Essential Hospitals Engagement Network (EHEN)
2014 Best Practice Survey: Highlights and Responses

Hospital-Acquired Conditions (HAC)

Hospital-Acquired Pressure Ulcers (HAPU)
Adverse Drug Events (ADE)
Venous Thromboembolism (VTE)
Falls

Background

- In May 2014, EHEN asked its hospitals to complete a survey of the interventions and practices they have implemented or plan to implement as part of their quality improvement efforts.
- Response rate: 12 of 22 hospitals responded (55 percent).

Report Information

- This report is not intended to recommend any one intervention or practice, nor is it intended to prove causation between interventions and outcomes.
- Hospitals were not necessarily able to answer every question.
- The highlight section provides comparisons between conditions and associations with relevant outcome data. The outcome data was collected though UHC's clinical database (CDB/CDB-lite) and UHC's Web Data Entry Portal. The remainder of the report is a full breakdown of responses to each question from the survey.
- For questions, please contact your improvement coach or e-mail EHEN@essentialhospitals.org.

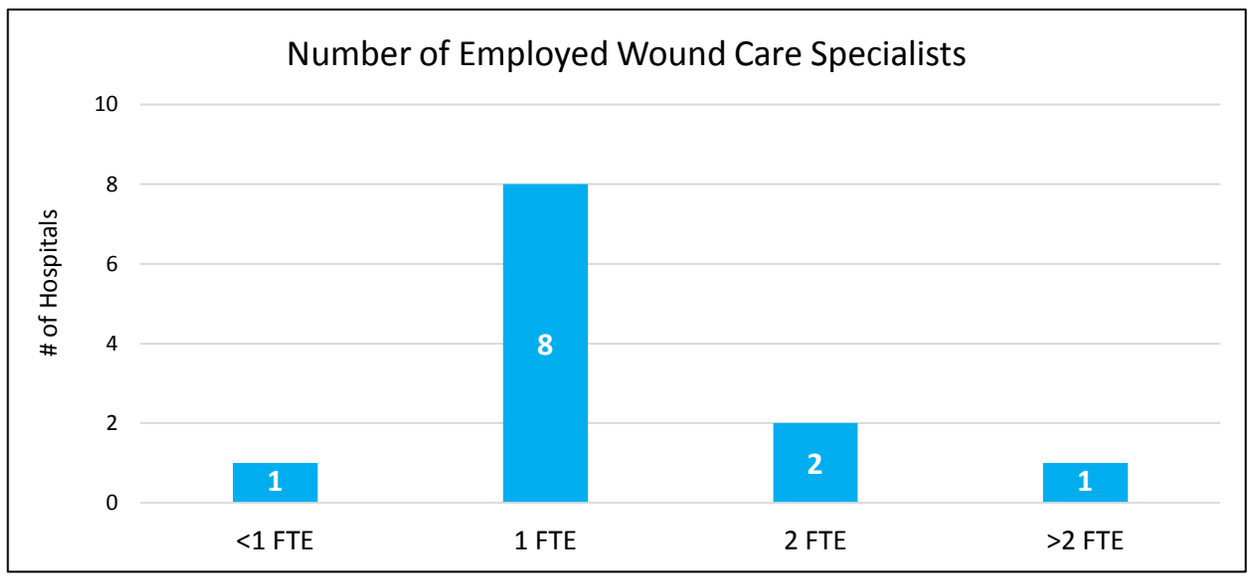
HAPU: Best Practice Survey Highlights

In their own words... Top three effective HAPU reduction strategies in the past 18 months from top performers.

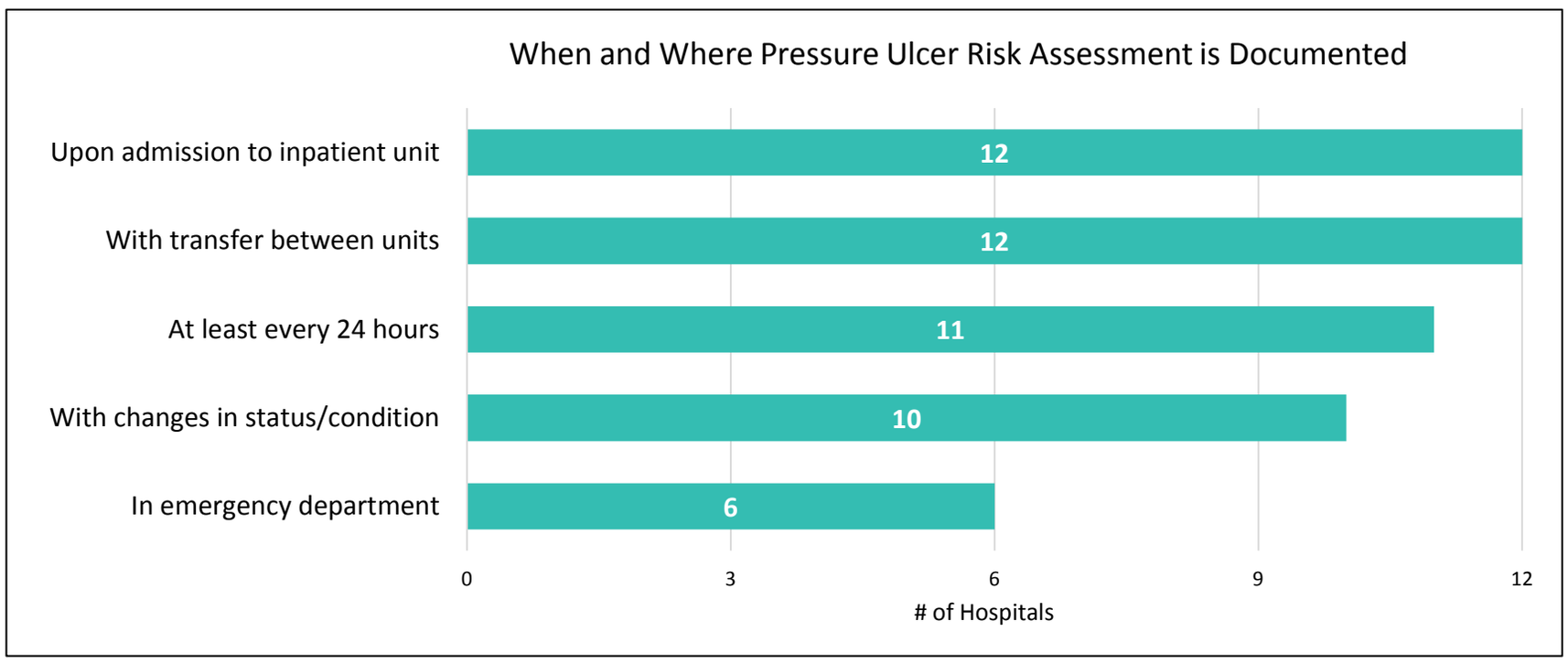
			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	**Sparkline**	**#1**	**#2**	**#3**
Contra Costa Regional Medical Center	Maintained Zero		4 Eye Skin Assessments beginning in the ED for patients with a Braden Score of 18 or less	Every admission from the previous 24 hours is reviewed to make sure skin assessments were done. If PU found, interventions are initiated.	Intentional hourly rounding on patients at high risk for pressure ulcers
Alameda Health System - Highland Campus	-100		Education of MDs and RNs on a variety of topics	Implementation of a dedicated mobility (turn) team	Standardization of effective wound care products
Santa Clara Valley Medical Center	-100		Skin Care Champions responsible for education, classes, inservices, and competency day	HAPU Leadership Committee	PU Tracking Tool
Maricopa Integrated Health System	-100		Skin Champion Team with purpose to educate nursing units on Wound Ostomy Prevention	Turn Team with goal to identify high risk patients to routinely turn and do a skin and linen assessment every 2 hours	Ensuring patient/staff/family aware of risk through patient care notes printed prior to patient discharge

Notes: Performance based on AHRQ PSI-3 collected through UHC CDB/CDB-lite. The baseline is 2010 for all, except Contra Costa, which has a baseline of Q3'12 to Q2'13. The performance period is Q2'14 for all. Sparklines show trend over time from baseline to Q2'14.

With limited staffing... The majority surveyed have one or less full-time equivalent (FTE) certified wound care specialist.



Beyond once... Risk is assessed at numerous points of care and for half of those surveyed in the emergency department.



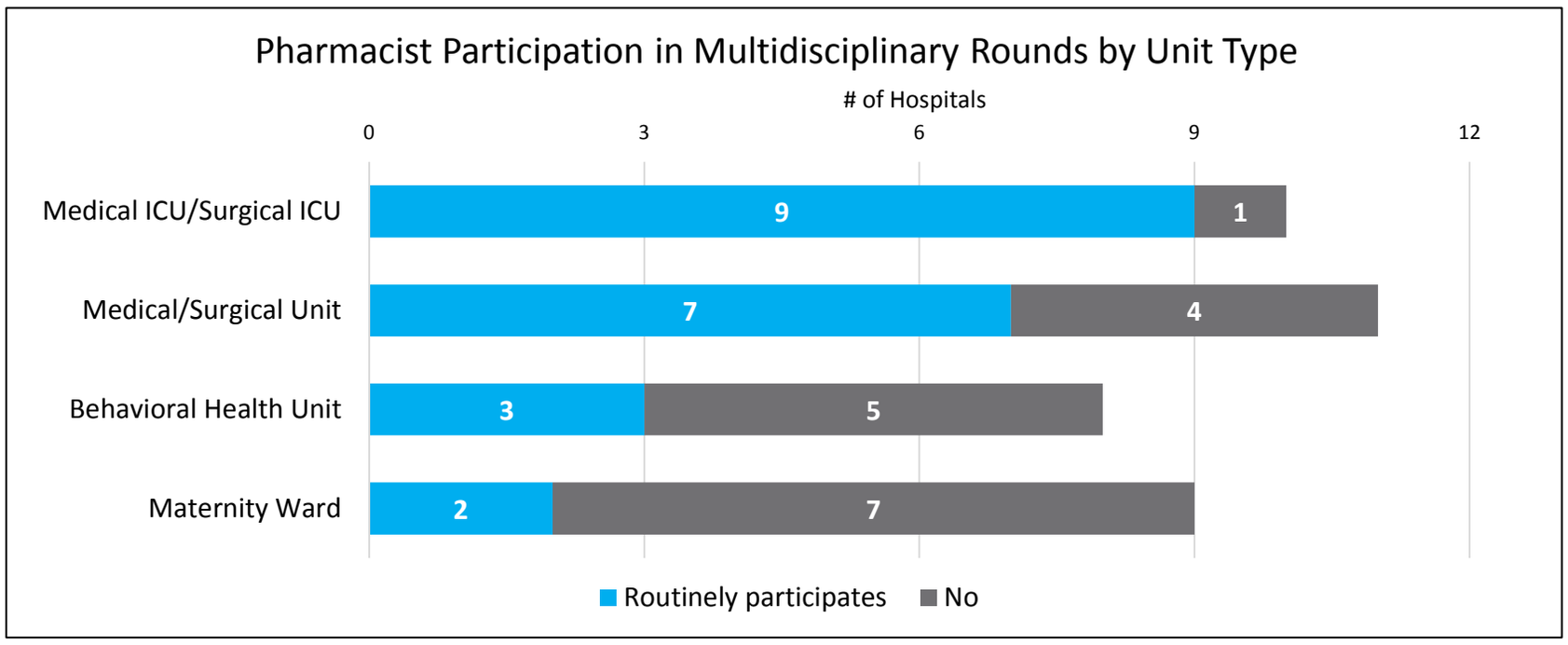
ADE: Best Practice Survey Highlights

In their own words... Top three effective ADE prevention strategies in the past 18 months from top performers.

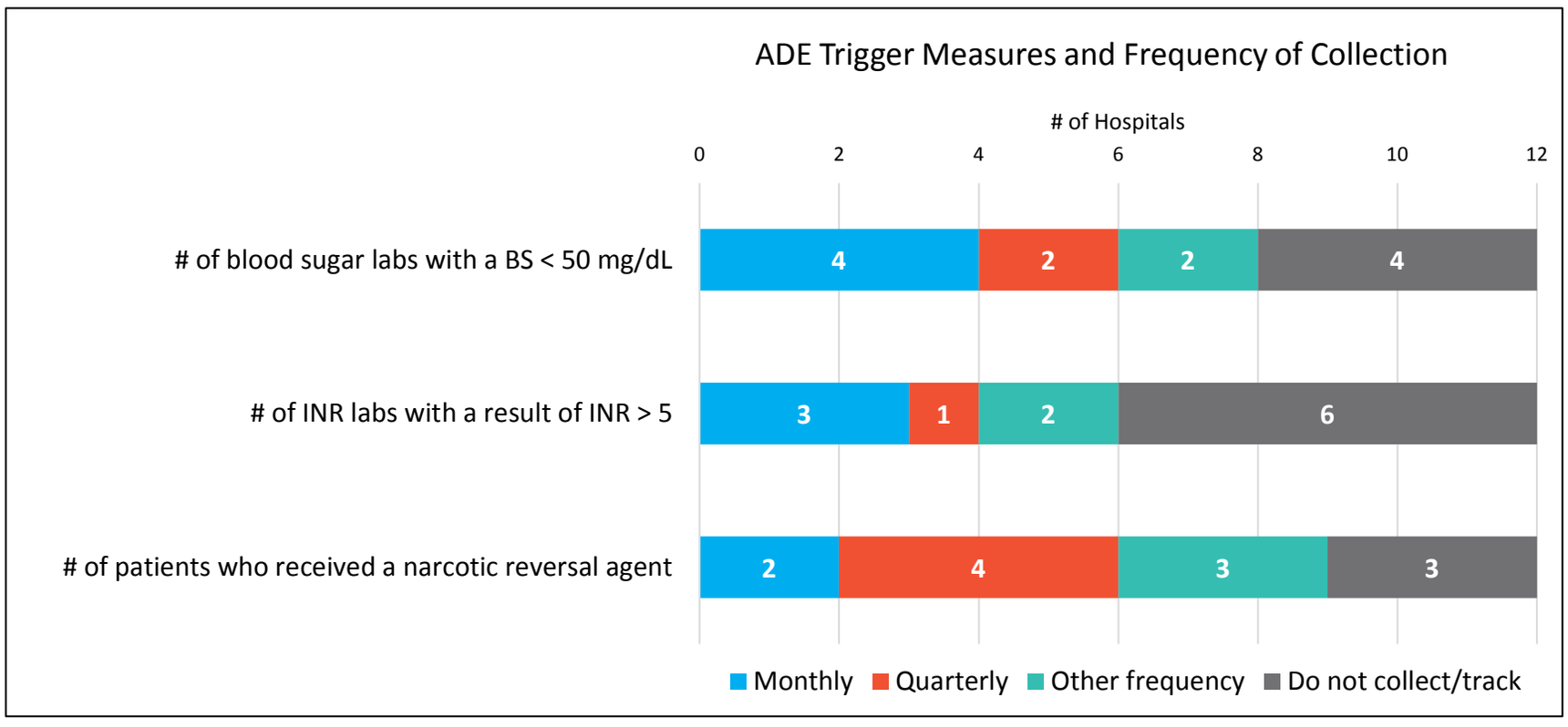
			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	**Sparkline**	**#1**	**#2**	**#3**
San Francisco General Hospital and Trauma Center	-50		Implemented metric unit as standard measurement	Policy and procedure for safe use of fentanyl patches implemented	Electronic medication reconciliation module and ePDP/Discharge module implementation
Maricopa Integrated Health System	-28.8		Implemented pop-up alerts for any time certain medications are administered (e.g. reversal agents alert state "if in response to ADE enter report")	Started asking students/residents to query during round "any ADEs to report"	
Truman Medical Centers-Hospital Hill	-9.3		Lower doses of narcotics	Daily INR monitoring by pharmacy	Bar coding technology
MetroHealth System	0		Minimize choice of pain medication per pain range	Opioid conversion chart placed in EPIC as a resource	Double checks for high risk medications with a sign off in EPIC

Notes: Performance based on All ADE data received through the Web Portal. The baseline is the first six months of reported data, and the performance period for all is Q2'14. Sparklines show trend over time from baseline to Q2'14.

With regards to collaboration... Clinical pharmacists do not as routinely participate in multidisciplinary rounds in behavioral and maternity units compared to others.

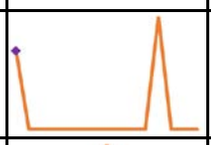


Because of data challenges... Only two hospitals collect and report all three ADE trigger measures on a monthly basis.



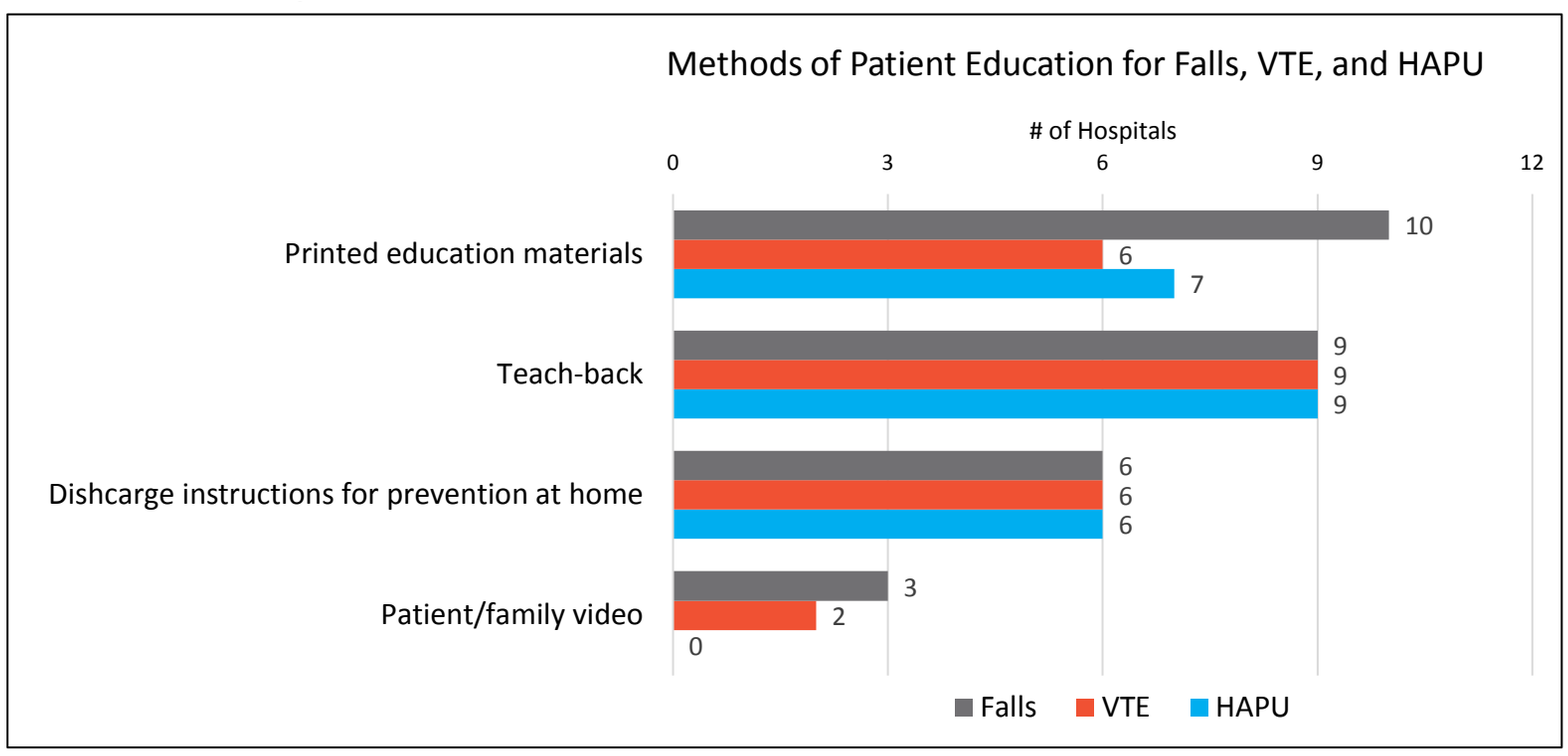
VTE: Best Practice Survey Highlights

In their own words... Top three effective VTE prevention strategies in the past 18 months from top performers.

			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	Sparkline	#1	#2	#3
San Mateo Medical Center	-100		Mandatory documentation	Automatic orders	Communication at meetings
Contra Costa Regional Medical Center	-100		Tripling the number of available sequential compression devices for inpatients	Daily auditing for compliance of DVT prophylaxis	
Rancho Los Amigos National Rehabilitation Center	-27		Uniform admission order set	Appropriate prophylaxis option list	Part of admission sign outs

Notes: Performance based on modified AHRQ PSI-12 data gathered from UHC's CDB/CDB-lite. The baseline is 2010 for all, except Contra Costa, which has a Q3'12-Q2'13 baseline. The performance period for all is Q2'14. Sparklines show trend over time from baseline to Q2'14.

About educating patients and families... Printed materials, teach-back, and discharge instructions for prevention at home are as common for VTE as they are for HAPU and Falls.



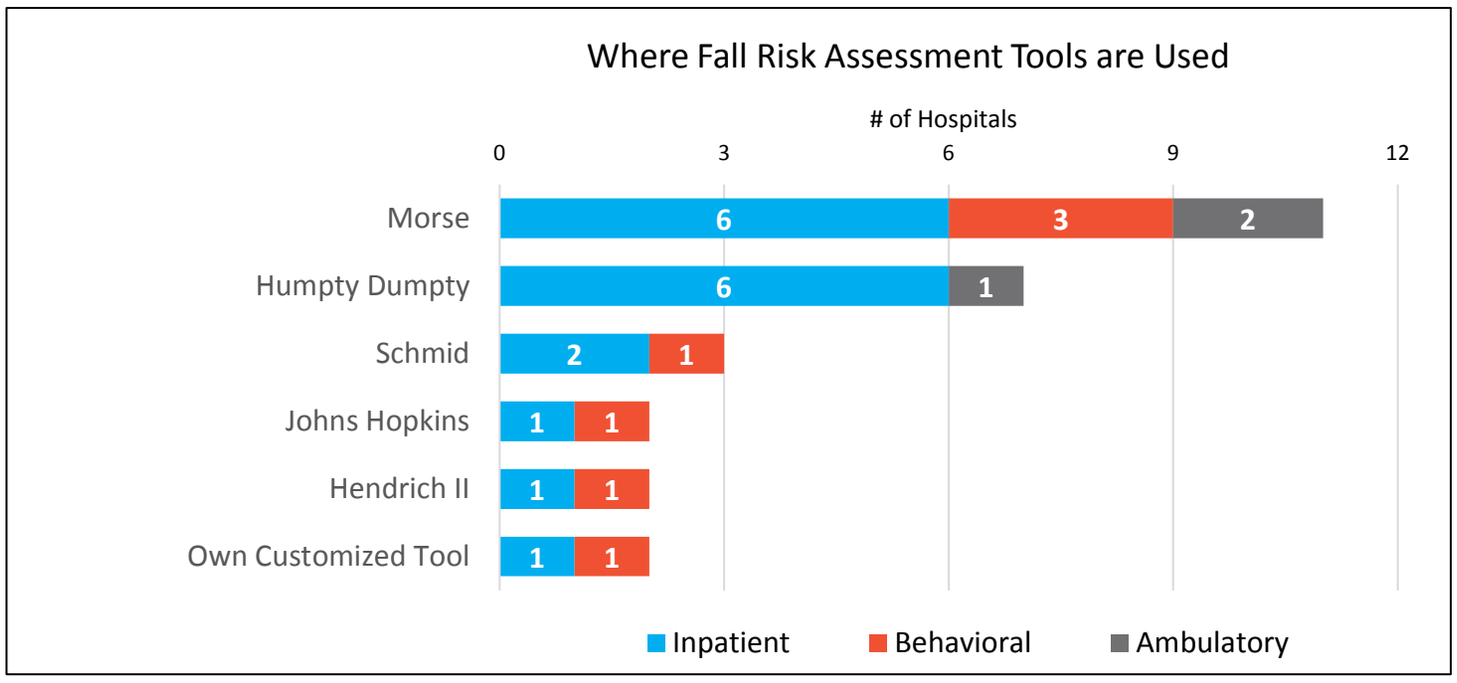
Falls: Best Practice Survey Highlights

In their own words... Top three effective Falls prevention strategies in the past 18 months from top performers.

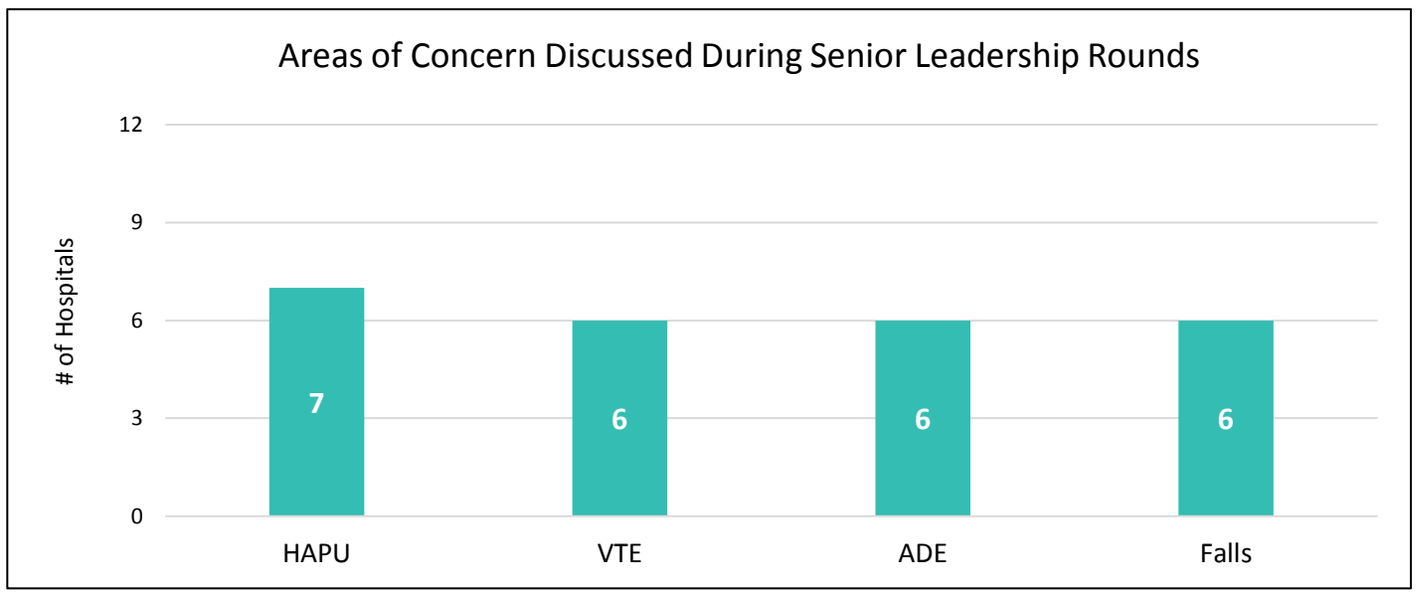
			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	Sparkline	#1	#2	#3
Rancho Los Amigos National Rehabilitation Center	-16.3		The safe zone	Post fall huddle	Supervision while toileting
Harbor-UCLA Medical Center	-15.8		Hourly rounding	Fall debriefing after every fall	Quality & safety boards on each unit with that unit's total monthly falls and lessons learned
Regional One Health	-5		Rounding for the 3 P's (pain, position, and potty)	Utilizing patient sitters or encouraging family to stay	Obtaining bed alarms

Notes: Performance based on All Fall Rate data collected through the Web Portal. The baseline is six months of data, and the performance period is Q2'14 for all. Sparklines show trend over time from baseline to Q2'14.

Out of many risk assessment tools... Morse and Humpty Dumpty stand out as the most predominately used.



Of equal concern to leaders... Falls is discussed on senior leadership rounds as often as VTE, ADE, and HAPU.



Essential Hospitals Engagement Network (EHEN)

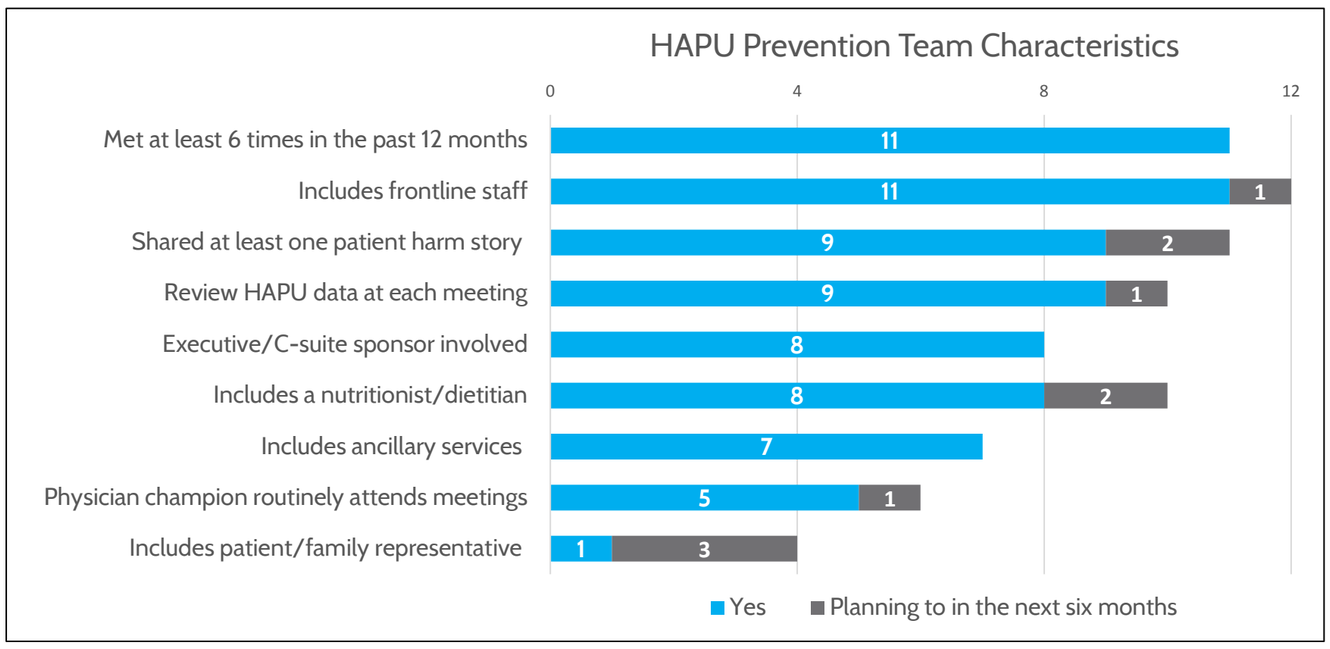
Best Practices Survey 2014 - Hospital-Acquired Pressure Ulcers (HAPU)

Red Numbers Represent Response (n=12)

1. **Does your facility have a multidisciplinary team (can be an existing committee/team) *actively* working on hospital-acquired pressure ulcer (HAPU) prevention?**

12 Yes
No (Go to Question 3)

2. **Please answer the following for your HAPU prevention team:**



3. **In the past two years, has your organization participated in a state/regional, national, grant-funded or hospitalwide HAPU prevention initiative?**

8 Yes
Name of the initiative: "PFP, EHEN, CALNOC, CALNOC, DSRIP"
4 No

4. **Do you report pressure ulcer data to any benchmarking organization?**

Organization:	Yes	No
NDNQI	**5**	**3**
CALNOC	**6**	**2**
Leapfrog	**3**	**5**

5. **How many certified wound care specialists does your hospital currently employ (number of FTEs)?**

Report .5 FTE	Report 1 FTE	Report 2 FTE	Report >2 FTE
1	**8**	**2**	**1**

6. Do you require and have a designated place to routinely document a skin assessment on patients? Check all that apply.

Practice:	Yes	No
Within six hours of admission to an inpatient unit	9	3
In the emergency department	8	3
At least every 24 hours	12	
With transfer between units	12	
Once per shift	11	1
In the operating room	10	2
In the recovery room	10	2
Return from special procedures (radiology, imaging, etc.)	6	6

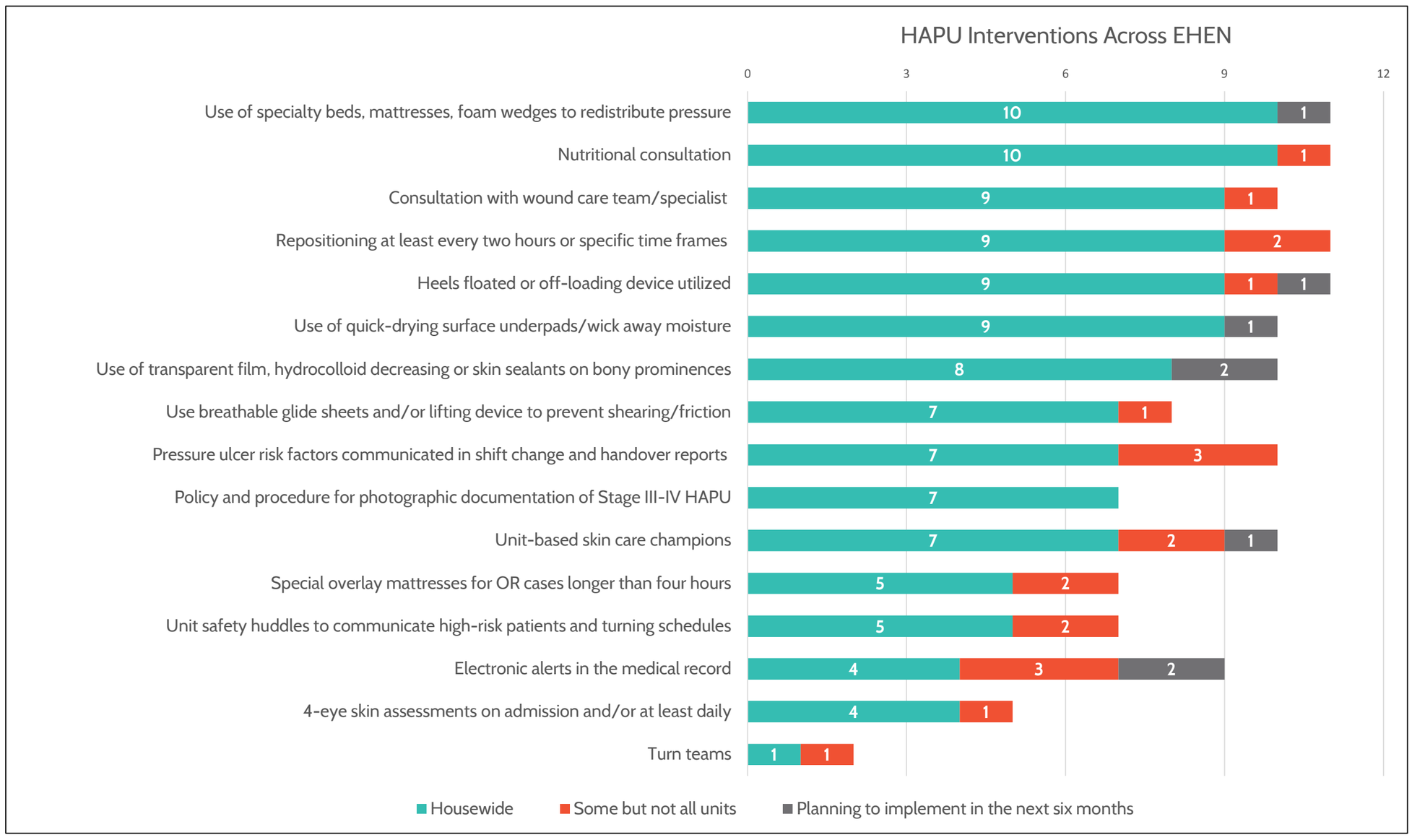
7. Which standardized pressure ulcer risk assessment tool do you use to determine which patients are more likely to develop a pressure ulcer? Check all that apply.

12	Braden
6	Braden Q
	Norton
	Waterlow
1	Hospital-developed tool
	Other:
	We don't use a standardized tool

8. If you use a standardized pressure ulcer risk assessment tool, does your hospital require and have a designated place to document pressure ulcer risk assessment in the medical record/EMR? Check all that apply.

Practice:		Yes	No	Plan to do within next six months
Upon admission to inpatient unit		12		
In emergency department		6	4	
At least every 24 hours		11	1	
With transfer between units		12		
With changes in status/condition		10	2	
Other:	"High risk for entire LOS"; "Every 3-4 hrs on some units"; "Upon transfer to another facility"	3		

9. Pressure ulcer prevention protocols are implemented based on a risk score. For patients assessed as being *at risk* , do you routinely and consistently activate the following interventions? Check all that apply.



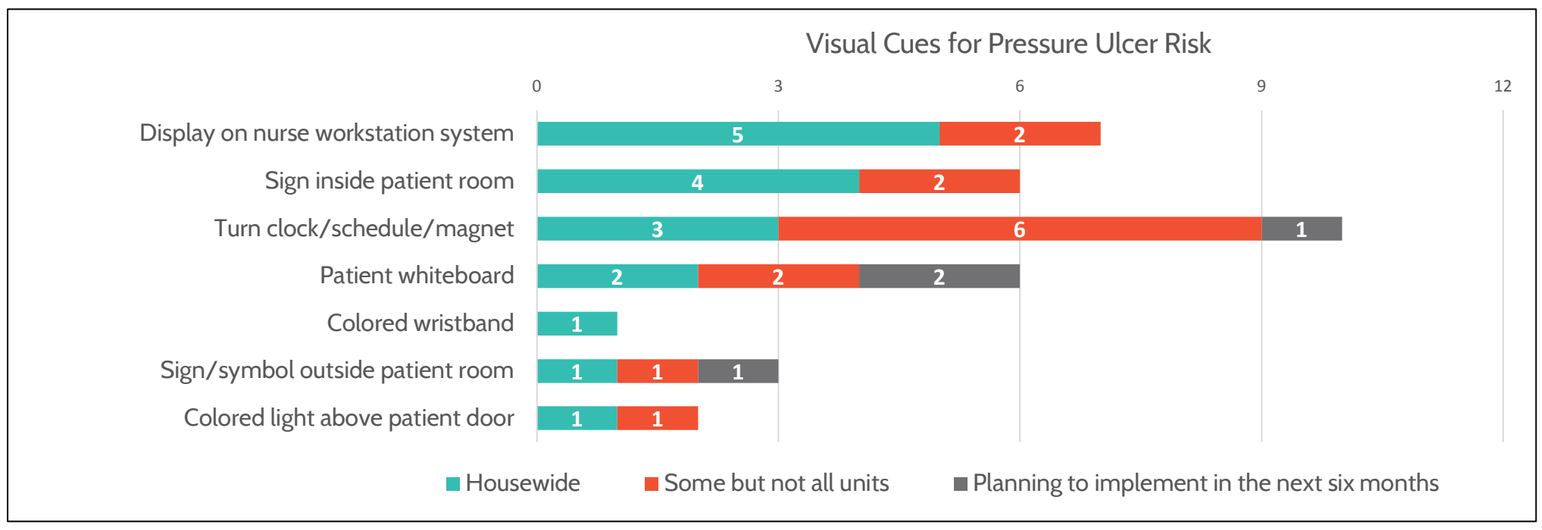
10. When do you complete a skin assessment and/or pressure ulcer risk assessment on surgical patients? Check all that apply.

10	On admission to the operating room
7	At discharge to the recovery room
7	Periodically in the OR for operations lasting more than four hours
8	At discharge to the inpatient unit/critical care unit
1	Other: "In PACU prior to going to OR"

11. Do you do a deep dive or root cause analysis to look for opportunities for improvement? Please check answer.

2	Yes, on all HAPU stage II or greater housewide
5	Yes, on all HAPU stage III, IV, and unstageable housewide
1	Only on HAPU, stage II or greater on selected units
1	Only on HAPU stage III, IV, and unstageable on selected units
2	We do not do RCA/in-depth reviews of HAPU

12. Which of the following visual cues do you use to communicate pressure ulcer risk to patients, families, and staff?



13. Do you complete device-related skin assessments at least every 24 hours?

Unit	Unit Does Not Exist in This Hospital	Device-related skin assessments are completed at least every 24 hours: Yes	Device-related skin assessments are completed at least every 24 hours: No
Medical unit(s)		10	
Surgical unit(s)		10	
Other (non-ICU) specialty units	1	9	
Medical intensive care units (MICU)	1	9	
Surgical intensive care units (SICU)	1	9	
NICU	3	7	
Emergency Department	1	6	3
Other: "Rehab"		1	

14. Is the development of new/hospital-acquired pressure ulcers included as an area of concern during senior leadership rounds?

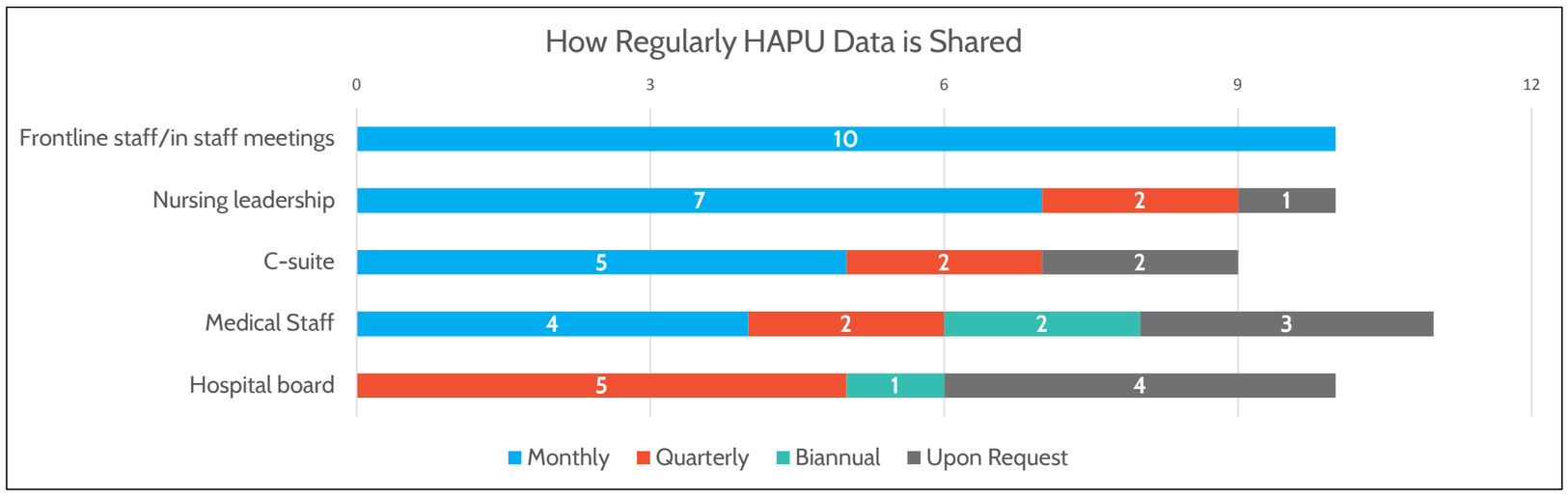
5	Yes
2	No
2	Yes, but only on some units
2	We do not do senior leadership rounds

15. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three top interventions/strategies for reducing HAPU you have implemented in the past 18 months

Section 8: Hospital-Acquired Pressure Ulcers (HAPU)

Return to Quick Link Navigation

16. How do you share data on hospital-acquired pressure ulcers on a regular basis to promote systemwide learning and transparency? Check the best answer for each.



17. Which methods do you use to display HAPU data in your hospital?

Method	ICU unit(s)		Medical/surgical unit(s)		Method not used
	Staff-only accessible areas	Public areas such as hallways	Staff-only accessible areas	Public areas such as hallways	
Run charts	3	4	4	3	4
Control charts	1	2	1	2	7
Bar graphs/pie charts	4	4	4	3	3
Harm counts	1	2	1	3	5
Days between HAPUs	1	1	1	2	5
Other: "Months since last HAPU"; "Line Graphs"	1	1	2	2	

18. How do you educate patients and families about the pressure ulcer risks and prevention measures? Please check all that apply.

- 7 Printed education materials
- 0 Patient/family video
- 9 Teach-back process
- 8 Designated place for and required documentation of pressure ulcer prevention education we provided to patients and family members
- 6 Discharge instructions include pressure ulcer prevention strategies at home
- 2 Other: "We encourage all patients to take their waffle mattresses/cushions home"; "WCOCN/Nurses provide patient education"

19. When do you provide education to nursing staff on HAPU prevention, such as how to perform, document, and communicate pressure ulcer risk assessment results? Check all that apply.

- 11 During new employee orientation
- 8 Annually
- 5 Other: "Depends on Unit need"; "Quarterly"; "Monthly"; "Skills fair and competencies"

Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Adverse Drug Events

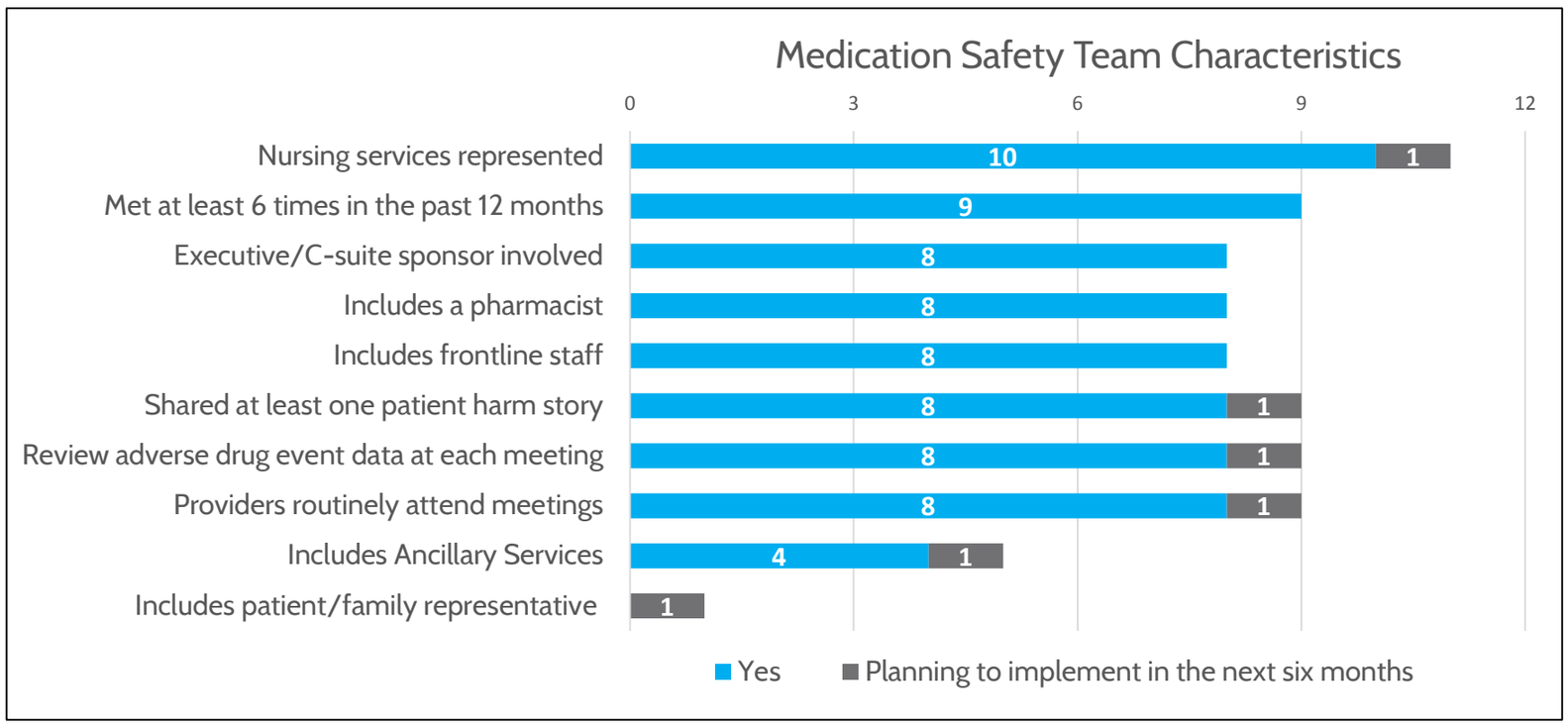
Red Numbers Represent Responses (n=12)

Section 5: Adverse Drug Events (ADE)

1. **Does your facility have a multidisciplinary team (can be an existing committee/team) *actively* working to address medication safety?**

10	Yes
2	No (Go to Question 3)

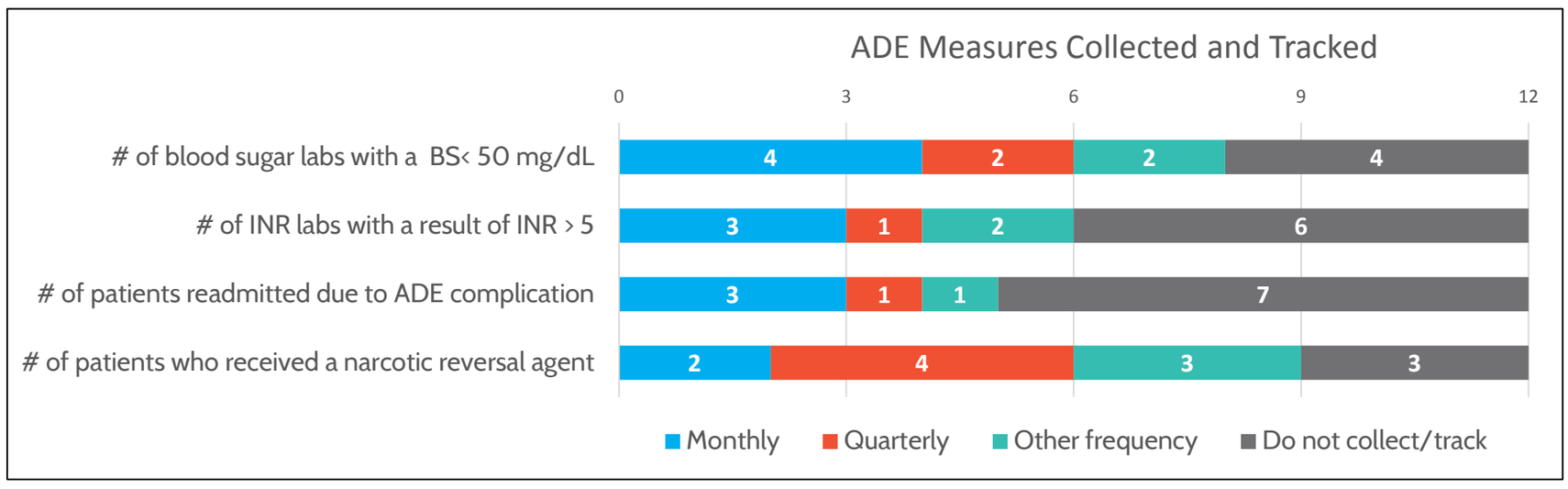
2. **Please answer the following for your medication safety team:**



3. **In the past two years, has your organization participated in a state/regional, national, grant-funded or hospitalwide medication safety initiative?**

8	Yes
	Name of the initiative:
3	No

4. **Our hospital collects and tracks data on the following adverse drug events on a routine basis. Check all that apply.**

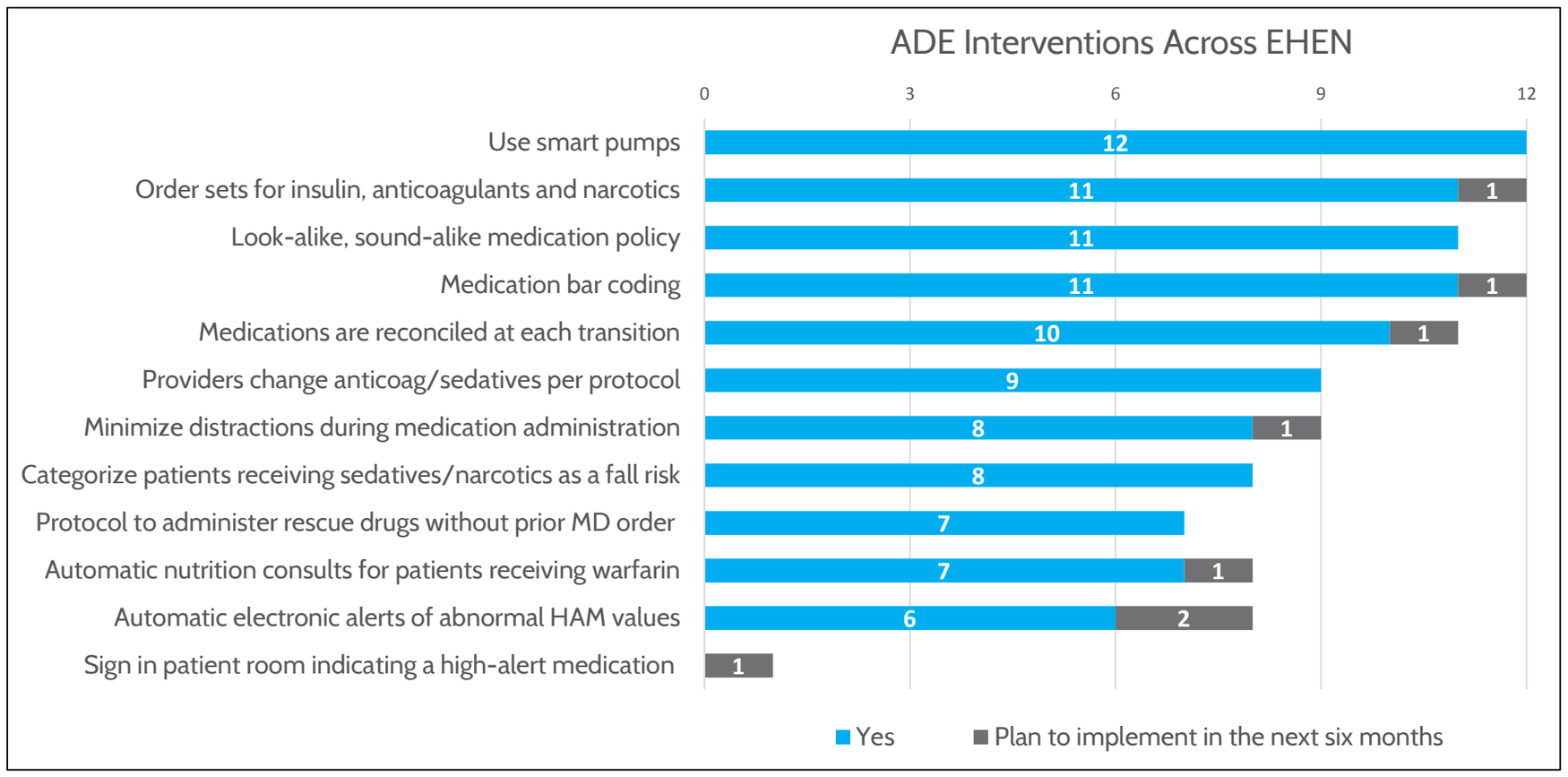


5. **Do you do a deep dive or root cause analysis to look for opportunities for improvement? Please check answer.**

4	Yes, on all adverse drug events, housewide
7	Only on selected adverse drug events, housewide
1	Only on selected adverse drug events on specific units
	We do not do RCA/in-depth reviews of ADEs

Section 5: Adverse Drug Events (ADE)

6. High-alert medications (HAMs) are associated with harm. Our hospital has implemented the following practices to prevent HAM-related ADEs.



7. Our hospital uses the following methods to enhance organizational awareness of adverse drug events: (check all that apply)

- 8 The Institute for Safe Medication Practices (ISMP) Medication Safety Self-Assessment at least annually
- 6 Medication trigger tool
- 10 Reports for medication errors/near misses
- Other:

8. For each unit, please indicate if a clinical pharmacist routinely participates in multidisciplinary rounds:

		Clinical pharmacist participates in rounds		
Unit	**Unit does not exist in this hospital**	**Yes**		**No**
Behavioral health (substance abuse, mental health, psychiatric)	3	3		5
Medical unit(s)		7		4
Surgical unit(s)		5		6
Other (non-ICU) specialty units	2	6		2
Medical intensive care units (MICU)	1	9		1
Surgical intensive care units (SICU)	2	8		1
Maternity ward(s)	1	2		7
Other: Stroger-NICU, Contra Costa-Palliative Care rounds		3		1

Section 5: Adverse Drug Events (ADE)

9. Our hospital uses the following strategies to prevent *Clostridium difficile* (CDI):

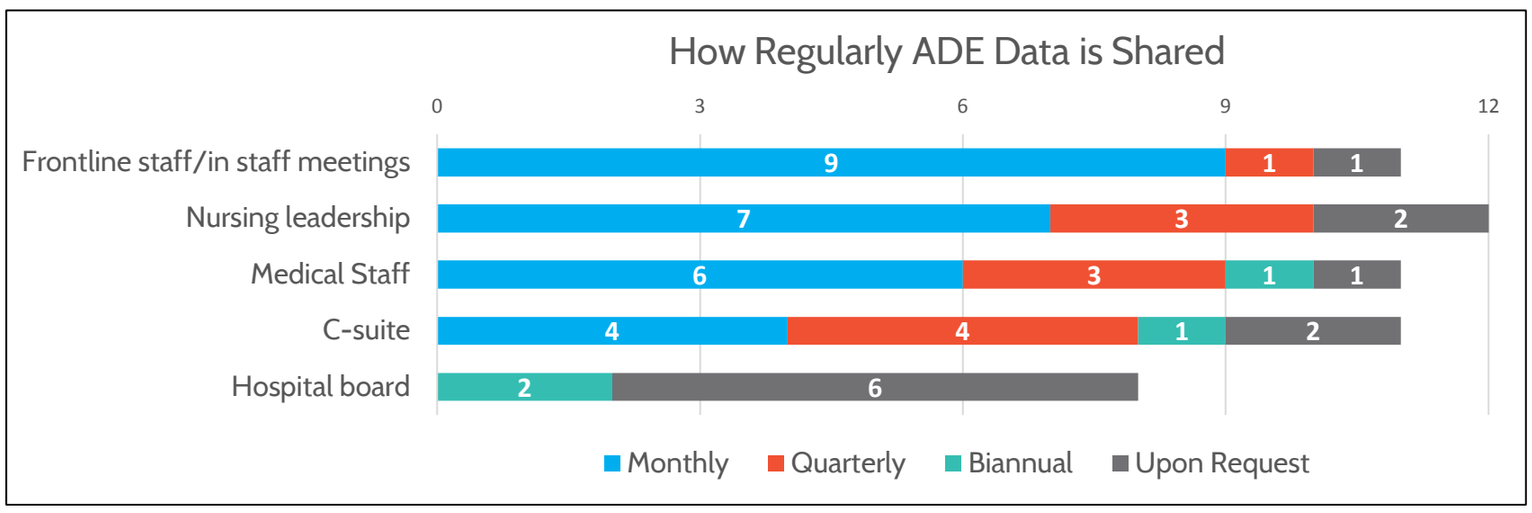
Interventions	Yes	No	Planning to implement in the next six months	Intervention not used; no plans to implement
Nurses are trained to recognize signs/symptoms of CDI	8		1	
Contact precautions implemented	9			
Antibiotic stewardship for CDI	10			
Chlorine-containing or other sporicidal product/technology is used for daily	6		1	
Hand hygiene, gloves, and gown required for all health care workers and visitors entering room	9			
Use dedicated equipment for CDI patients	5	1		
Nursing and environmental services staffs receive regular training on appropriate disinfection and cleaning techniques for CDI	7	1		
Private room for CDI patient or cohorting if private room unavailable	8			
Review all cases of CDI for improvement	4	1		1
Electronic alerts in the medical record	2	3	1	
CDI included in nurse shift handoff	7			
Patient and family education is provided on CDI	6			

10. Is harm from adverse drug events included as an area of concern during senior leadership rounds?

- 6 Yes
- 2 No
- 4 We do not do senior leadership rounds

11. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for reducing adverse drug events you have implemented in the past 18 months.

12. ADE data are shared on a regular basis to promote systemwide learning and transparency. Select the best answer for each.



13. How do you educate patients and families about potential adverse drug events? Check all that apply.

- 10 Printed education materials
- 2 Patient/family video
- 6 Teach-back process
- 5 We have a designated place for and required documentation of ADE education we provide to patients and family members

Section 5: Adverse Drug Events (ADE)

14. When do you provide education to health care personnel on ADEs for high-alert medications? Check all that apply.

12	During new employee orientation
6	During new physician/resident orientation
3	Annually
9	When new relevant information is available
	Other:

Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Venous Thromboembolism

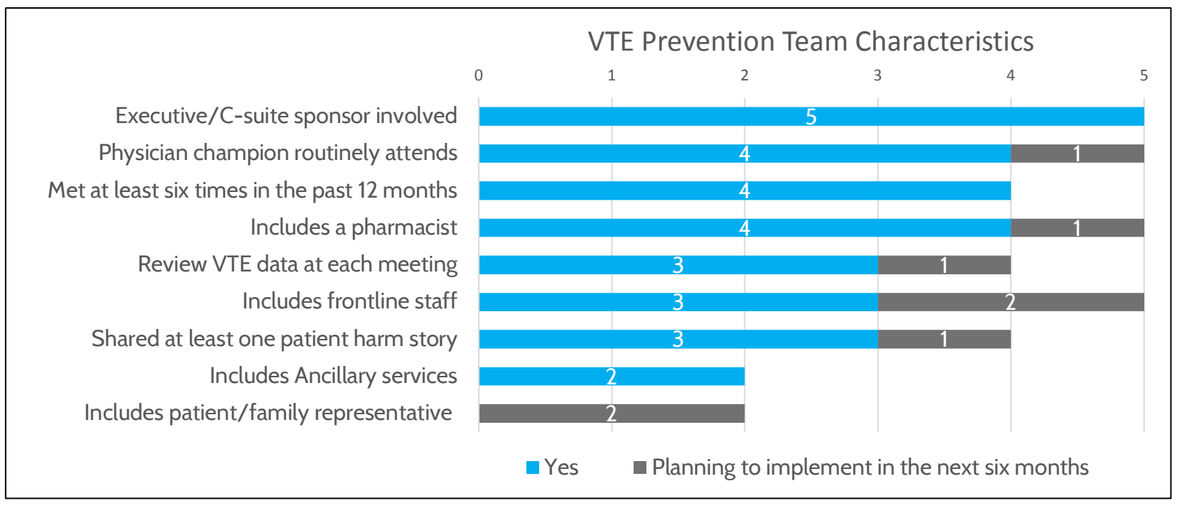
Red Numbers Represent Responses (n=12)

Section 7: Venous Thromboembolism (VTE)

1. Does your facility have a multidisciplinary team (can be an existing committee/team) *actively* working on hospital-acquired venous thromboembolism (VTE) prevention?

5	Yes
6	No (Go to Question 3)

2. Please answer the following for your VTE prevention team:



3. In the past two years, has your organization participated in a state/regional, national, grant-funded or hospitalwide VTE prevention initiative?

4	Yes, name of initiative: "DSRIP"
6	No

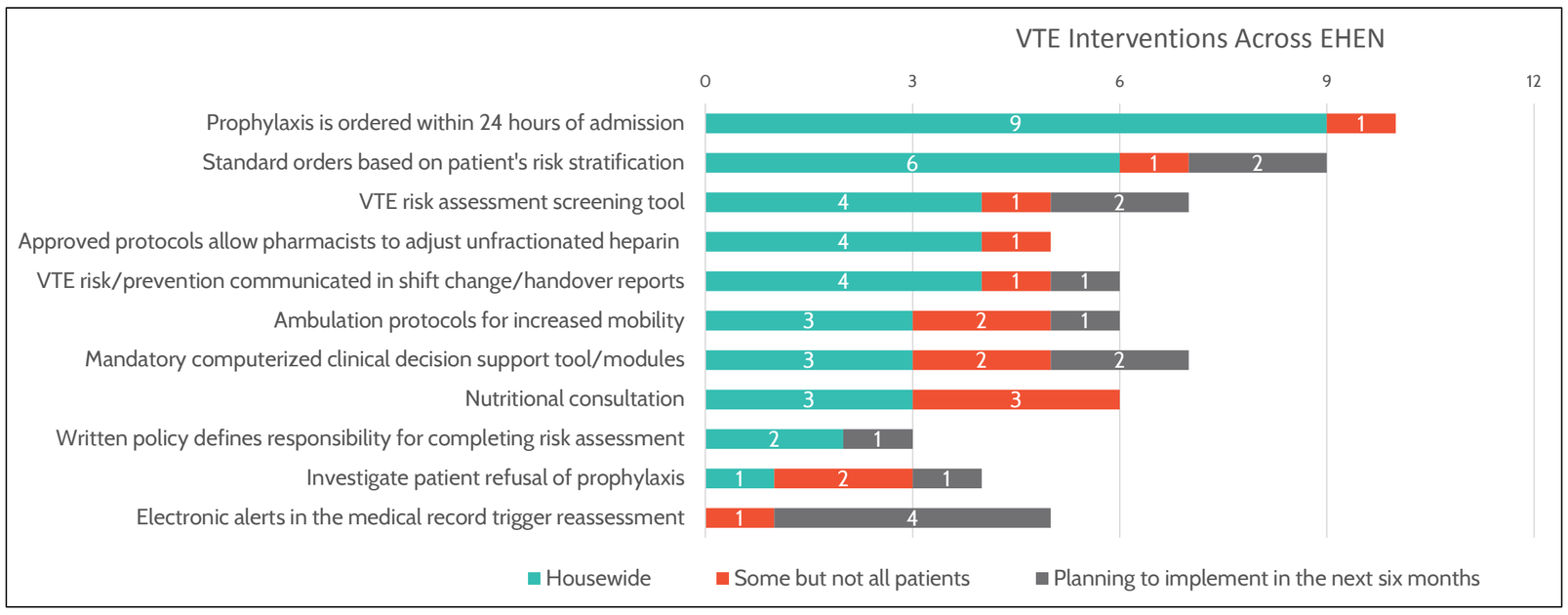
4. Do you require and have a designated place in the medical record to routinely document a VTE risk assessment?

Practice	All Adult Patients	Only Service-Specific Patients	No
Upon hospital admission	**6**	**1**	**3**
At change in level of care	**4**		**6**
Re-assessed within 24 hours of admission	**3**		**7**
Post-surgical procedures	**4**	**1**	**5**

5. Our VTE protocol includes the following: Check all that apply

7	A standardized risk assessment
8	Menu of appropriate pharmacologic prophylaxis options based on risk
7	Method to determine contraindications to pharmacologic VTE prophylaxis
10	Mechanical prophylaxis options
	Other:
	We do not have a VTE protocol

6. Interventions aimed at preventing hospital-acquired VTE are routinely and consistently activated. Select the best response for each intervention.



7. Does VTE prophylaxis begin in the Emergency Department for boarded patients awaiting bed placement?

5	Yes
3	No
1	Working to implement within the next six months

Section 7: Venous Thromboembolism (VTE)

8. Do you do a deep dive or root cause analysis to look for opportunities for improvement?

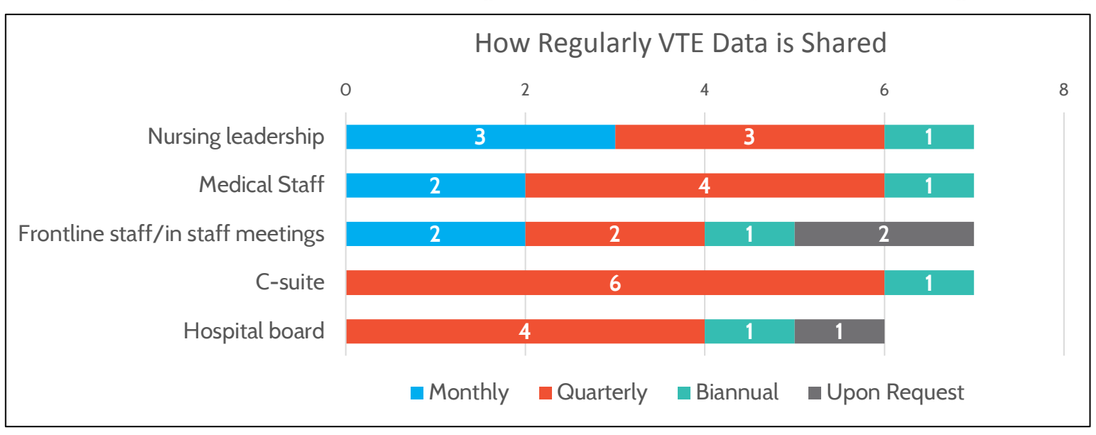
3	Yes, on all hospital-acquired VTEs, housewide
4	Only on targeted post-surgical cases
1	We do not do RCA/in-depth reviews of VTE

9. Is the development of hospital-acquired VTE included as an area of concern during senior leadership rounds?

2	Yes, all units
4	Yes, but only on some units
	No
3	We do not do senior leadership rounds

10. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for reducing hospital-acquired VTE you have implemented in the past 18 months.

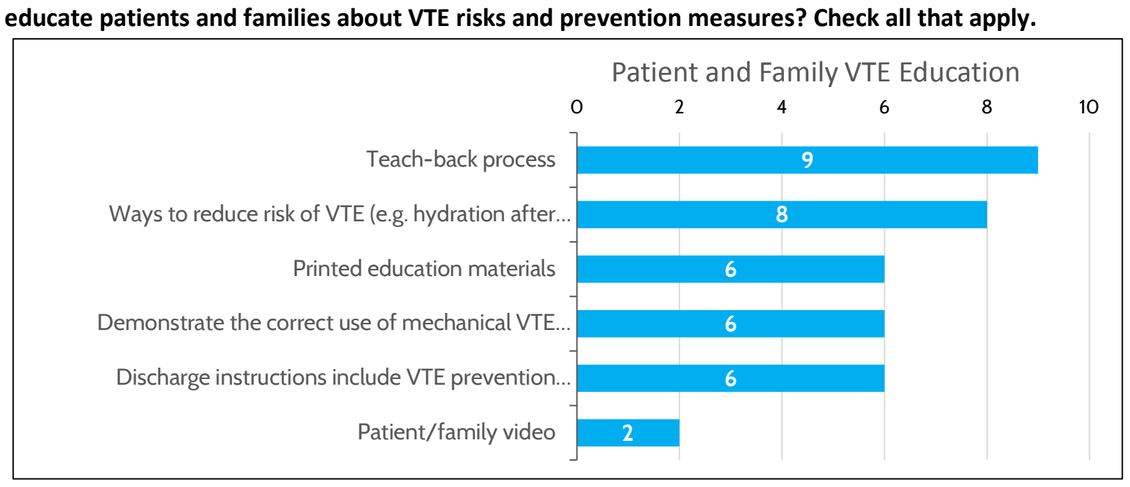
11. How do you share data on hospital-acquired VTE on a regular basis to promote systemwide learning and transparency? Select the best answer for each.



12. Which methods do you use to display VTE data in your hospital? Select all that apply.

Method	ICU unit(s)		Medical/surgical unit(s)		Method not used
	Staff-only accessible areas	Public areas (e.g. hallways)	Staff-only accessible areas	Public areas (e.g. hallways)	
Run charts	1		1		5
Control charts					7
Bar graphs/pie charts	1		1		7
Harm counts		2		2	5
Days between falls					5
Other: Regional One- Chart that is a daily drill down on all patients receiveing heparin; data includes bolus information and rate changes	1		1		

13. How do you educate patients and families about VTE risks and prevention measures? Check all that apply.



14. When do you provide education to nursing staff on VTE prevention? Check all that apply.

7	During new employee orientation
3	Annually
3	Other: "As needed"; "Unit council meetings"

Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Falls

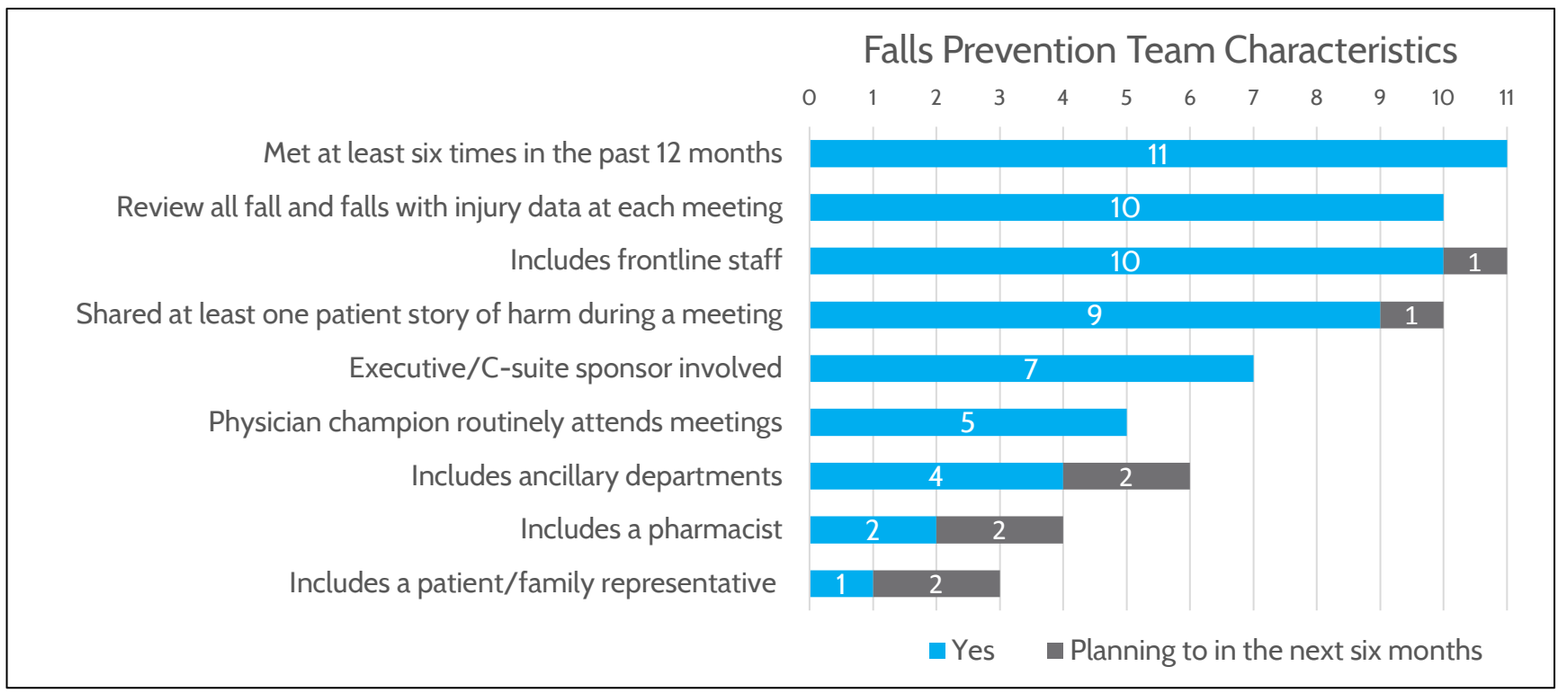
Red Numbers Represent Responses (n=12)

Section 6: Falls

1. Does your facility have a multidisciplinary team (can be an existing committee/team) *actively* working on falls prevention?

11	Yes
1	No (Go to Question 3)

2. Please answer the following for your falls prevention team:



3. Do you report falls/falls with injury data to any benchmarking organization?

Organization:	All Falls	Falls with Injury
NDNQI	**6**	**4**
CALNOC	**4**	**2**
Other	**2**	**2**

4. In the past two years, has your organization participated in a state/regional, national, grant-funded or hospitalwide falls prevention initiative?

8	Yes
	Name of the initiative:
4	No

5. Which standardized falls risk assessment tool do you use in your organization?

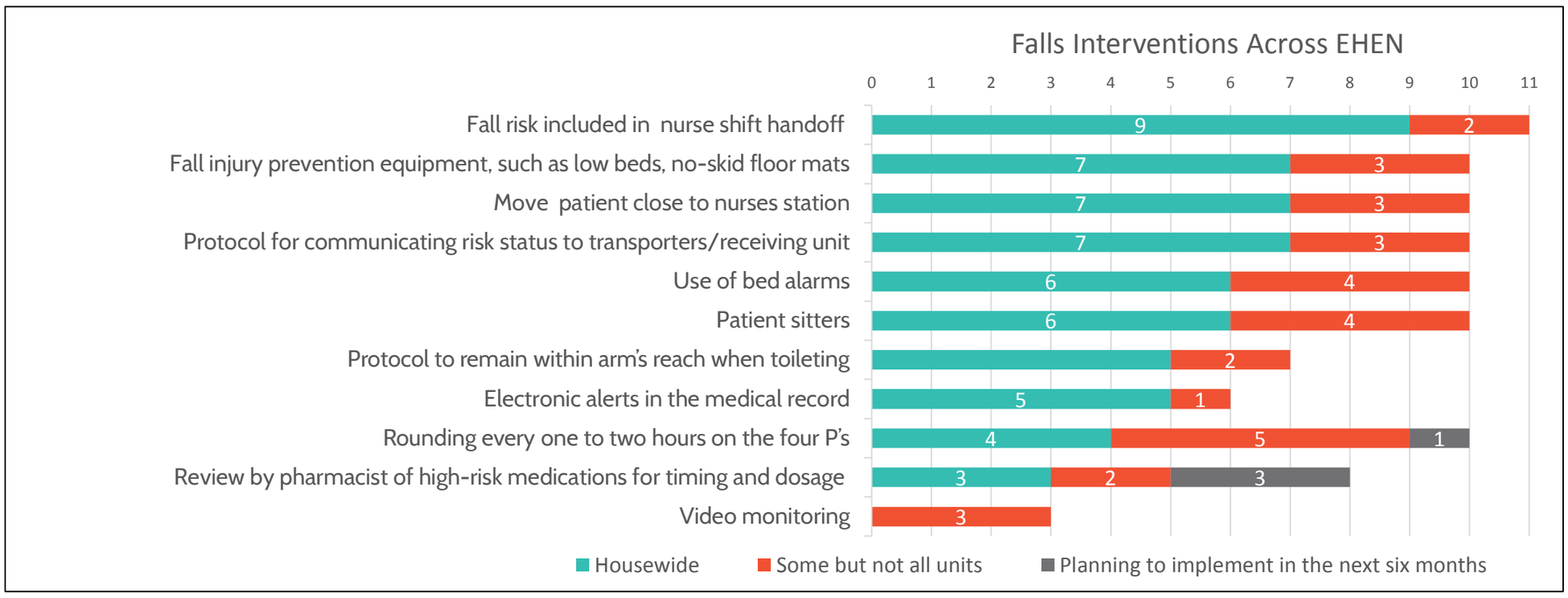
	Location Type		
Fall Risk Assessment	**Inpatient Units**	**Ambulatory Settings**	**Behavioral Health**
Morse	**6**	**2**	**3**
Hendrich II	**1**		**1**
Schmid	**2**		**1**
Get Up and Go/Timed			
STRATIFY			
Johns Hopkins	**1**		**1**
Humpty Dumpty	**6**	**1**	
Our own customized tool	**1**		**1**
Other: Regional One-"Modified Morse Scale"	**1**	**2**	

Section 6: Falls

6. Do you require and have a designated place to document screening/rescreening of patient fall risk?

Practice:	Yes	No
Upon admission to an inpatient unit	11	
In the emergency department	8	1
At least every 24 hours	10	1
With transfer between units	11	
With changes in status/condition (e.g. post-procedure, high-risk medication changes)	11	
Post-fall	11	

7. For patients assessed as high-risk for falls, do you routinely and consistently activate the following interventions? Check all that apply.



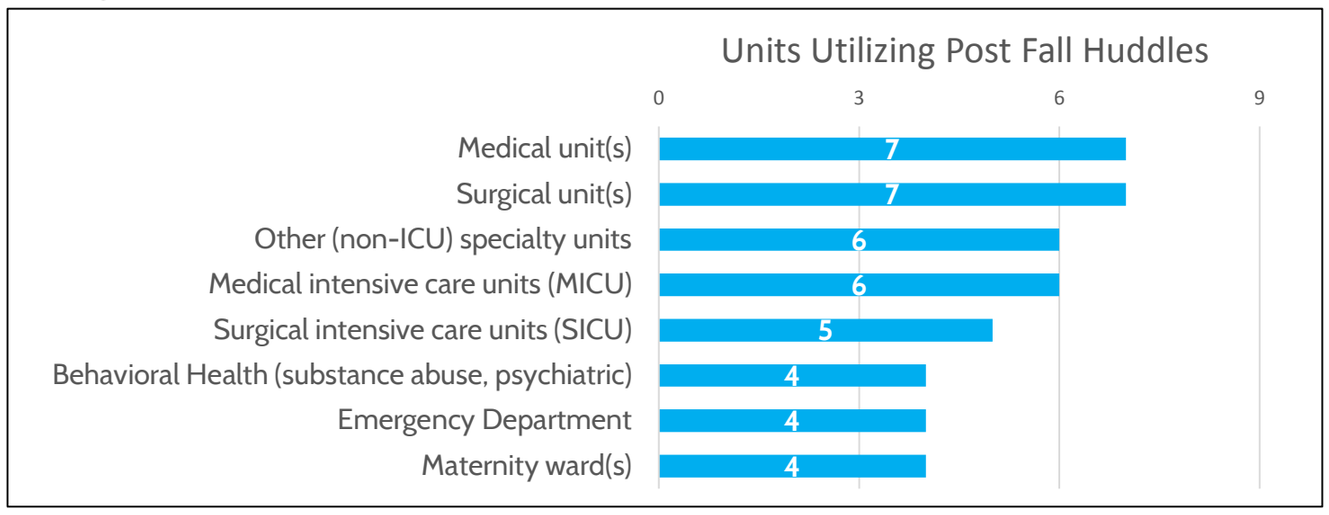
8. Do you do a deep dive or root cause analysis to look for opportunities for improvement? Please check answer.

3	Yes, on all falls housewide
2	Only falls on selected units
2	Only falls with injury, housewide
3	Only falls with injury, on selected units
1	We do not do RCA/in-depth reviews of falls

9. Do you have a process in place to conduct a post-fall safety huddle after a fall occurs?

8	Yes, all falls
1	Yes, but only falls with injury
	Plan to implement in the next six months
2	No

10. If you answered yes for all falls or only falls with injury on Question 9, for each unit please indicate if post-fall huddles occur immediately after an event:



Section 6: Falls

11. Which visual cues do you use to communicate falls risk to patients, families, and staff?

Visual cue	Housewide	Some but not all units	Planning to implement in the next 6 months	Intervention not used; no plans to implement
Wristband	6	3		1
Colored socks	3	1		6
Sign outside patient room (e.g. falling star)	9			2
Sign inside patient room	8	2		1
Colored gown		2		8
Display on nurse workstation system	2	1	1	6
Colored light above patient door	1	1		8
Other:				

12. Is harm from falls included as an area of concern during senior leadership rounds?

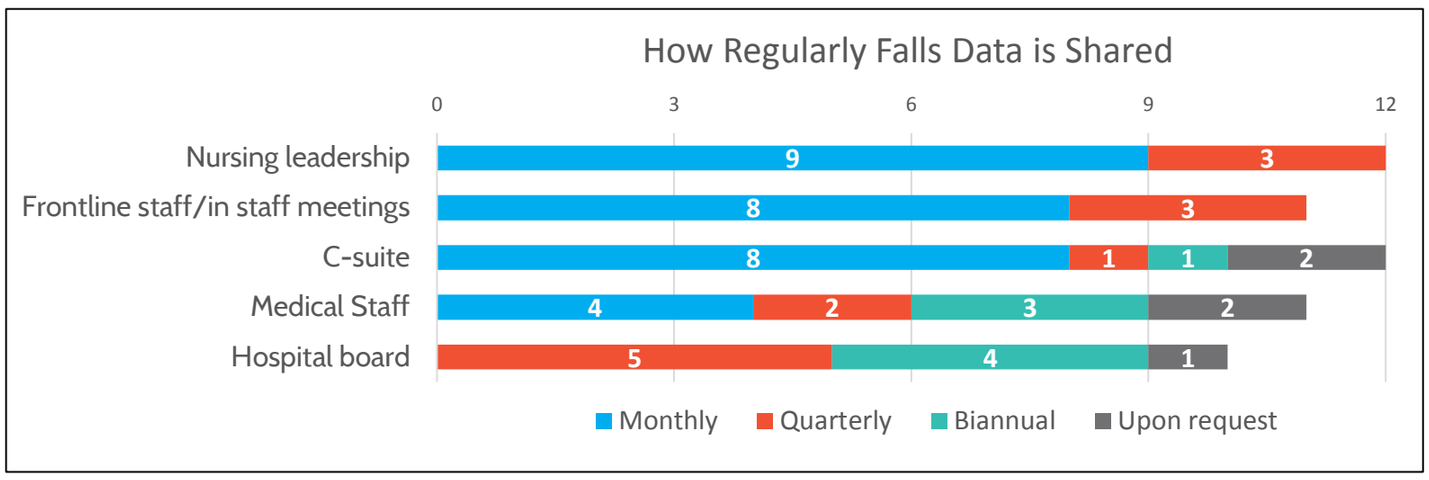
6	Yes
2	No
	Yes, but only on some units
3	We do not do senior leadership rounds

13. Has your hospital implemented a "No Pass Zone" initiative, where all employees are expected to respond to patient call lights?

1	Yes
1	Plans are in place to implement in the next six months
9	No

14. Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three most effective interventions/strategies for reducing falls/falls with injury you have implemented in the past 18 months.

15. How do you share data on falls/falls with injury on a regular basis to promote systemwide learning and transparency? Select the best answer for each.

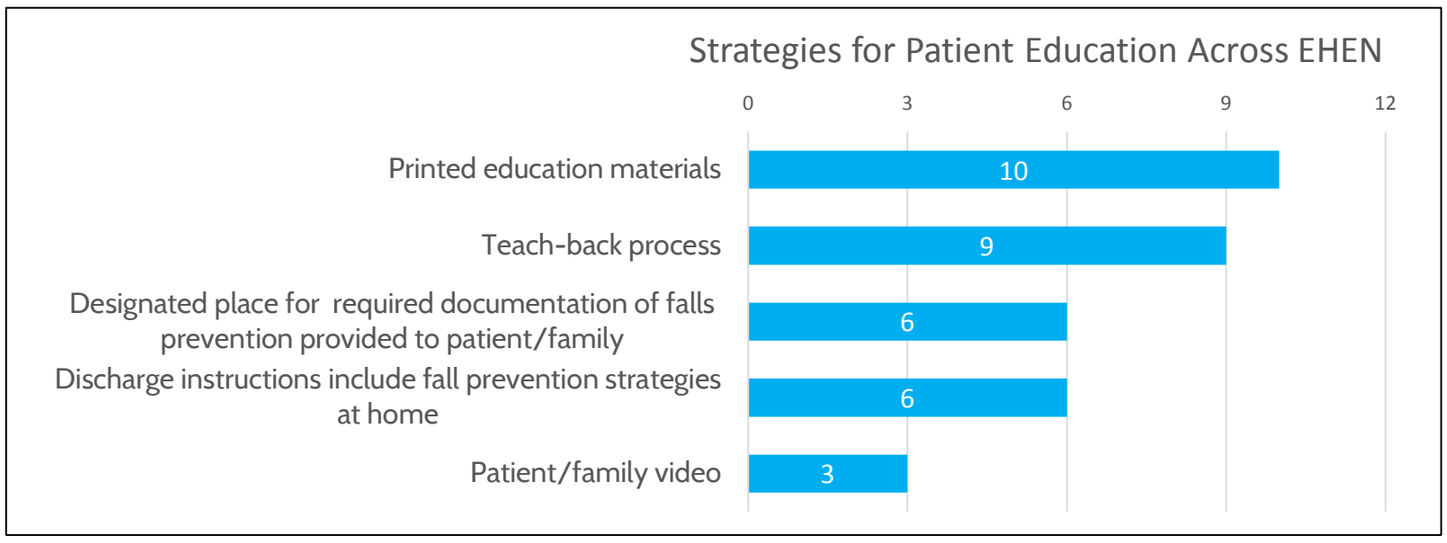


16. Which methods are used to display falls or falls with injury data in your hospital? Check all that apply.

Method	ICU unit(s)		Medical/surgical unit(s)		Method not used
	Staff-only accessible areas	Public areas (e.g. hallways)	Staff-only accessible areas	Public areas (e.g. hallways)	
Run charts	2	3	3	3	5
Control charts	1	2	1	2	6
Bar graphs/pie charts	2	1	2	2	2
Harm counts	2	5	1	4	3
Days between falls	1	3	1	2	4
Other:	1	2	1	2	

Section 6: Falls

17. How do you educate patients and families about fall risks and prevention measures? Please check all that apply.



18. When do you provide education to nursing staff on falls prevention, such as on how to perform, document, and communicate fall risk assessments results? Check all that apply.

12 During new employee orientation
7 Annually
5 Other: Rancho Los Amigos-"DHS and Orientation manual, hospital wide inservice education"
Maricopa-"During unit huddle when implementing some of the new interventions"
Harbor UCLA-"Skills Fair, DHS competencies"
Truman Medical Centers-"skills verification"
San Mateo-"Staff meetings and inservices"