Patient Safety and Clinical Quality Update

NIH CC Research Hospital Board

July 2020

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Director, Office of Patient Safety and Clinical Quality

Agenda

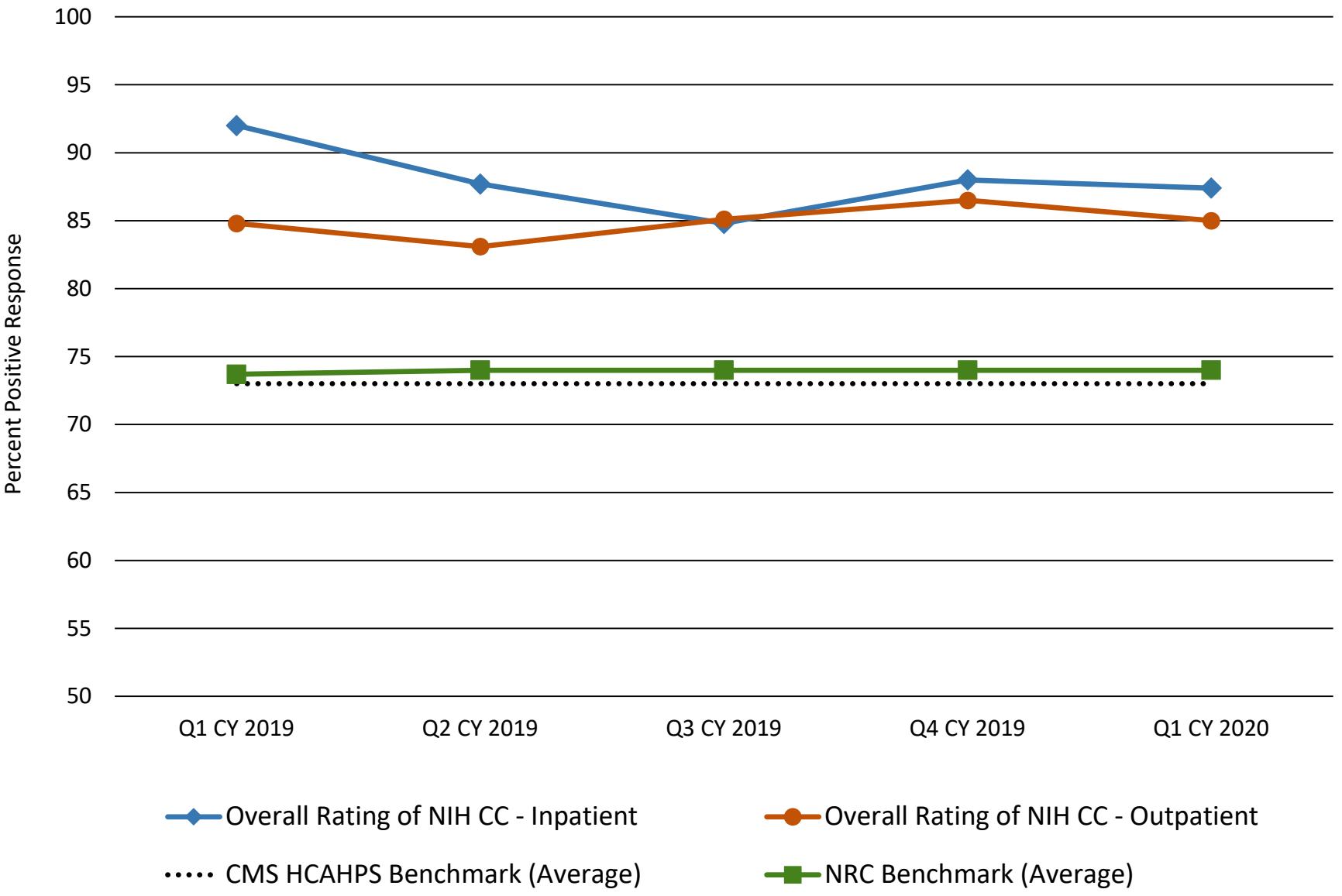
- Performance Metrics
- Accreditation Activities
- Patient Safety Event Reporting
- Clinical Practice Review: “Trigger Tool”
- In the News…

Performance Metrics

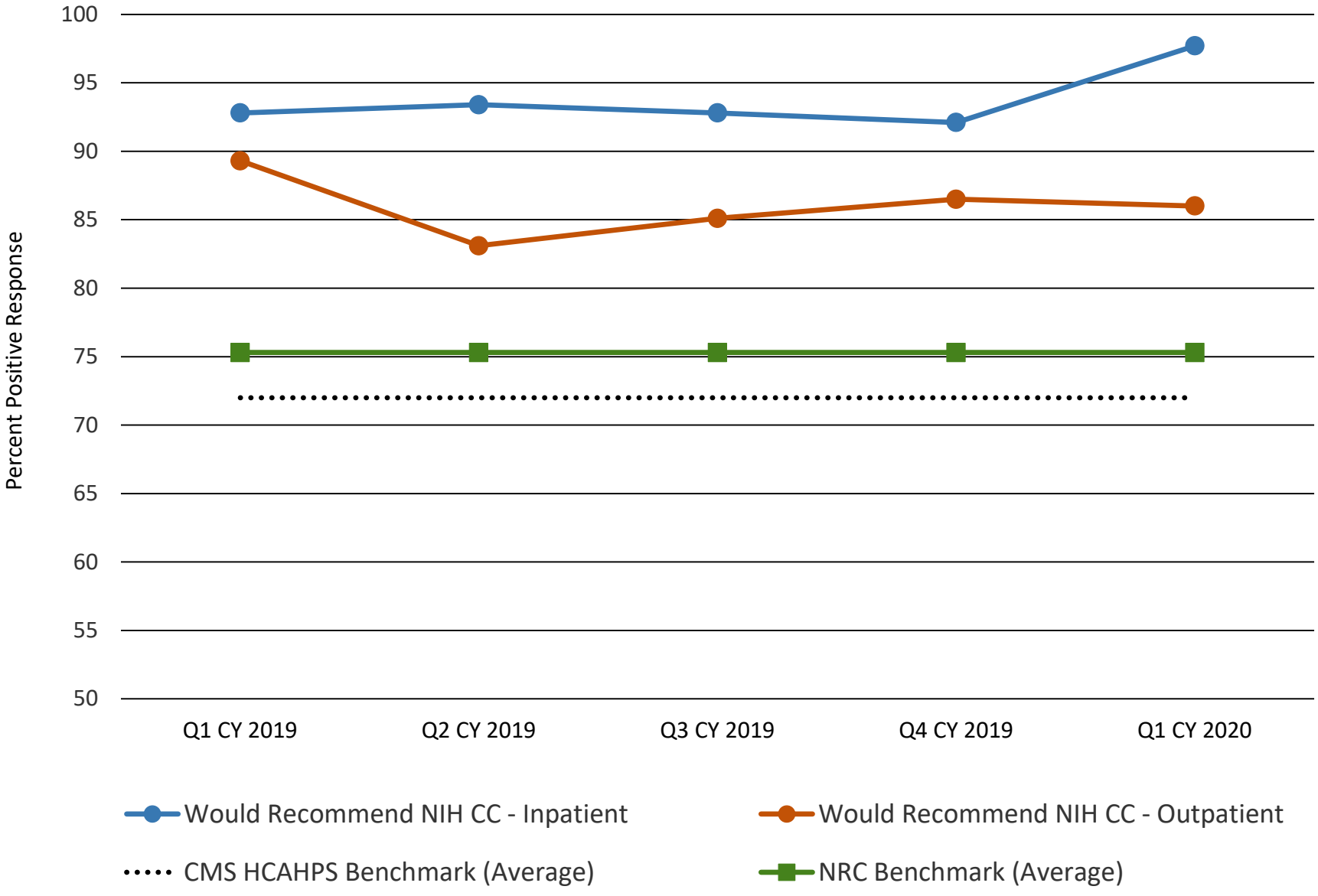
Patients' Perceptions

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

Overall Hospital Rating



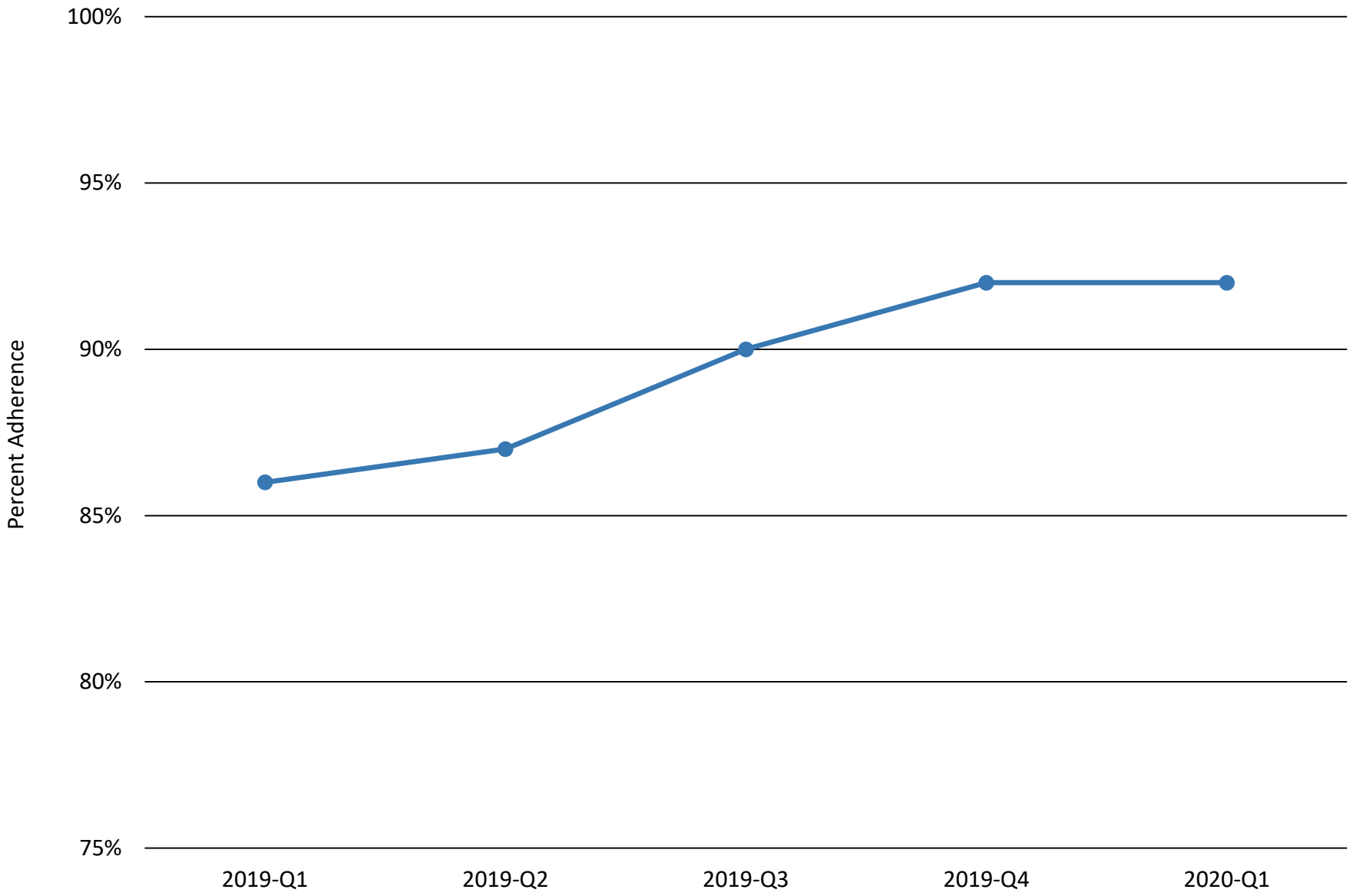
Would You Recommend the NIH CC?



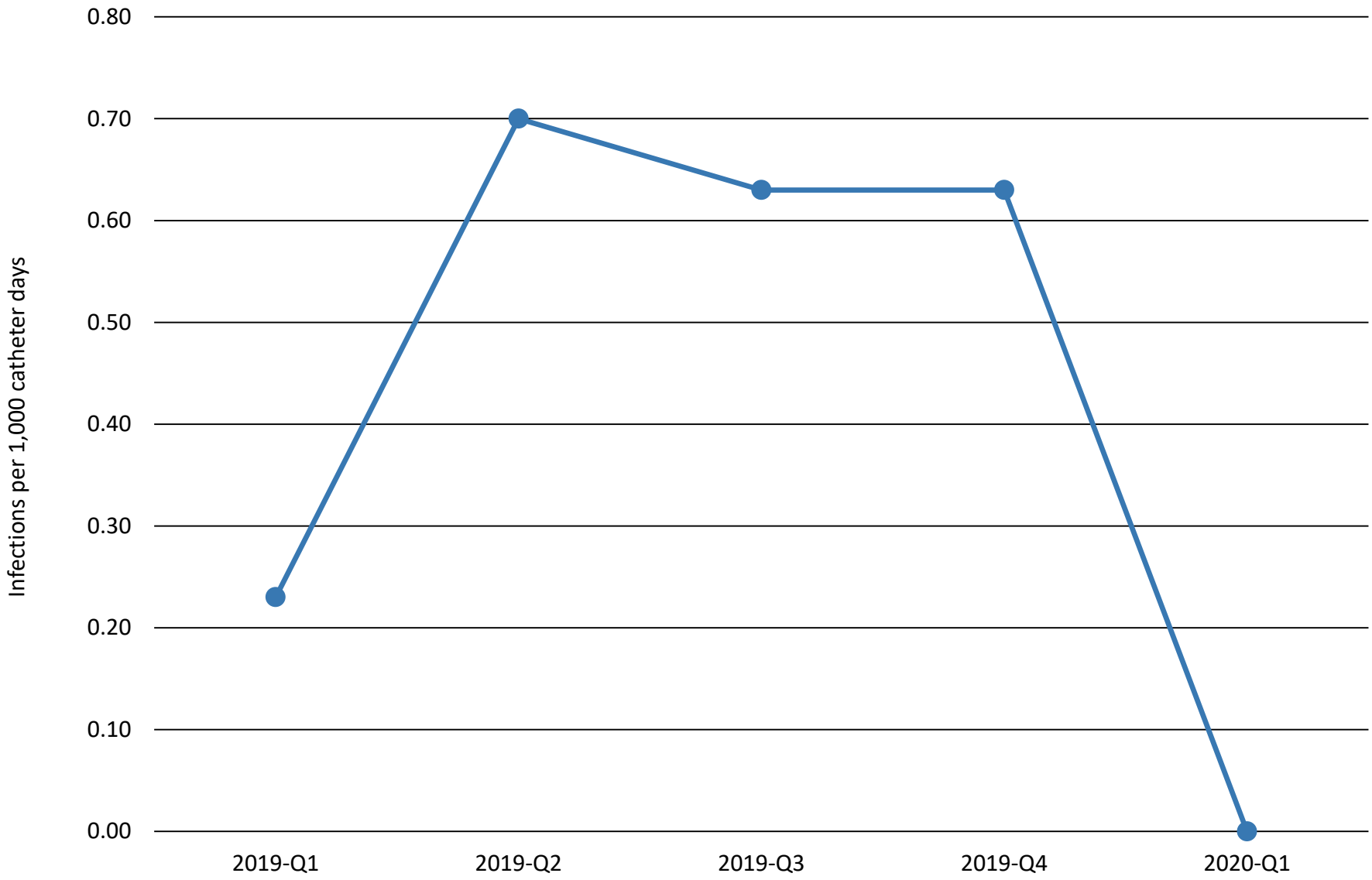
Infection Control Metrics

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

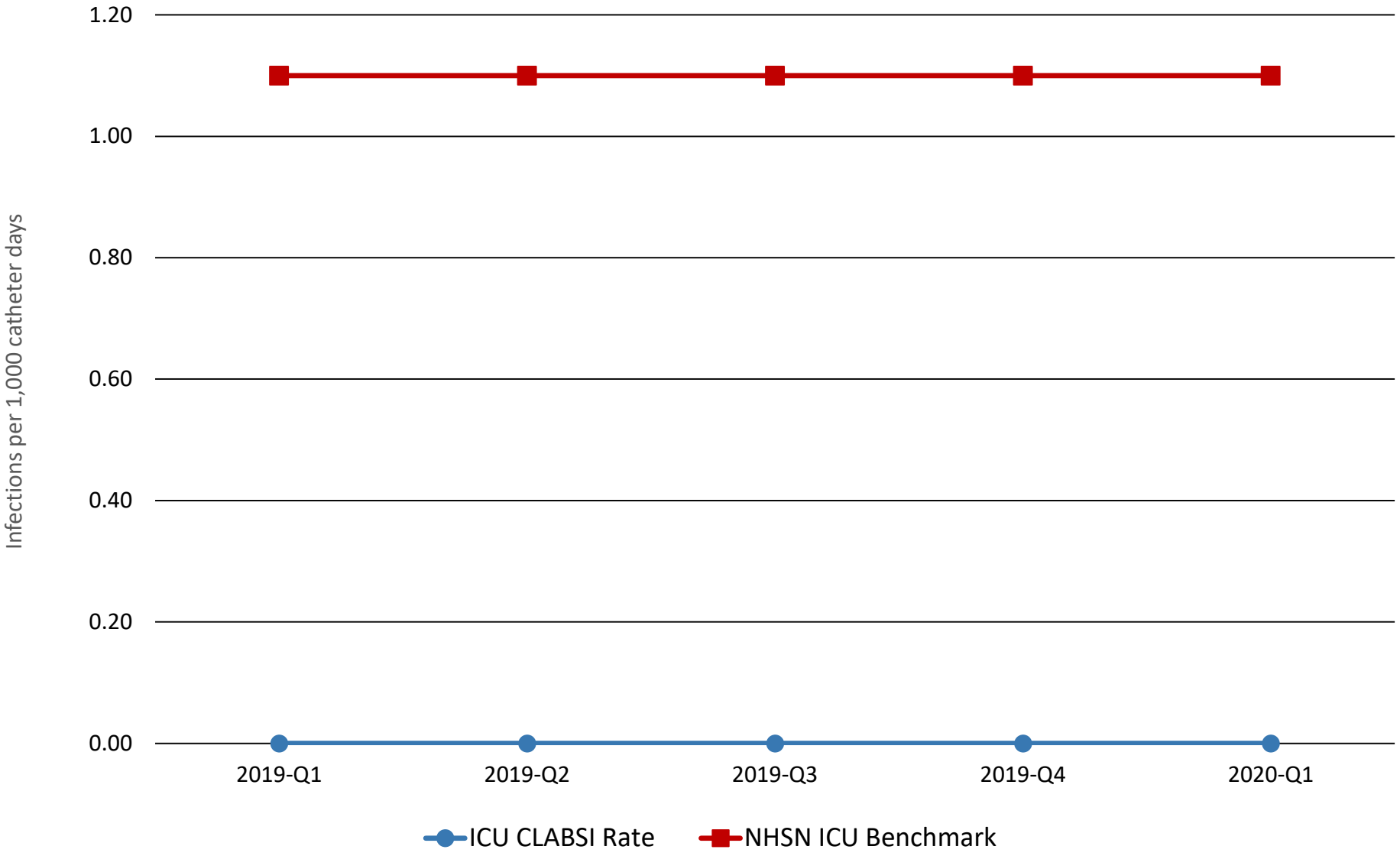
Hand Hygiene Compliance



Wholehouse Central-Line Associated Bloodstream Infection (CLABSI) Rate

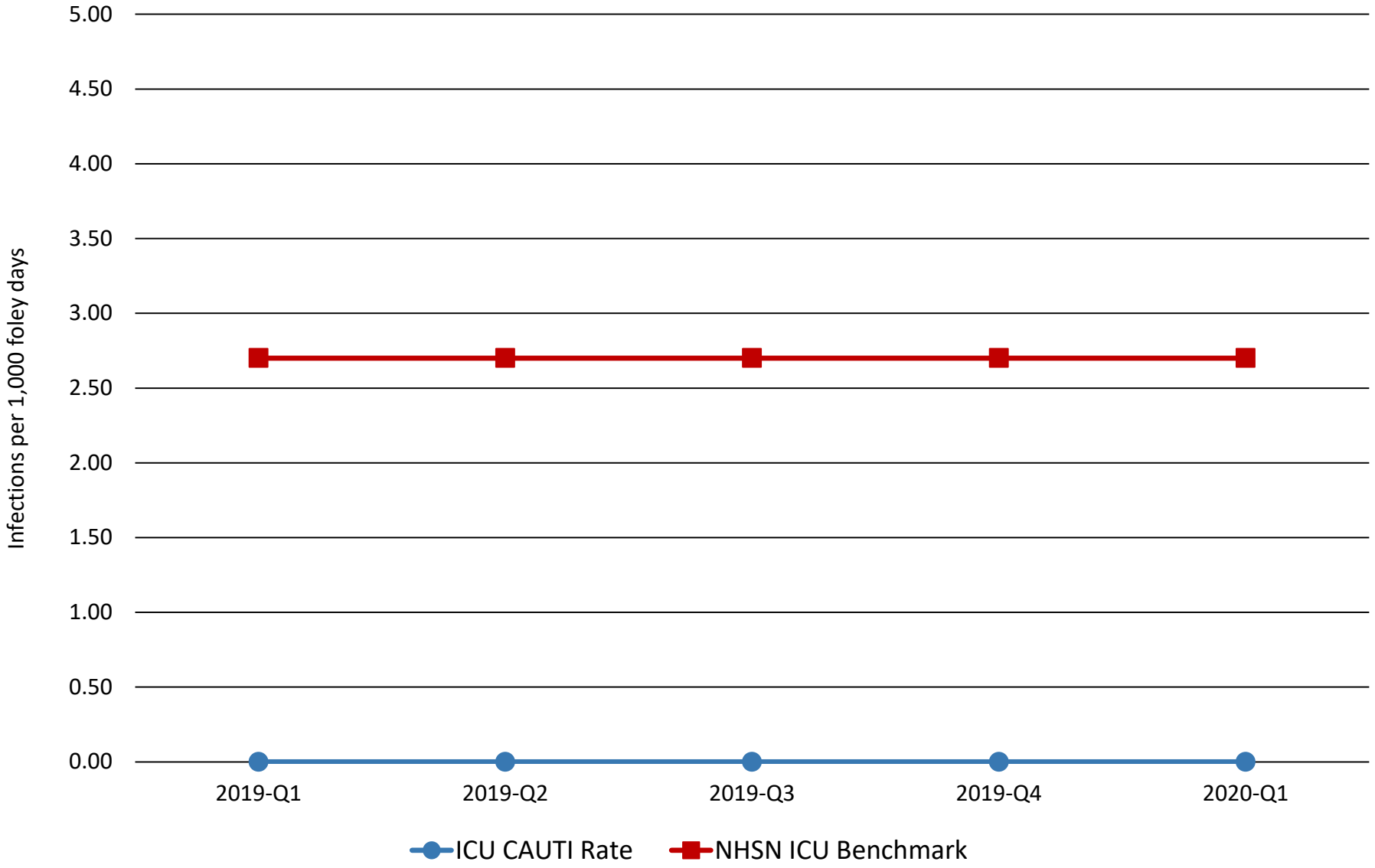


ICU Central-Line Associated Bloodstream Infection (CLABSI) Rate



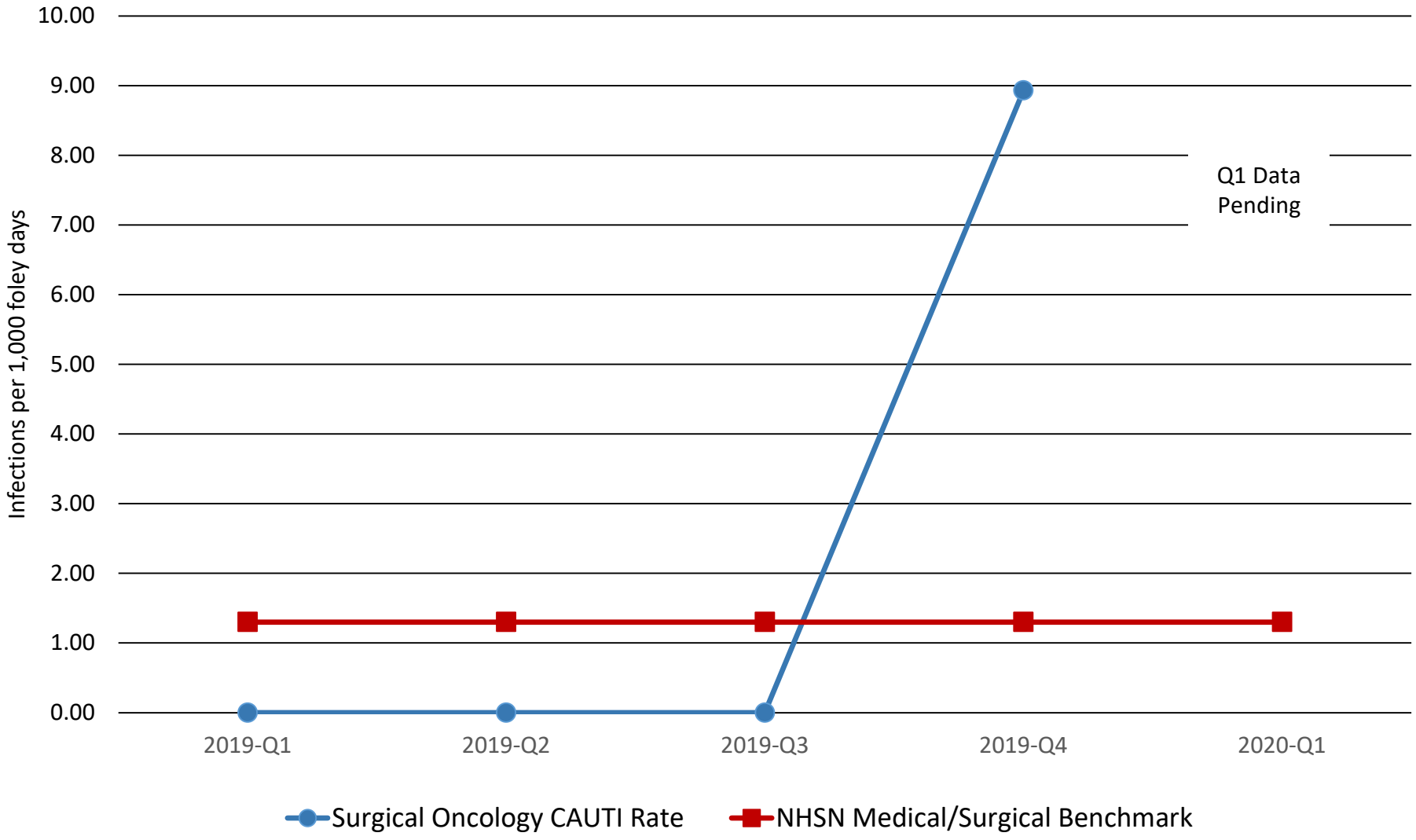
2013 CDC National Healthcare Safety Network (NHSN) Benchmark: Critical Care Units, Medical/Surgical -major teaching mean 1.1

ICU Catheter-Associated Urinary Tract Infections (CAUTI) Rate



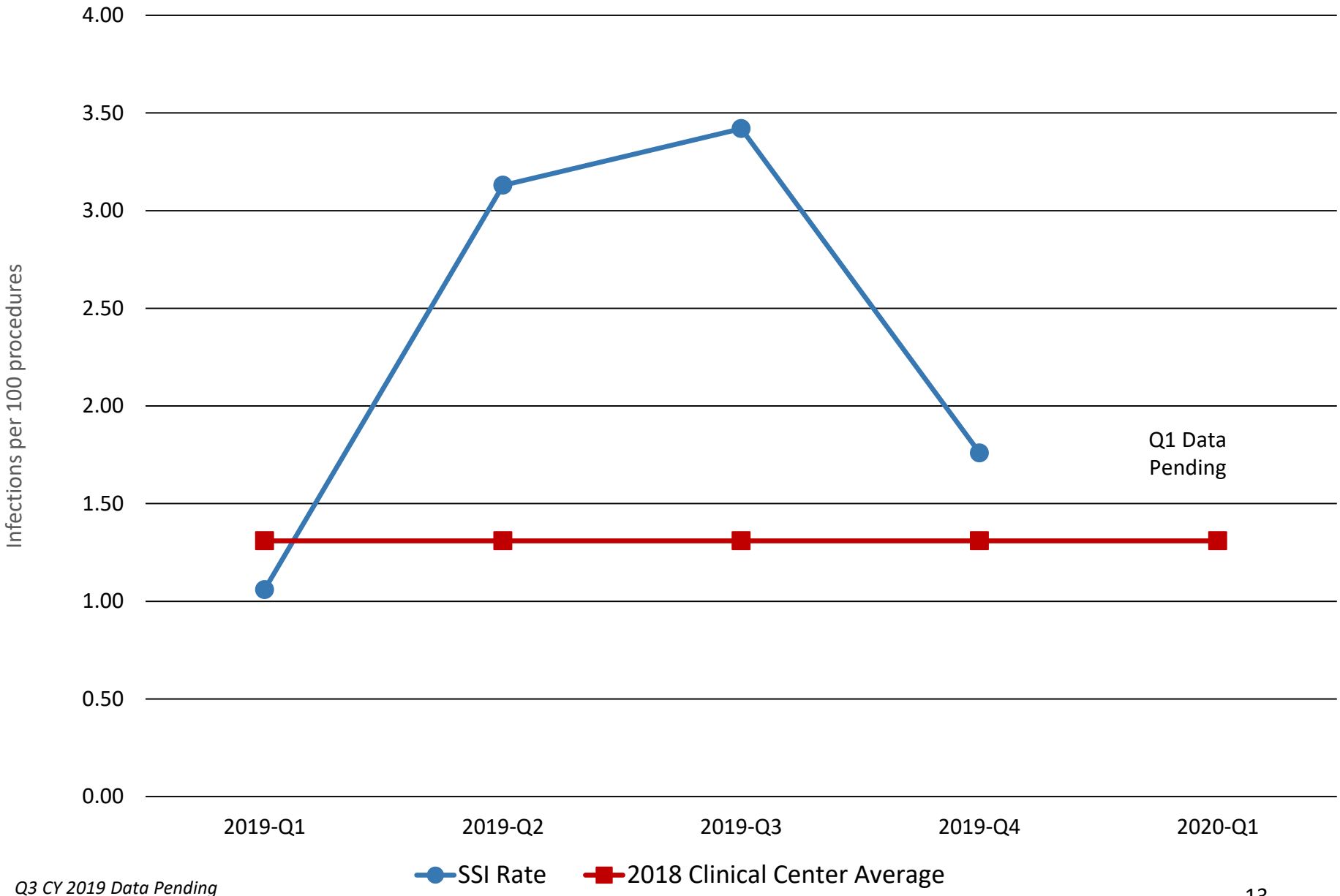
2013 CDC National Healthcare Safety Network (NHSN) Benchmark: Critical Care Units, Medical/Surgical -major teaching mean 2.7

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



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

Surgical Site Infections (SSI) Rate

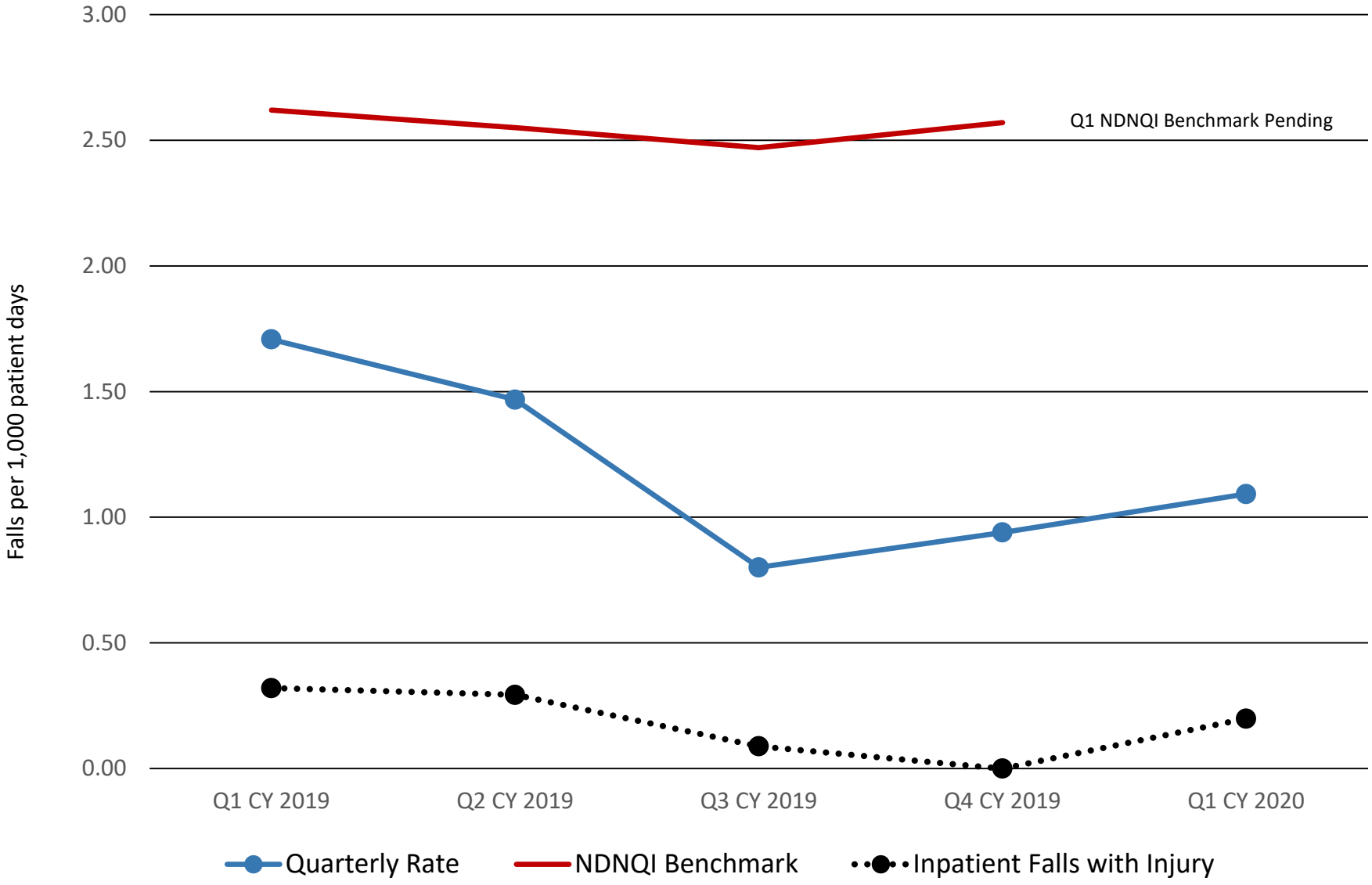


Q3 CY 2019 Data Pending

Nursing Quality Metrics

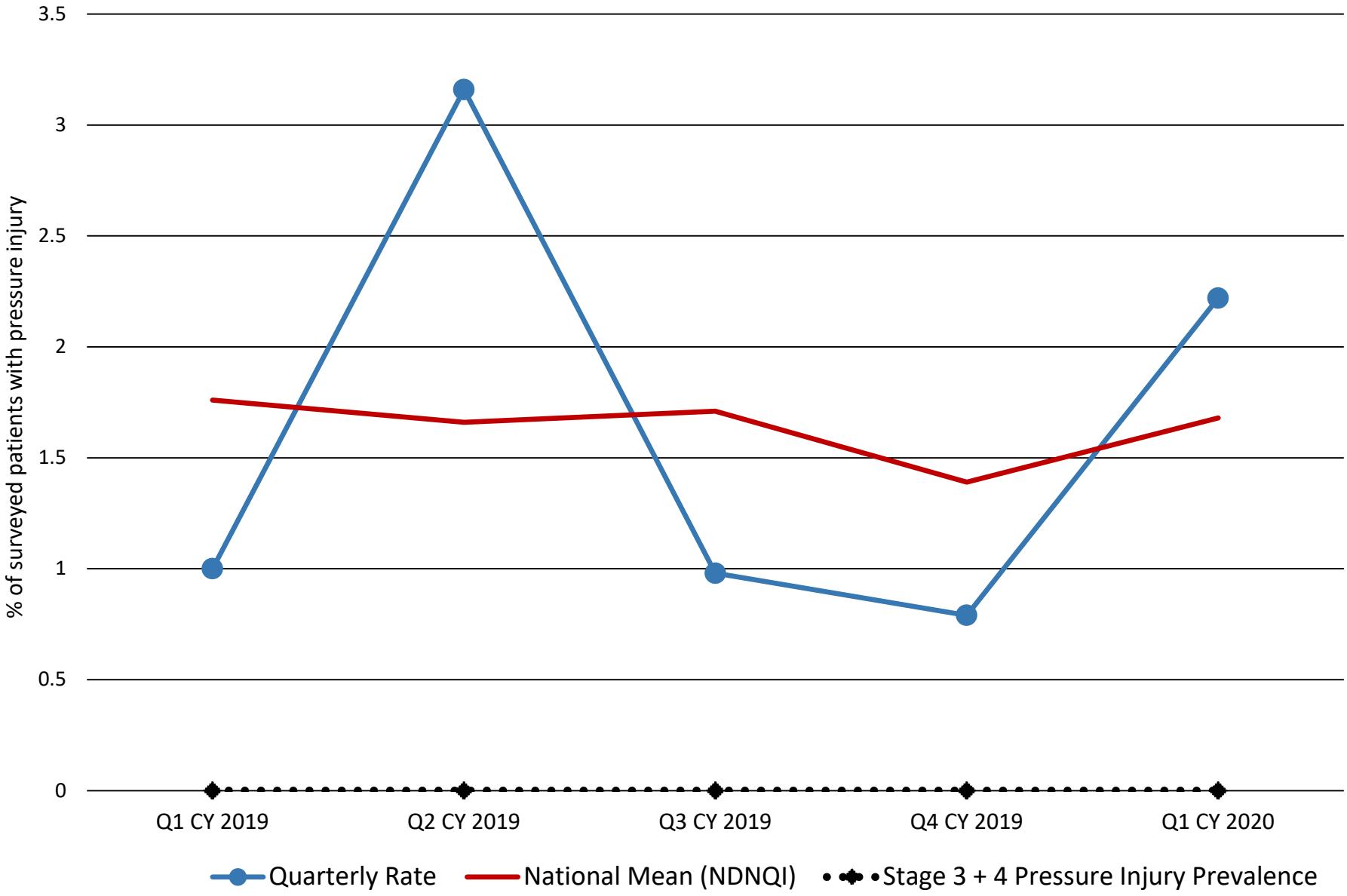
- Falls
- Pressure Injury
- Medication Administration Barcoding

Inpatient Falls Rate



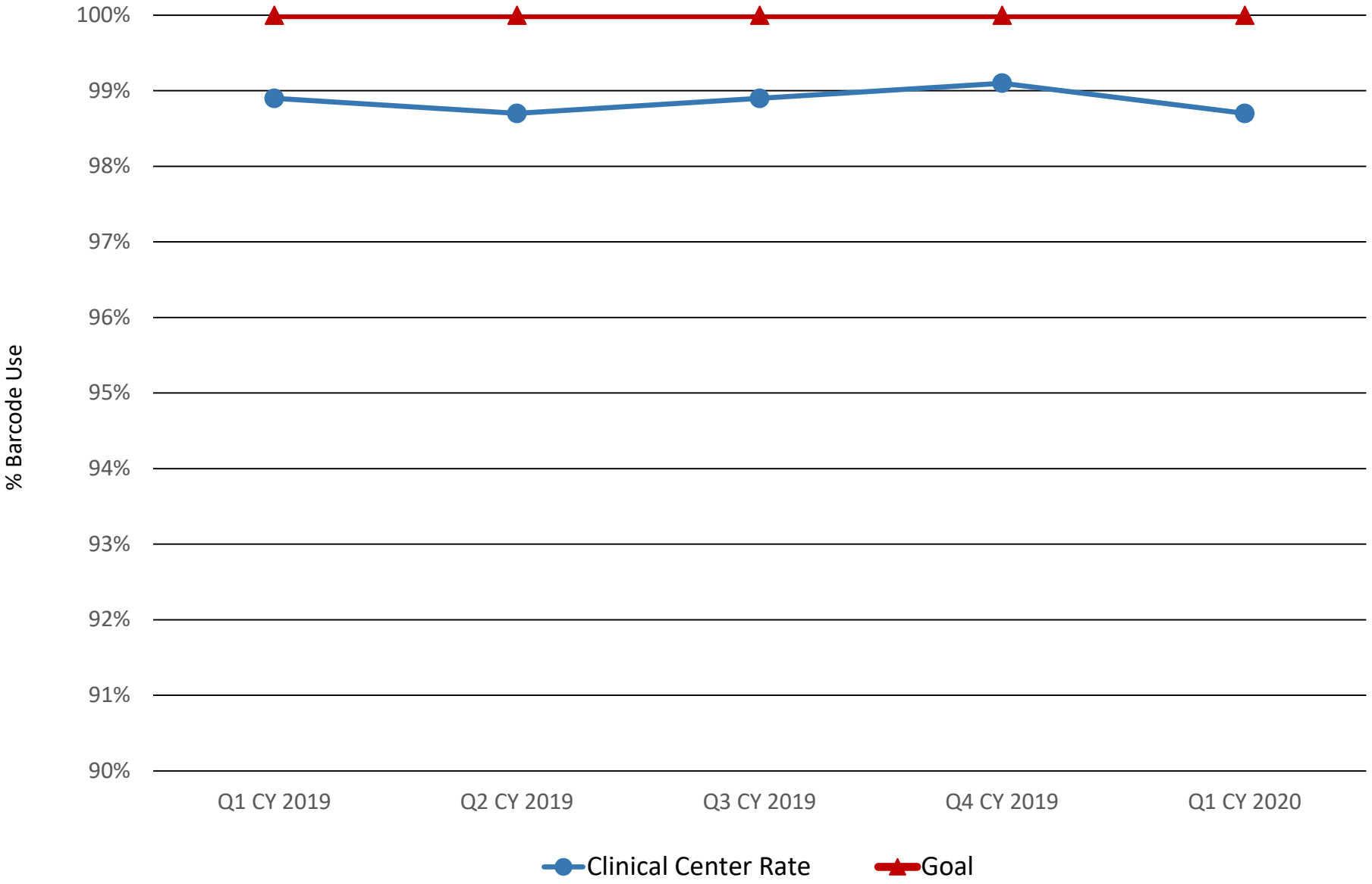
NDNQI benchmark for Total Falls Rate Only

Pressure Injury Prevalence



NDNQI Benchmark for Total Pressure Injury Rate only

Medication Administration Barcode Use



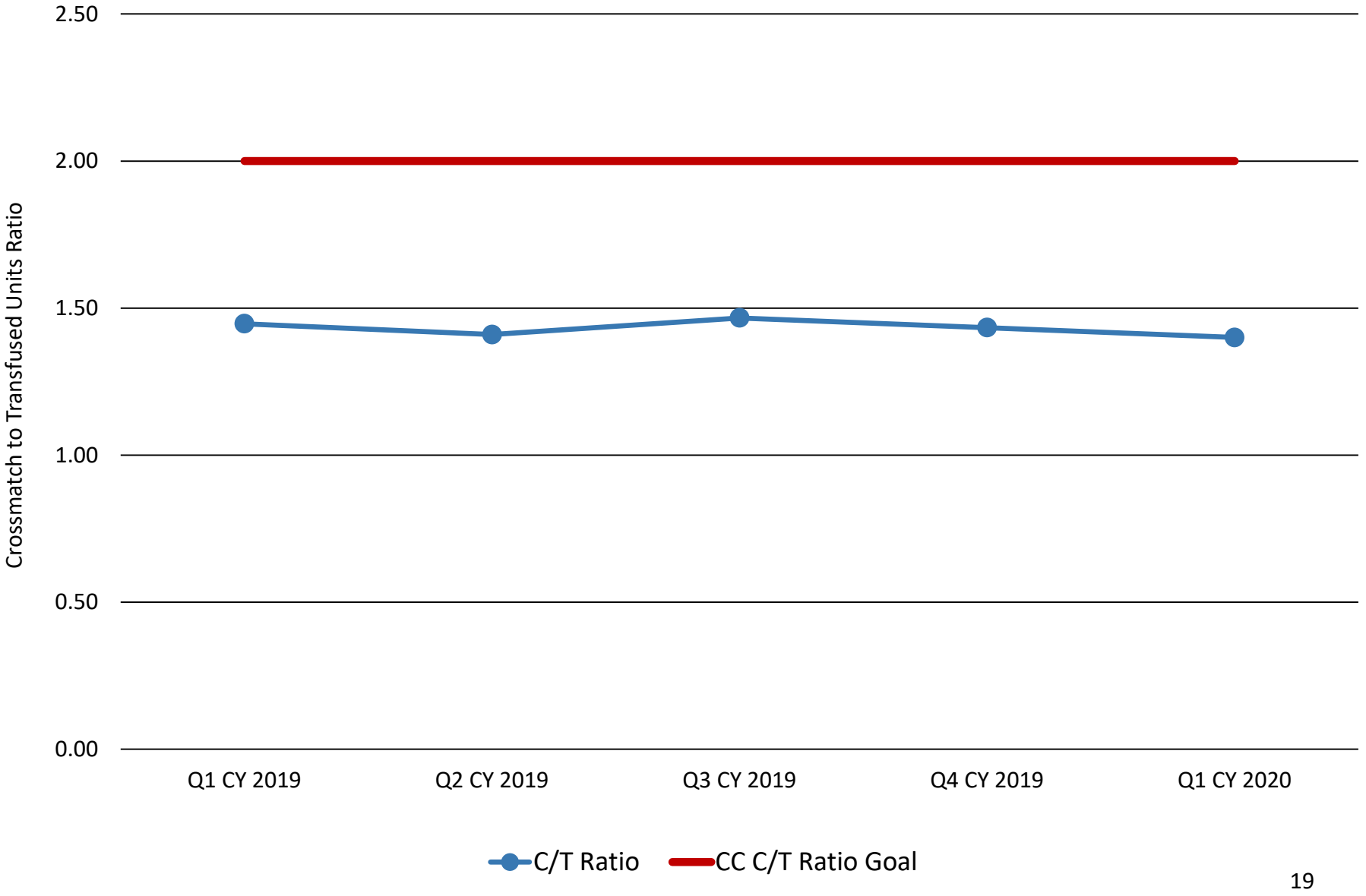
Beginning Q1 CY 2020 contrast media excluded from KBMA data

Blood and Blood Product Use

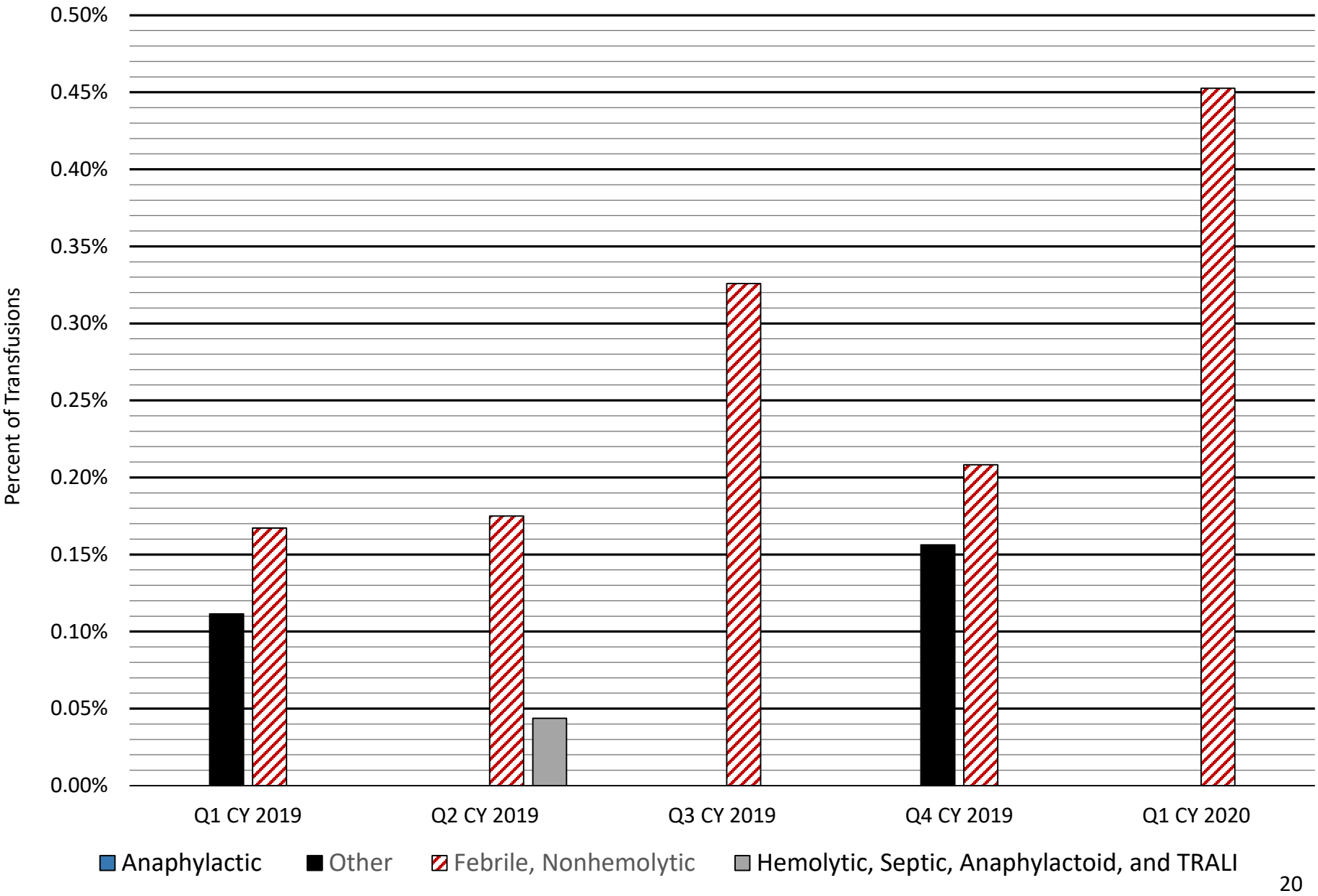
- Crossmatch to Transfusion (C:T) Ratio
- Transfusion Reaction by Class
- Unacceptable Blood Bank Specimens

Crossmatch to Transfusion (C/T) Ratio

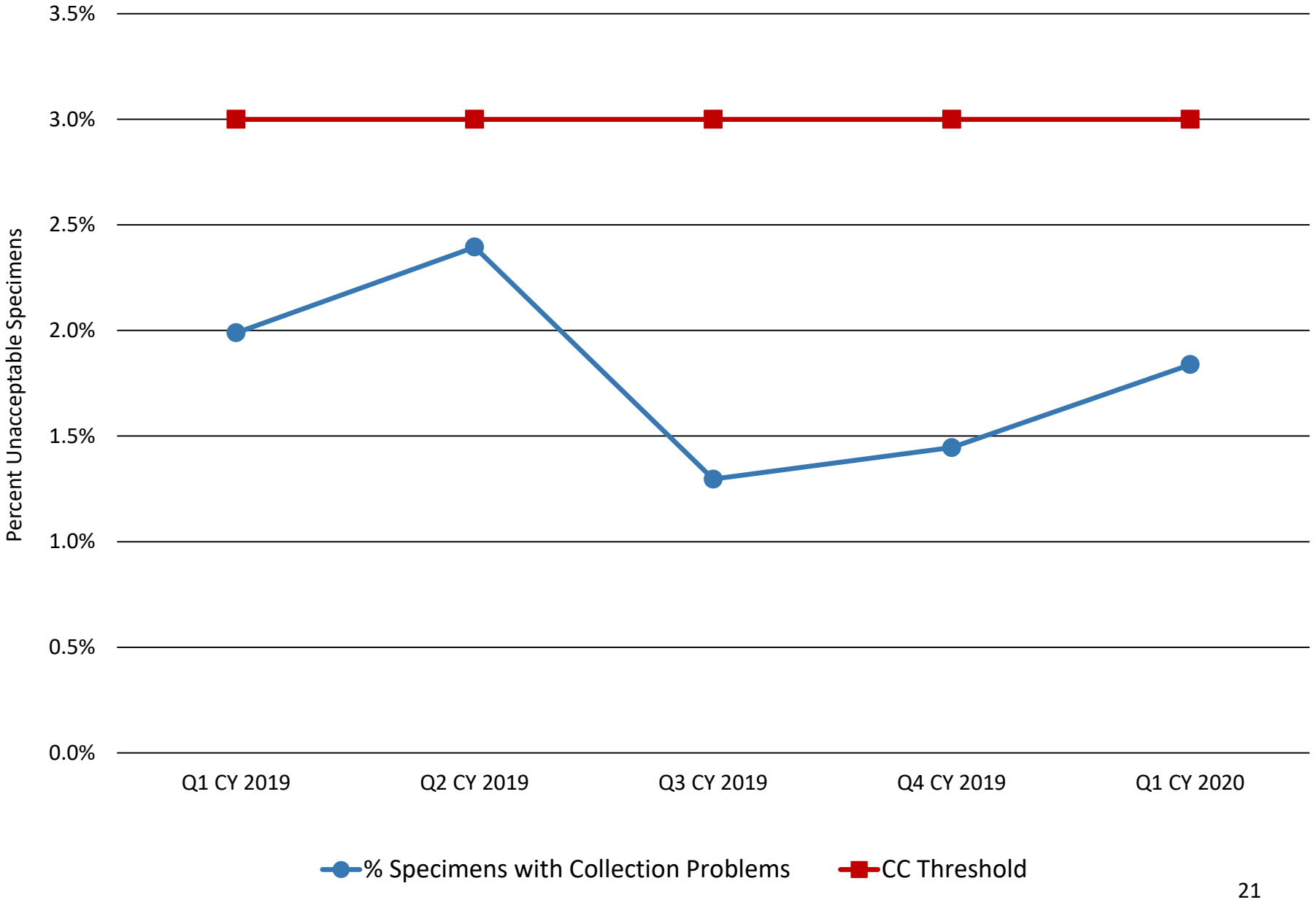
(The NIH CC goal is to have a C:T ratio of 2.0 or less. Monitoring this metric ensures that blood is not held unused in reserve when it could be available for another patient.)



Transfusion Reactions by Class



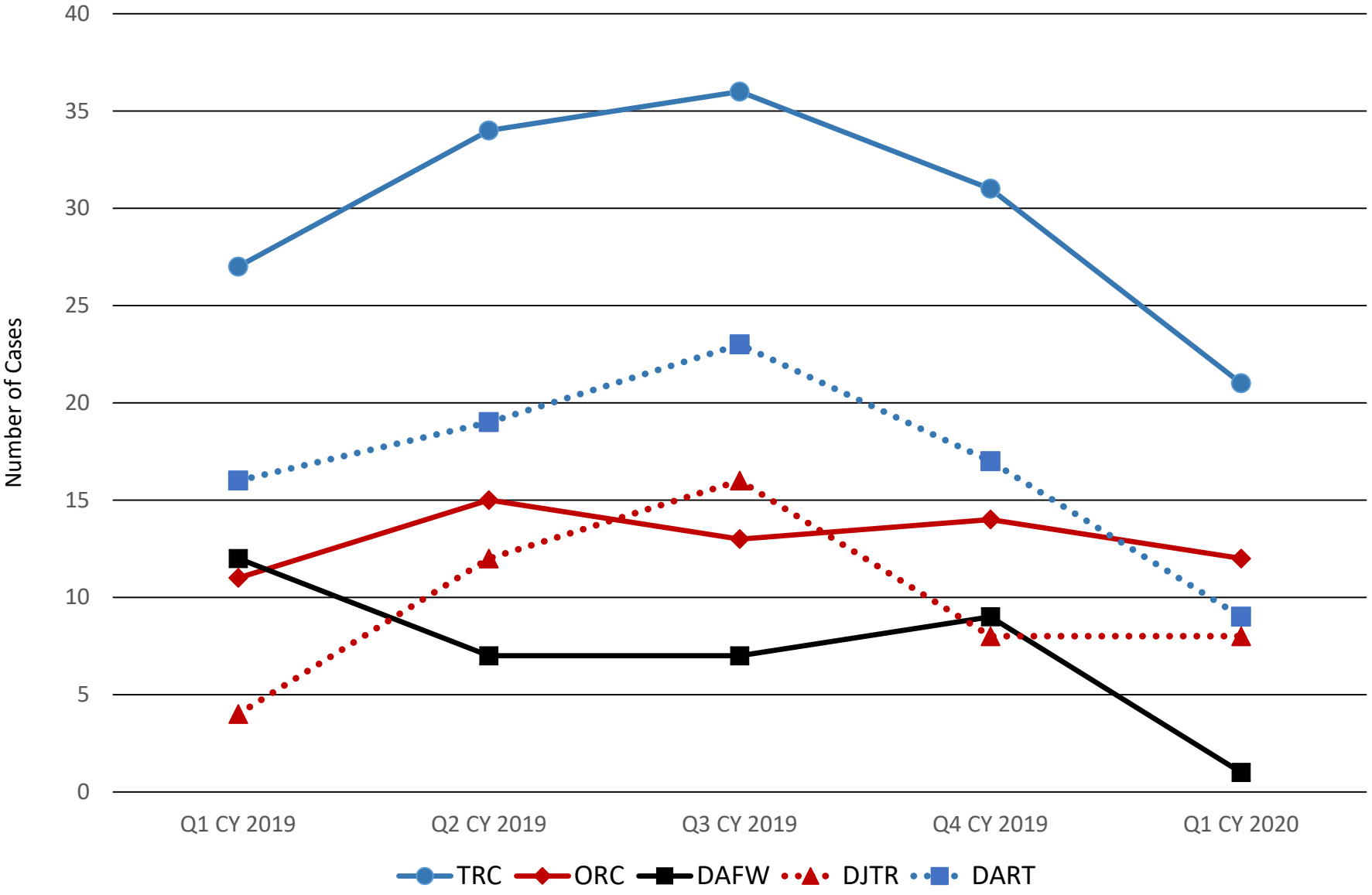
Unacceptable Blood Bank Specimens



Employee Safety

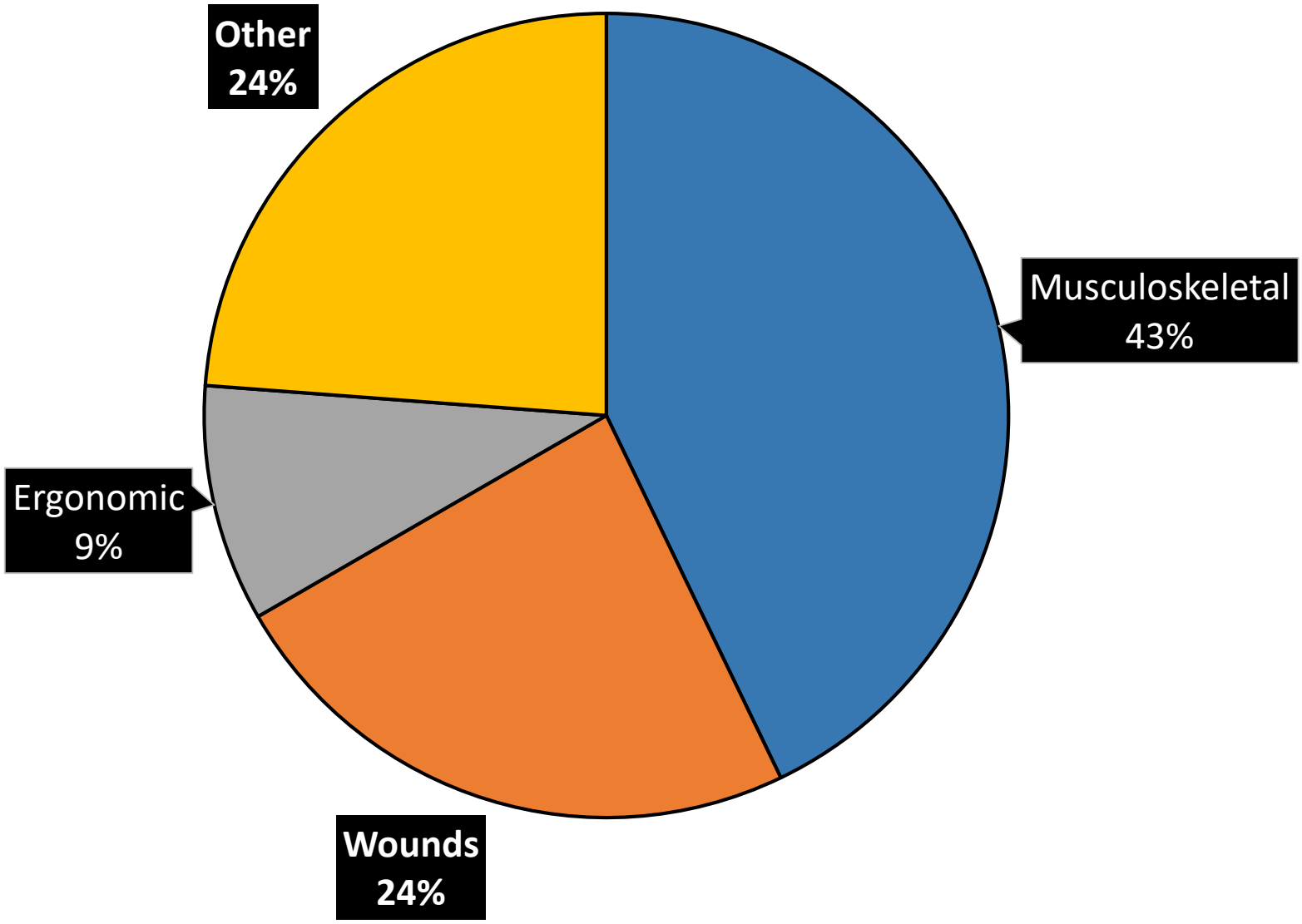
- Occupational Injury and Illness

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
Jan - Mar 2020 n= 21



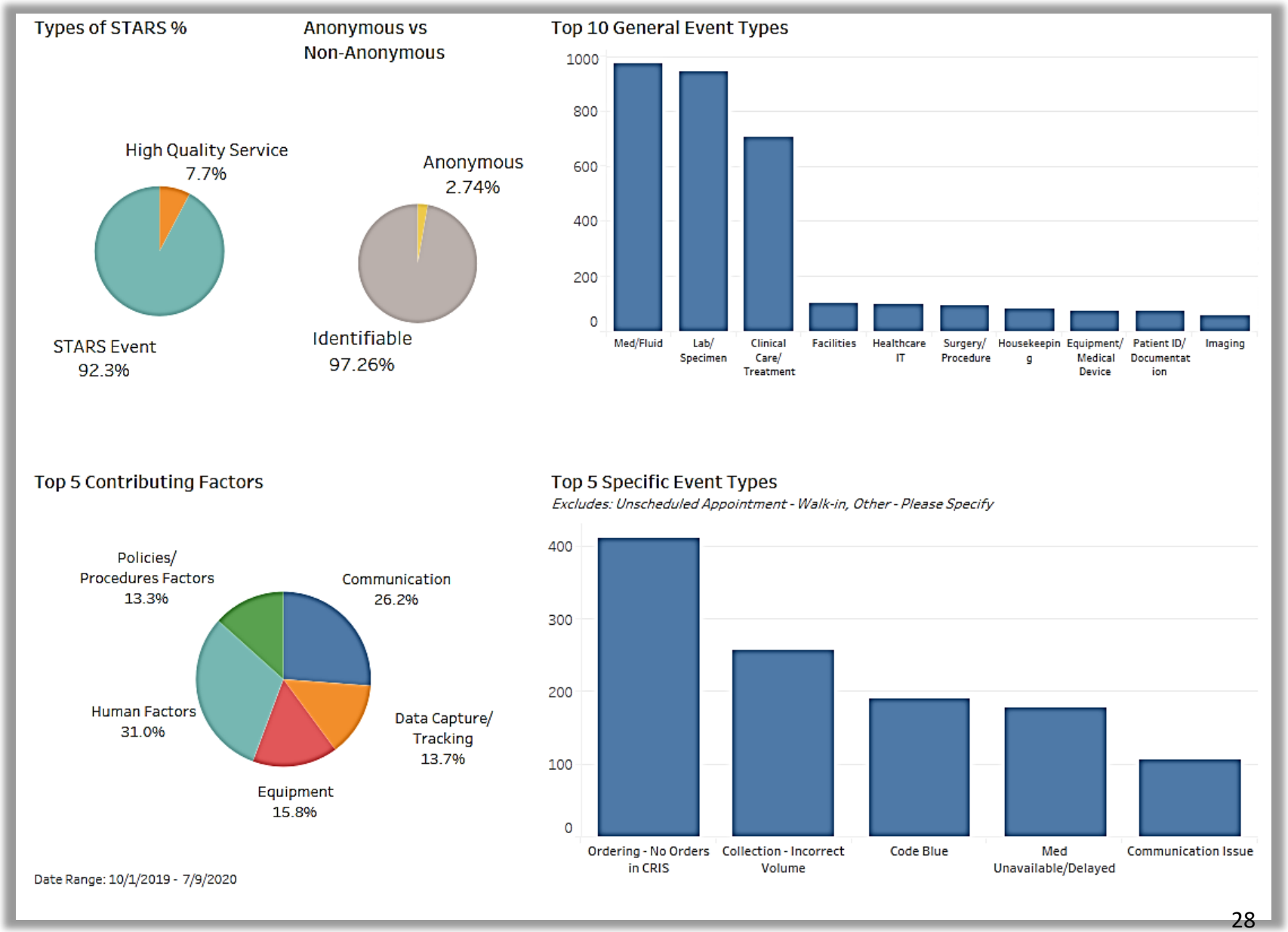
Accreditation Update

Joint Commission Update

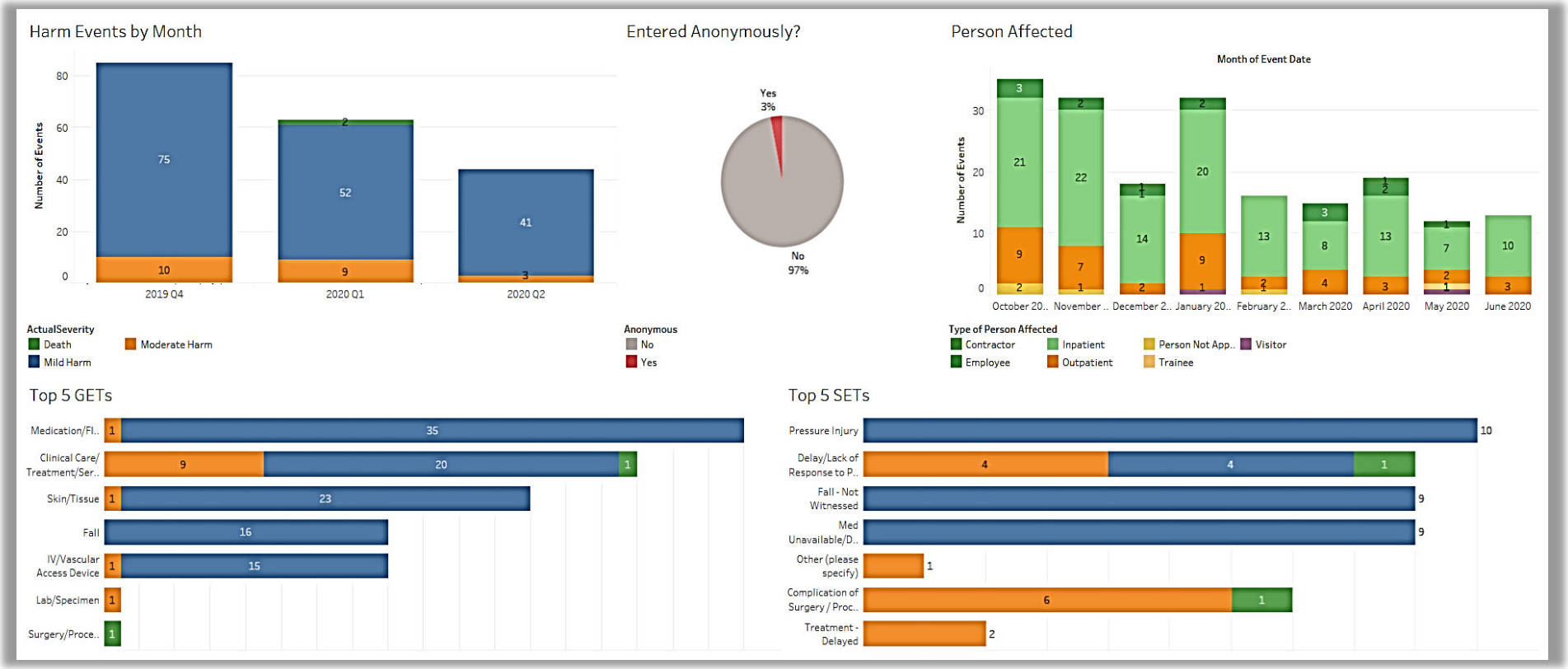
- **Intra-Cycling Monitoring: Focused Standard Assessment**
  - Annual self-assessment of adherence with Joint Commission standards
    - 18 chapters
    - 250 standards
  - Four month deep dive
    - Data and policy reviews
  - Findings:
    - *Pain Management (Performance Improvement; Medical Staff; Provision of Care)*
      - Management of the individual patient versus monitoring effectiveness in the aggregate
      - Pain Management and Assessment Workgroup
      - Metrics dashboard
    - *Graduate Medical Education (Medical Staff)*
      - "Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs are provided to the organized medical staff and hospital staff."

Patient Safety Event Reporting

Safety, Tracking and Reporting System Dashboard



Events with Harm Dashboard



Harm Outcomes Assessment: Trigger Tool Review

Trigger Tool Review

- Qualitative peer review of patient harm
- Trigger case: ICU admission
- 453 trigger cases identified (7/1/19 – 3/13/20)
- Each trigger case categorized by "clinical performance level"

  Level I: Most providers would have handled the case similarly

  Level II: Some providers would have handled the case differently

  Level III: Most providers would have handled the case differently

- Three cases reviewed bimonthly by Trigger Tool team:
  - Licensed Independent Practitioner lead
  - ICU physician
  - Three second year fellows (surgery, oncology, infectious diseases)
  - Nursing
  - Pharmacy
  - CC Office of Patient Safety and Clinical Quality staff
- "Deep dive" into a total of 47 cases (7/1/19 – 3/13/20)

	Planned ICU Admission	*Unplanned ICU Admission*	*%*
Level I Most providers would have handled the case similarly	287	90	83%
Level II Some providers would have handled the case differently	11	40	11%
Level III Most providers would have handled the case differently	6	19	6%

Level III Harm: Categories

Harm Category	Number of Cases
Clinical Management	18
System Failure	4
Patient Factor	1
Disease Progression	1
Adverse Event	2

Level III Harm: “Common Threads”?

“Thread”	Number of Cases
Branches/Services	13
Attendings	17
Patient Care Units	8
Subspecialty	Surgery Oncology
Patient Acuity	Complex High Acuity

Level III Harm: Themes

- Protocol Attending engagement
- Hand-off lapses and transitions of care
- Delay in recognizing acute changes

In the News….

The Joint Commission Journal on Quality and Patient Safety 2020; 46:417–426

From Pilot to Practice: Implementation of a Suicide Risk Screening Program in Hospitalized Medical Patients

Deborah J. Snyder, MSW; Barbara A. Jordan, DNP, RN, NEA-BC; Jeasmine Aizvera, MSSW; Marilyn Innis, MSW; Helen Mayberry, MSN, RN, CPPS; Minnie Raju, RN, MS; Diane Lawrence, MSN, RN, CRNP; Anne Dufek, MS, CPNP-PC, RN, CPHON; Maryland Pao, MD; Lisa M. Horowitz, PhD, MPH