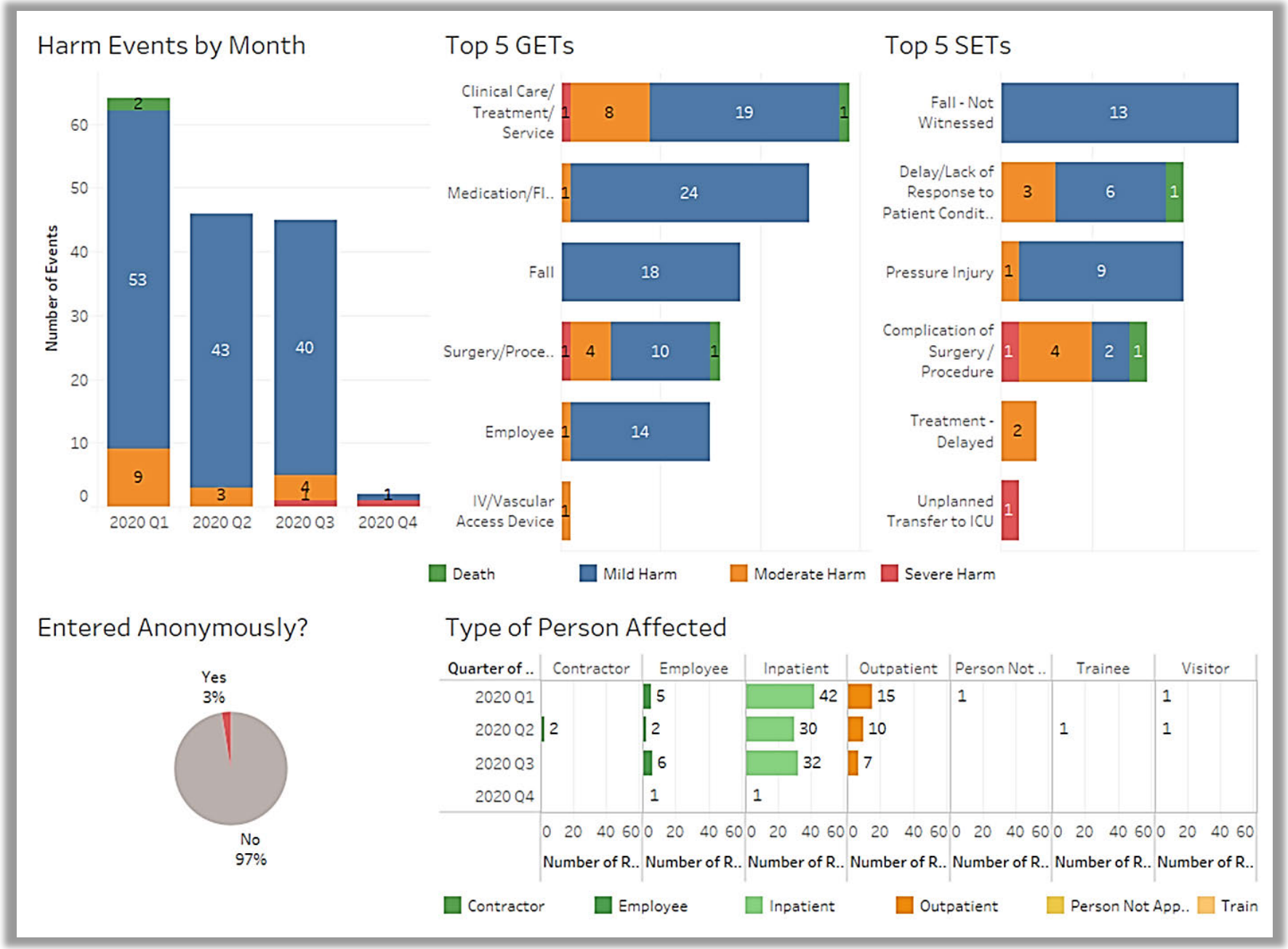
Percent of Occupational Injuries and Illnesses

Apr Jun 2020 n= 6



Patient Safety Event Reporting

Safety, Tracking, and Reporting System Dashboard



Events with Harm Dashboard

Events Entered Between 3/10/2020 – 10/7/2020

168
Total COVID
Related Events

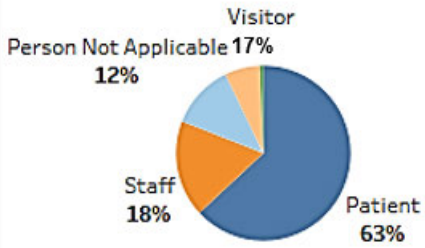
General Event Types

Infection	62
Clinical Care/Treatment/Service	40
Lab/Specimen	17
Safety/Security	12
Professional Conduct	11
Employee	6
Surgery/Procedure	3
Supplies	3
Patient ID/Documentation/Consent	3
Facilities	3
Diagnostic Imaging	3
Blood Product/Cellular Therapy	2
Medication/Fluid	1
Housekeeping	1
Healthcare IT	1
Grand Total	**168**

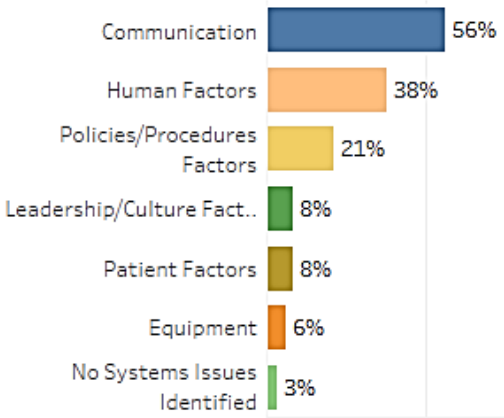
Top 10 Specific Event Types

Process Issue/Procedure Not Followed	48
Communication Issue	23
Suspected Infection	7
Inappropriate Unprofessional Behavior	7
Collection (Delay/Wrong Time/Not Collected)	5
Treatment Delayed	5
Access Issues/Trespassing	4
Unplanned Admission	3
Code Blue	3
Admissions/Registration Issue	3

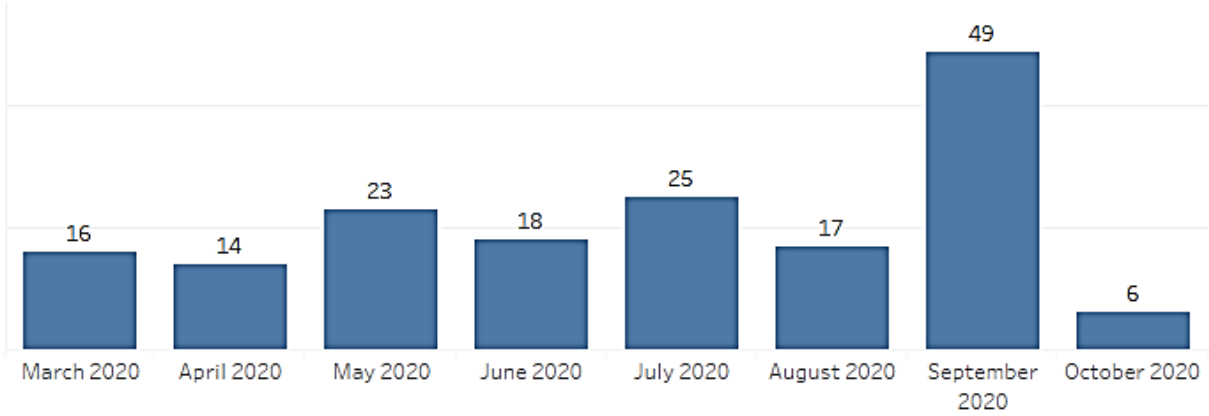
Person Affected



Contributing Factors



Date of Event



COVID Related STARS Reports

Culture of Patient Safety Survey

Culture of Patient Safety Survey

Designed by AHRQ to evaluate domains of safety culture

- Communication/Hand-offs
- Teamwork
- Non-punitive response to errors
- Reporting
- Organizational learning
- Leadership support

Survey last fielded in 2017

Clinical Center 2020 survey specifics

- CRIS Users and CC Staff
- 1,172 total participants
- 65% have direct patient contact

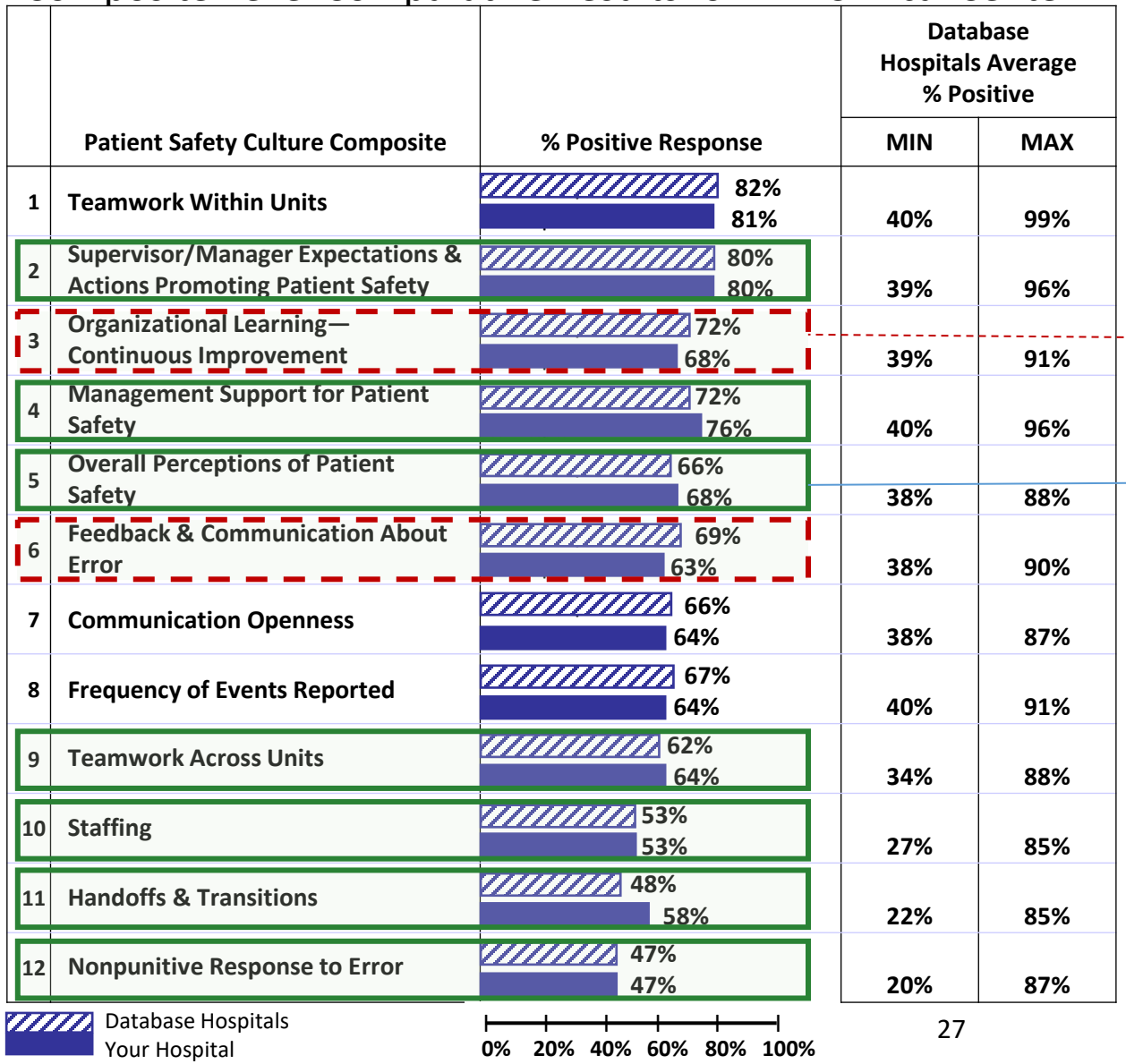
Clinical Center Scores 2020 and 2017

Composite Level Trending Results

	Patient Safety Culture Composite	Your Hospital 's % Positive		Difference	Change
		Recent	Previous		
1	Teamwork Within Units	81%	73%	8	↑
2	Supervisor/Manager Expectations & Actions Promoting Patient Safety	80%	76%	4	↑
3	Organizational Learning—Continuous Improvement	68%	64%	4	↑
4	Management Support for Patient Safety	76%	70%	6	↑
5	Overall Perceptions of Patient Safety	68%	58%	10	↑
6	Feedback & Communication About Error	67%	61%	2	↑
7	Communication Openness	64%	60%	4	↑
8	Frequency of Events Reported	64%	59%	5	↑
9	Teamwork Across Units	64%	55%	9	↑
10	Staffing	53%	48%	5	↑
11	Handoffs & Transitions	58%	37%	21	↑
12	Nonpunitive Response to Error	47%	41%	6	↑

Clinical Center Compared to AHRQ Hospitals 2020

Composite-Level Comparative Results for NIH Clinical Center



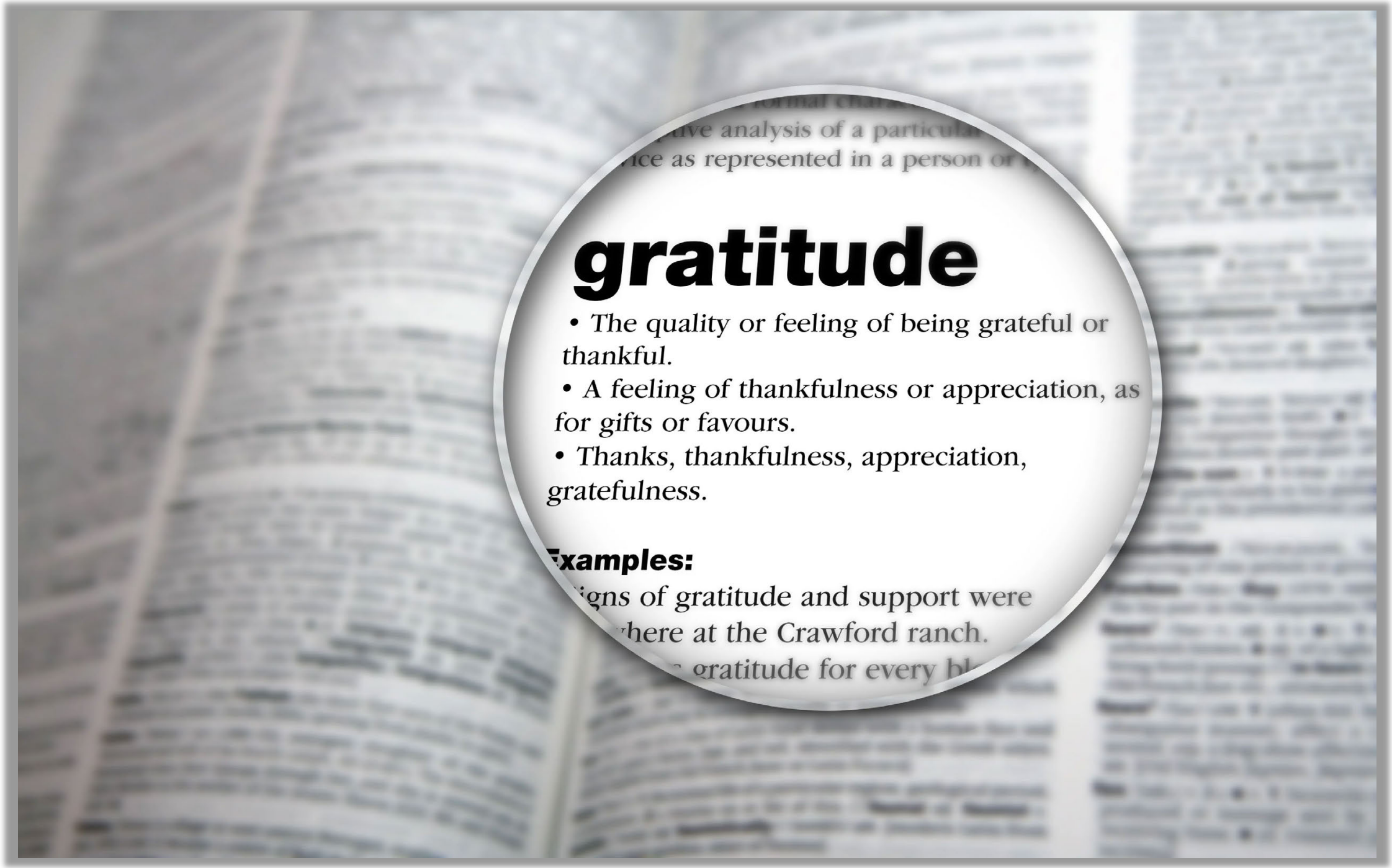
2017

Below national average in 12 of the 12 domains

2020

Equal to or above in 7 of the 12 domains


It takes a
VILLAGE!


gratitude
• The quality or feeling of being grateful or thankful.
• A feeling of thankfulness or appreciation, as for gifts or favours.
• Thanks, thankfulness, appreciation, gratefulness.
Examples: