AGENDA

Quality, Patient Care and Patient Experience Committee Meeting of the El Camino Hospital Board

Monday, February 1st, 2016, 5:30 p.m.
El Camino Hospital, Conference Room A & B
2500 Grant Road, Mountain View, California
Katherine Anderson will be participating via teleconference from the following address:
Alpha Motoazabu 3-8-48, Motoazabu, Minatu-ku, Tokyo
Jeffrey Davis, MD will be participating via teleconference from the following address:
Diamante' Beachfront, Cabo San Lucas, Mexico

Purpose: The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee") is to advise and assist the El Camino Hospital (ECH) Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, and to ensure delivery of effective, evidence-based care for all patients. The Quality Committee helps to assure that excellent patient care and exceptional patient experience are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods and assuring appropriate resource allocation to achieve this purpose.

	AGENDA ITEM	PRESENTED BY		
1.	**CALL TO ORDER**	David Reeder, Chair Quality Committee		5:30 – 5:31 p.m.
2.	**ROLL CALL**	David Reeder, Chair Quality Committee		5:31 – 5:32
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Chair Quality Committee		5:32 – 5:33
4.	**CONSENT CALENDAR ITEMS:** Any Committee Member may pull an item for discussion before a motion is made.	David Reeder, Chair Quality Committee	*public comment*	**Motion Required** 5:33 – 5:38
	Approval: a. Minutes of Quality Committee Meeting - December 7th, 2015 **Information:** b. Pacing Plan c. Research Article **ATTACHMENT 4**			
5.	**REPORT ON BOARD ACTIONS**	David Reeder, Chair Quality Committee		**Discussion** 5:38 – 5:43
6.	**FY16 EXCEPTION REPORT** **ATTACHMENT 6**	Eric Pifer, MD, Chief Medical Officer		**Discussion** 5:43 – 6:08
7.	**ICARE UPDATE** **ATTACHMENT 7**	Mick Zdeblick, Chief Operating Officer		**Discussion** 6:08 – 6:23
8.	**PUBLIC COMMUNICATION**	David Reeder, Chair Quality Committee		**Information** 6:23 – 6:26

A copy of the agenda for the Regular Committee Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at 650-988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

Agenda: El Camino Hospital Quality, Patient Care, and Patient Experience Committee Meeting
February 1st, 2016

	AGENDA ITEM	PRESENTED BY		
9.	**ADJOURN TO CLOSED SESSION**			6:26 - 6:27
10.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Chair Quality Committee		6:27 – 6:28
11.	**CONSENT CALENDAR** Any Committee Member may pull an item for discussion before a motion is made.	David Reeder, Chair Quality Committee		**Motion Required** 6:28 - 6:33
	Approval: Meeting Minutes of the Closed Session *Gov't Code Section 54957.2.* - December 7th, 2015 **Information:** Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* - Meeting Minutes of Quality Council December 2nd, 2015			
12.	Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* Red Alert and Orange Alert Update	Eric Pifer, MD Chief Medical Officer		**Discussion** 6:33 – 6:48
13.	Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* The Joint Commission Update	Eric Pifer, MD Chief Medical Officer		**Discussion** 6:48 – 6:58
14.	**RECONVENE OPEN SESSION/REPORT OUT**	David Reeder, Chair Quality Committee		6:58 – 6:59
	To report any required disclosures regarding permissible actions taken during Closed Session.			
15.	**ADJOURNMENT**	David Reeder, Chair Quality Committee		7:00 p.m.

FY 16 Quality Committee Meetings

- **February 29, 2016**
- **April 4, 2016**
- **May 2, 2016**
- **June 1, 2016**

FY 16 Board and Committee Educational Gatherings

- **March 23, 2016**

a. Minutes of Quality Committee Meeting th - December 7 , 2015

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, December 7th, 2015
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California
Katherine Anderson participated via teleconference from the following address:
Alpha Motoazabu 3-8-48, Motoazabu, Minatu-ku, Tokyo

Members Present	Members Absent	Members Excused
Dave Reeder; Peter Fung, MD; Jeffrey Davis, MD; Diana Russell, RN; Nancy Carragee, RN; Mikele Bunce, Alex Tsao, Melora Simon, Lisa Freeman, and Katie Anderson (via teleconference).	Wendy Ron	Robert Pinsker, MD

A quorum was present at the El Camino Hospital Quality, Patient Care and Patient Experience Committee on the 7th day, December, 2015 meeting.

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER	The meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order by Committee Chair Dave Reeder at 5:36 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Stephanie Iljin to take a silent roll call.	***None***
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Reeder asked if any Committee member or anyone in the audience believes that a Committee member may have a conflict of interest on any of the items on the agenda. No conflict of interest was reported.	***None***
4. CONSENT CALENDAR ITEMS	Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. None were noted. **Motion:** To approve the consent calendar (Open Minutes of the November 2nd, 2015 Meeting, and Environment of Care Policies). **Movant:** Davis **Second:** Russell **Ayes:** Tsao, Carragee, Davis, Russell, Bunce, Fung, Reeder, Simon. **Noes:** None **Abstentions:** None **Absent:** Ron	***The Open Minutes of the November 2nd, 2015 Meeting, and Environment of Care Policies were approved.***

Agenda Item	Comments/Discussion	Approvals/Action
	Excused: Pinsker **Recused:** None	
5. REPORT ON BOARD ACTIONS	Chair Reeder reported that the Board has requested that the Quality Committee review monthly the Follow up of Red Alerts and Closed Action Plans in order to maintain their stability.	***None***
6. FY 16 EXCEPTION REPORT	Dr. Pifer, Chief Medical Officer, reviewed the exception report and noted the continued concerning trends in 2 areas: patient falls, and medication administration errors. Dr. Pifer introduced Chris Tarver, Director of Medical and Surgical Services, and asked that she address the Medication Errors and action plans. Ms. Tarver described a weekly medication safety meeting that has been convened to address a host of issues that are causing some of the safety risks. Ms. Tarver reported that in order to address the risky period in the short term, pharmacists have been added to increase staffing and vigilance related to medication errors. Some examples of medication error types: a) Adult orders entered on pediatric patients. b) Incorrectly "mapped" medicines (very few of these and all addressed). c) Delays in medicine administration related to a variety of issues. d) Complex medication orders (several issues). Cheryl Reinking, Chief Nursing Officer also submitted the Falls Committee data to reflect the current action plans in place for falls and discussion ensued amongst the Committee Members.	***None***
7. ICARE UPDATE	Mick Zdeblick, Chief Operating Officer, gave a brief overview of the iCare Implementation and current post go-live metrics. The committee discussed the success of the iCare program and recognized the massive amounts of work that have been done to bring the system live and optimize it. Mr. Zdeblick expressed the need for still more work to be done to reduce the likelihood of error and patient harm.	***None***
8. PATIENT AND FAMILY CENTERED CARE	R.J. Salus, Director of Patient Experience, updated the Committee on the continued development of the Patient and Family Centered Care theme. Mr. Salus presented materials on: 1. Key Steps Since Summer 2015 to include: Securing partnership with Planetree, Ensuring Patient Centered go-live of iCare, Joining Beta-Gateways	***None***

Agenda Item	Comments/Discussion	Approvals/Action
	Program on Patient Family Advisory Councils (PFAC), Transitioning Inaugural PFAC and Created New PFAC, and Evolving Discussions around Pilot area for PFCC work. 2. Phased Plan and Timing 3. End of Life Care Models – Possible Continuum of Options: Department Specific, Service Line Approach, Physician/Patient Management, and Community Engagement. 4. Next Steps to include: Finalize concept of model line to launch – scope and scale, Planning meeting to confirm all proper steps, Learning Journey – site interviews and surveys, Gap Analysis, and Model lines and scale/pace of organizational change. Dr. Pifer asked for the Committee's opinion on the proposed timeline as well as approach to end of life models and discussion ensued. The committee discussed to possibility of choosing a relatively confined area (As example: Cancer Care is too broad but perhaps end of life care for cancer patients may work well) and develop clearly defined goals around communication and shared decision making.	
9. PUBLIC COMMUNICATION	None	***None***
10. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:25 p.m. **Movant:** Davis **Second:** Russell **Ayes:** Tsao, Carragee, Davis, Russell, Bunce, Fung, Reeder, Simon. **Noes:** None **Abstentions:** None **Absent:** Ron **Excused:** Pinsker **Recused:** None	***A motion to adjourn to closed session at 7:25 p.m. was approved.***
11. AGENDA ITEM 15 RECONVENE OPEN SESSION/ REPORT OUT	*Agenda Items 11 – 14 were reported in closed session.*	***None***
12. AGENDA ITEM 16 ADJOURNMENT	There being no further business to come before the Committee, the meeting was adjourned at 7:41pm.	***None***

Attest as to the approval of the Foregoing minutes by the Quality Committee and by the Board of Directors of El Camino Hospital:

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Dave Reeder
Patient Experience Committee

Pacing Plan

QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE

FY2016 PACING PLAN (Revised 2.1.16)

FY2016: Q1		
JULY - No Meeting	**AUGUST 3, 2015**	**AUGUST 31, 2015**
Routine Consent Calendar Items: ▪ Approval of Minutes ▪ FY 2016 Committee Goal Completion Status ▪ Pacing Plan ▪ Quality Council Minutes ▪ Patient Story ▪ Research Article	▪ Review and discuss quality summary with attention to risks and overall performance ▪ Corporate scorecard trending **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ APPROVE FY 2016 Organizational Goals (Metrics) ▪ Approve FY 15 Organizational Goal Achievements ▪ Update on PaCT Plan ▪ Year-end review of RCA **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**
FY2016: Q2		
OCTOBER 5, 2015	**NOVEMBER 2, 2015**	**DECEMBER 7, 2015**
▪ Safety Report for the Environment of Care (consent calendar) **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ Committee Goals for FY16 Update ▪ ICare Update **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ iCare Update **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**

QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE

FY2016 PACING PLAN (Revised 2.1.16)

FY2015: Q3		
JANUARY – No Meeting	**FEBRUARY 1, 2016**	**FEBRUARY 29, 2016**
	▪ Patient and Family Centered Care ▪ Service Line Update ▪ Top Risk Case Review **Committee Members to complete on-line self-assessment tool.* **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ Begin Development of FY 2017 Committee Goals (3-4 goals) ▪ Peer Review/Care Review Process ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**
FY2016: Q4		
APRIL 4, 2016	**MAY 2, 2016**	**JUNE 1, 2016**
▪ Finalize FY 2017 Committee Goals ▪ Proposed Committee meeting dates for FY2017 ▪ Review DRAFT FY2017 Organizational Goals ▪ Annual Review of Committee Charter ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ Review DRAFT FY17 Organizational Goals (as needed) ▪ Set proposed committee meeting calendar for FY 2017 ▪ Review Committee Assessment Results ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ PFAC Update (6 months since Jan) ▪ Review and Discuss Self-Assessment Results ▪ Develop Pacing Calendar for FY17 ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**

Research Article

By Mark R. Chassin

DOI: 10.1377/hlthaff.2013.0809
HEALTH AFFAIRS 32,
NO. 10 (2013): 1761–1765

VIEWPOINT

Improving The Quality Of Health Care: What's Taking So Long?

Mark R. Chassin (mchassin@jointcommission.org) is president and CEO of the Joint Commission, in Oakbrook Terrace, Illinois.

ABSTRACT **Nearly fourteen years ago the Institute of Medicine's report, *To Err Is Human: Building a Safer Health System*, triggered a national movement to improve patient safety. Despite the substantial and concentrated efforts that followed, quality and safety problems in health care continue to routinely result in harm to patients. Desired progress will not be achieved unless substantial changes are made to the way in which quality improvement is conducted. Alongside important efforts to eliminate preventable complications of care, there must also be an effort to seriously address the widespread overuse of health services. That overuse, which places patients at risk of harm and wastes resources at the same time, has been almost entirely left out of recent quality improvement endeavors. Newer and much more effective strategies and tools are needed to address the complex quality challenges confronting health care. Tools such as Lean, Six Sigma, and change management are proving highly effective in tackling problems as difficult as hand-off communication failures and patient falls. Finally, the organizational culture of most American hospitals and other health care organizations must change. To create a culture of safety, leaders must eliminate intimidating behaviors that suppress the reporting of errors and unsafe conditions. Leaders must also hold everyone accountable for adherence to safe practices.**

A sense of mounting frustration at the slow pace of improvement in health care quality is evident in conversations with many stakeholders lately. Their comments often go something like this: What's [illegible] right? It's not rocket science.

The evidence supporting this frustration is substantial. Hand hygiene in hospitals fails about 60 percent of the time.[1] Communication across various transitions of care fails 40 percent

was not a high enough priority locally or nationally. Hospitals were not devoting enough resources to solving the problems. National leadership was lacking, and good solutions didn't exist. All of these excuses have melted away in the nearly fourteen years that have passed since the Institute of Medicine's *To Err Is Human: Building a Safer Health System* sparked a nationwide movement to improve patient safety.[8]

Since the publication of that report, an unprecedented national effort to improve health care quality and safety has taken place. Health care leaders no longer deny the magnitude of quality problems. A National Quality Strategy is in place,[9] and major national investments in improvement have been made. Hospitals have devoted considerable time, energy, and resources to solving safety and quality problems. Some progress has occurred.[10] But the improvements have been slow and have not spread throughout the delivery system. Nor have they affected the breadth of available health services. Altogether, they do not constitute an adequate response to the manifestly large and growing roster of quality problems confronting health care.

Clearly, those of us who are involved in improving quality in the United States must change what we have been doing if we want different results. Unfortunately, there are no highly successful efforts that we can import from other countries, because all developed health care systems around the world are struggling with exactly the same quality problems as exist in the United States. No other health care systems have produced effective, long-lasting solutions. The following three fundamental weaknesses of current US improvement efforts must be addressed to make substantial advances in safety and quality. First, current efforts are focused too narrowly on preventable complications. Second, they rely too heavily on older improvement methods that are proving to be ineffective in attacking many of the complex problems facing today's health care delivery system. Finally, insufficient attention has been devoted to changing the organizational culture that exists in most modern health care organizations, especially hospitals—a culture that is incompatible with sustained excellence.

selected but is then poorly provided,"[11(p3472)] thereby increasing the risk of preventable complications. Health care–associated infections, hospital-acquired conditions, and adverse events such as wrong-site surgery and operating-room fires are all examples of misuse problems. In addition, some modest efforts have been made to address underuse, which is the failure to provide a health service when doing so would improve the outcome. Of course, these are extremely important problems to solve.

Until very recently, however, overuse—the use of health care services in circumstances when the services' benefits are absent or negligible—has been almost entirely left out of the quality improvement discourse. This omission is a long-standing phenomenon. Over the past twenty-five years, as research has focused on assessing the magnitude of misuse problems and the effectiveness of a variety of improvement interventions directed at them, overuse has been almost entirely neglected. As a consequence, current, comprehensive data on overuse are lacking, and very few well-documented examples of successful interventions to combat the problem exist.[12]

Eliminating overuse may be the most effective way to improve quality and reduce health care costs simultaneously. Two recent efforts have begun to attract more attention to the overuse problem. The Choosing Wisely campaign, initiated by the ABIM Foundation, encourages frank conversations between physicians and patients with the aim of avoiding unnecessary tests, treatments, and procedures.[13] And in 2012 more than a hundred health care organizations participated in the National Summit on Overuse. The summit was convened by the Joint Commission and the American Medical Association's Physician Consortium for Performance Improvement. It focused on developing specific recommendations for remedying five particularly important overuse problems, including the use of antibiotics in patients with colds and the use of tympanostomy tubes for children with brief middle-ear effusions.[14]

One of the problems addressed by the National Summit has led to improvement activities that may be models worthy of emulation. Elective delivery before thirty-nine weeks of gestation

A different strategy is needed—one that recognizes that problems are complex and defy simple solutions.

port to the effort as well.[15–17] Many more multistakeholder efforts of this kind will be needed if we are to gain national traction on overuse.

One Size Does Not Fit All

Given that the substantial efforts of the past fourteen years have not produced quality improvement of sufficient magnitude, questions must be raised about how exactly those improvement efforts have been conducted. For the most part, quality improvement activities consist of variations on a single theme: the "one size fits all" best practice. Whether it is evidence-based guidelines for reducing catheter-associated urinary tract or bloodstream infections, tool kits and protocols for preventing wrong-site surgery, or bundles and checklists for avoiding ventilator-associated pneumonia, the improvement strategy leads to the recommendation that everyone should implement the same interventions. This strategy usually leads to some improvement, but the results are often less than stellar. Even impressive results are typically difficult to sustain over time. A different strategy is needed—one that recognizes that these problems are complex and defy simple solutions.

Complicated problems, such as ensuring and maintaining high levels of hand hygiene, require more sophisticated problem-solving strategies. A new approach is beginning to demonstrate that it is up to the challenge. Tools such as Lean, Six Sigma, and change management that General Electric and Best Buy and other compa-

ing health care today. These techniques are proving to be far more effective in tackling tough clinical quality problems than were the tools and methods that came out of industry in the 1980s: total quality management and continuous quality improvement.

In brief, what distinguishes RPI from older improvement methods is its disciplined, systematic approach to rigorous measurement of the magnitude of a particular problem, meticulous determination of all of the causes of the problem, focused implementation of interventions targeted to the most important causes, and careful attention throughout the improvement process to sustaining effective interventions. Although it was possible to achieve good results with older methods, RPI typically produces far greater improvement by this methodical and consistent strategy for dissecting complex problems.

Three key findings have repeatedly emerged from this work, no matter whether the problem under investigation is wrong-site surgery, hand-hygiene compliance, or patient falls. First, there are many causes or contributing factors that explain these failures—often as many as thirty or more. Second, each cause requires a different intervention to deal with it effectively. Third, although it is typical for five or six causes to explain the majority of the reasons for a particular problem in one hospital, a different group of important causes is found when a different hospital is examined. Thus, for a given problem, it is typically possible to package five or six targeted interventions that will work to make major improvements in one hospital. However, it is unlikely that those same interventions will be equally successful in another hospital, where the principal causes of the same problem are different.[21]

For example, one hospital may discover that its major risks for wrong-site surgery occur because the surgical scheduling system fails to obtain standardized and complete data for patient identification or the specification of exactly what procedure is planned. Another hospital may find that its most important risks relate to failures to correctly mark the surgical site. A third hospital may have inadequate operating-room processes in place to verify the intended procedure by ex-

Culture Matters

Finally, health care leaders must change the organizational culture in hospitals. A small but growing number of hospitals and health systems are applying lessons learned from organizations in other industries that function at extremely high levels of safety in the face of hazards that are every bit as dangerous as the ones health care confronts.[22] One of the most important lessons from these high-reliability organizations is the importance of an organizational culture of safety. Whether they be commercial airlines, aircraft carriers, or nuclear power plants, these organizations stay safe because all workers know that they have key roles to play. Workers all understand and act on their obligation to recognize and report unsafe conditions, inappropriate behaviors, and errors. Those reports identify problems in safety systems at a very early stage, long before they pose substantial risk. The organization acts rapidly to remedy the problems and communicates those improvements to the people who provided the initial reports. In addition, workers in these organizations hold themselves accountable for consistently adhering to safety procedures. Imagine a protocol that is as essential to the safety of a nuclear power plant as hand hygiene is to preventing infections in hospitals—it is inconceivable that workers in the power plant would exhibit a compliance rate of only 40 percent.

Today's typical hospitals have a long way to go before they achieve the kind of safety culture that exists in high-reliability organizations.[23] They fall short on both of its crucial features: first, encouraging the reporting of and learning from blameless errors and unsafe conditions; and second, assuring accountability for adherence to agreed-upon safe practices. There can be no higher priority today for health care leaders than eliminating the barriers to a strong and vibrant culture of safety. One of the most important of these barriers is the nearly ubiquitous intimidating and disrespectful behaviors that suppress the identification and reporting of unsafe conditions. Front-line caregivers—including nurses, pharmacists, physical therapists, housekeepers, and food service workers—report that physicians and nonphysicians alike frequently refuse to answer questions, ignore requests, make condescending or demeaning responses to questions, and deliver outright verbal abuse.[24] The necessary next steps toward creating a safety culture include eradicating such behaviors; celebrating and acting upon reports of close calls or near misses; and establishing and enforcing clear and transparent disciplinary procedures for blameworthy acts that are applied equitably, regardless of who commits them.

There can be no higher priority today for health care leaders than eliminating the barriers to a strong and vibrant culture of safety.

Conclusion

Public frustration over the slow progress toward far higher levels of safety and quality than exist today is understandable. Health care must and can do better. But let us not underestimate the magnitude of the task. The critics are right. It's not rocket science. It's much more difficult. All rocket scientists have to do is get a machine to behave the way they want it to. Our health care quality challenge ultimately is to create something that doesn't exist anywhere in the world today: hospitals and health systems in which preventable harm does not occur. Some effective next steps toward this goal include addressing overuse problems as vigorously as preventable complications, embracing much more effective process-improvement strategies and tools, and changing the culture within our health care organizations to one that supports high reliability. ■

NOTES

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Currently, the Library is populated with well over 400 documents of real-life examples of solutions to standards compliance and patient safety problems. The Library is an ever-evolving collection of solutions provided by accredited organizations, professional associations, and the Joint Commission's field staff. Submissions are screened by relevant staff prior to posting to ensure they are consistent with our standards.

BoosterPak™

Where to Find: Joint Commission Connect (Extranet) under Continuous Compliance Tools

A *BoosterPak™* is designed to consolidate all of the key information available from The Joint Commission and other relevant sources about challenging or complex Standards into one easy-to-access and easy-to-use resource. It contains comprehensive information by providing the background to the Standard, the actual requirements, any Frequently Asked Questions, suggestions for compliance, links to other resources such as any evidence-based studies or publications, and any relevant CMS Conditions of Participation and Interpretive Guidelines.

The currently published BoosterPaks include:

- FPPE/OPPE, HAP & CAH (MS 08.01.01, MS 08.01.03,);
- Suicide Risk, HAP & BHC (NPSG 15.01.01);
- Sample Collection, Multiple programs (HR 01.04.01, NPSG 07.01.01, IC 02.01.01, EC 02.01.01, EC 02.06.01, DC 01.01.01 LAB only, DC 01.02.01 LAB only, NPSG 01.01.01, PL 01.01.01, LD 03.06.01)
- Environment of Care, HAP (EC 040101, EC040103, EC040105);
- Management of Hazardous Waste, HAP (EC 01.01.01, EC 02.01.01, EC 02.02.01, HR 01.04.01, LD 04.01.01, MM 01.01.03);
- Use of Restraint and Seclusion for Deemed Status HAP (PC 03.05.01, PC 03.05.03, 03.05.05, PC 03.05.07, PC 03.05.09, PC 03.05.11, PC 03.05.13, PC 03.05.15, PC 03.05.17, PC 03.05.19;
- Medication Management, HAP (03.01.01)

Joint Commission Resources (JCR)

Where to Find: http://www.jcrinc.com

Through our variety of resources—publications, software, educational conferences and webinars, and consulting services—JCR is the single, expert resource you can count on when it comes to building and sustaining improvements.

Education	Consulting	Publications
National conferences	Continuous Service Readiness®	Accreditation manuals
Regional seminars	Accreditation preparation	Books

Stages of Development on the Pathway to High Reliability

(Consistency of Safety and Quality Performance over Long Periods of Time)

	Stages of Maturity			
Organizational Characteristic	**Beginning**	**Refining**	**Maturing**	Circle One in Each Box Below
Leadership				
Quality Activities	Quality activities focused on regulatory requirements	Chief executive officer leads proactive quality agenda	Organization commits to goal of high reliability for all clinical services	Beginning Refining Maturing
Quality Prioritized	Strategic importance of quality improvement not recognized	Board reviews adverse events	Organization aims for near zero failure rates in some vital clinical processes	Beginning Refining Maturing
Quality Rewarded	Metrics for quality goals not part of strategic plan or incentive compensation	Organization sets a few measurable quality aims	Staff rewards system prominently reflects quality goals accomplishment	Beginning Refining Maturing
Information Technology Support	Information technology provides little support for quality improvement	Information technology supports some quality and safety initiatives	Information technology integral to sustaining quality improvement	Beginning Refining Maturing
Physician Engagement	Physician not actively engaged in quality improvement	Physician leaders champion quality goals in some areas	Physicians routinely lead quality efforts	Beginning Refining Maturing
Safety Culture				
Safety Culture Program	No specific program to assess safety culture	Establishing safety culture accorded high priority by leaders at all levels	Safety culture is well established	Beginning Refining Maturing
Safety Culture Implementation	No assessment of trust or intimidating behavior	First measures of safety culture deployed	Measurement of safety culture is well established	Beginning Refining Maturing
Safety Culture Embedded	Root cause analyses limited to most serious adverse events; close calls not recognized or evaluated	Beginning initiatives to encourage reporting and analysis of close calls	Regular reporting of close calls and unsafe conditions leads to early problem resolution	Beginning Refining Maturing
Robust Process Improvement				
Use of Improvement Tools	No formal quality management/improvement	Organization commitment to strong	Improvement Tools used	Beginning Refining

Lines

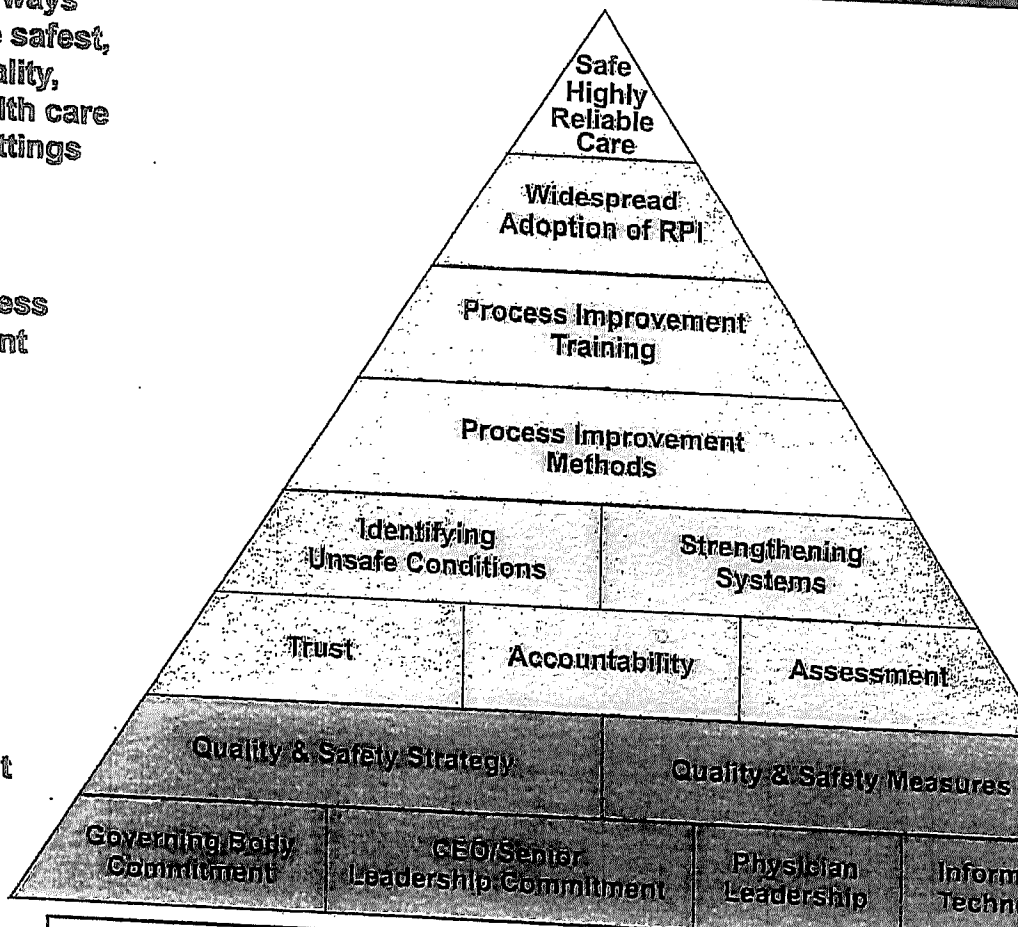
Building Blocks to Achieving High Relia

All people always experience the safest, highest quality, best value health care across all settings

Robust Process Improvement

Safety Culture

Leadership Commitment



Compliance with Joint Commission Standards & National Patient Saf
Excellent Accountability Measure Performance

The Joint Commission

ATTACHMENT 6

BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	FY16 Exception Report
	Responsibility party:	Dr. Eric Pifer, Chief Medical Officer
	Action requested:	For Discussion
	Background: Please find attached the El Camino Hospital exception report. This report is intended to be a brief snapshot showing trends across several key metrics. Each month, we will review these trends and provide action plans related to poor trends. The intent of the report is to provide an entree to discuss safety and quality programs. Our goal is to maintain performance or incrementally improve across many of these programs even as we drive for top tier performance in our key quality theme (patient centered care).	
	Committees that reviewed the issue and recommendation, if any: Quality, Patient Care and Patient Experience Committee on February 1st, 2016	
	Summary and session objectives : This month's exception report shows an increase in average length of stay and medication errors in November. Data is not yet reported for medication errors for December, but we know from counts of medication events filed as QRRs that we are continuing to see high numbers of serious near miss events, ordering errors and pharmacy interventions. The safety of the medication delivery process is a top organizational priority right now, after the iCare implementation. In response to this high risk time, we have: • Created a weekly medication safety committee • Added pharmacy staffing on 3rd shift and weekends • Increased our focus on the Epic pharmacy module and the build associated with it For this month's discussion we have included the tracking sheet for the weekly medication safety committee and we will (once again) invite Chris Tarver, nurse chair of the medication safety committee to our meeting. The increase in length of stay is to be expected given the iCare implementation and we will discuss it in more detail next month. We have several interventions in place aimed at lowering length of stay. Respectfully Submitted, Eric Pifer MD CMO	

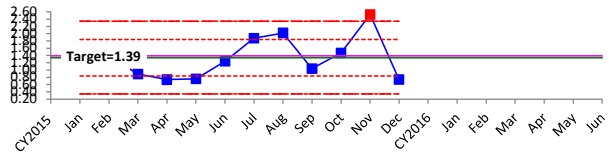
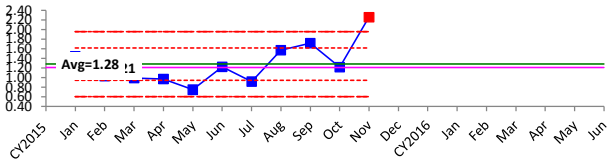
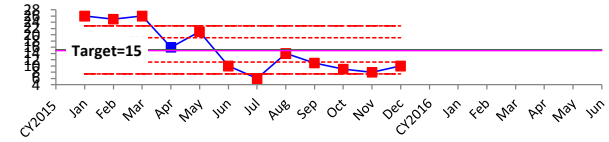
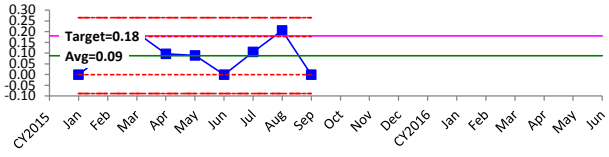
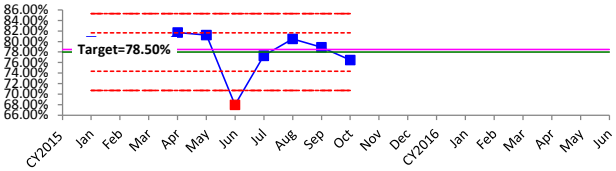
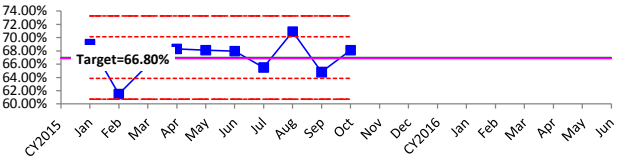
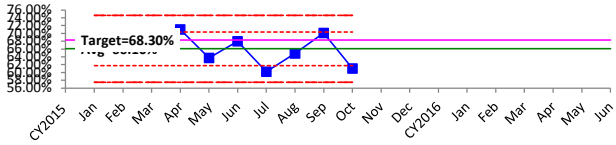
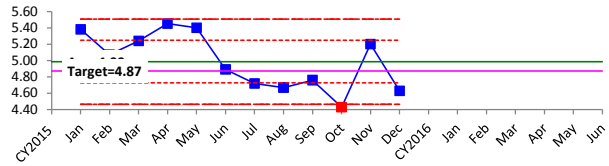
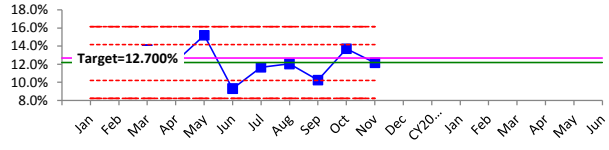
BOARD MEETING AGENDA ITEM COVER SHEET

	Suggested discussion questions: N/A
	Proposed board motion, if any: None
	LIST OF ATTACHMENTS: Att 6 - Exception Report, Weekly Medication Safety Minutes

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Quality and Safety Dashboard (Monthly)

Date Reports Run: 1/25/2016

		Performance		Baseline	FY16 Goal	Trend
SAFETY EVENTS				FY2015	FY2016	
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: December 2015*	4/5427	0.74	1.39	1.39	
2	**Medication Errors** *Errors / 1000 Adj Total Patient Days* *Date Period: November 2015*	30/13249	2.26	1.21	1.21	
3	**Specimen Labeling Errors** *# Specimen Labeling Errors / Month* *Date Period: December 2015*	10	10	23	15	
COMPLICATIONS				FY2015	FY2016	
4	**Surgical Site Infection (SSI)** *SSI per 100 Surgical Procedures* *Date Period: September 2015*	1/952	0.11	0.19	0.18	
SERVICE				FY2015	FY2016	
5	**Communication with Nurses** *(HCAHPS Score)* *Date Period: October 2015*	145/189	76.5%	78.5%	78.5%	
6	**Responsiveness of Hospital Staff** *(HCAHPS Score)* *Date Period: October 2015*	122/179	68.1%	66.8%	66.8%	
7	**Communication About Medicines** *(HCAHPS Score)* *Date Period: October 2015*	76/125	61.0%	68.3%	68.3%	
EFFICIENCY		Performance		Jan-Jun 2015	Jan-Jun 2016	
8	★Organizational Goal **Average Length of Stay (days)** *(Medicare definition, MS-CC, ≥ 65, inpatient)* *Date Period: December 2015*	**FYTD 1st 6m** 2406 **2nd 6m** 261	**FYTD 1st 6m** 4.74 **2nd 6m** 5.14	5.17	5.07 (Min) 4.97 (Target) 4.87 (Max)	
9	★Organizational Goal **30-Day Readmission (Rate, LOS-Focused)** *(ALOS-Linked, All-Cause, Unplanned)* *Date Period: November 2015*	**FYTD 1st 6m** 1943 **2nd 6m** TBD	**FYTD 1st 6m** 11.94 **2nd 6m** TBD	12.67	At or below 12.67	

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2015 Definition	FY 2016 Definition	Source
Patient Falls	Joy Pao; Cheryl Reinking	Falls Committee	All Med/Surg/CC falls reported to CALNOC per 1,000 CALNOC (Med/Surg/CC) patient days CALNOC Fall Definition: The rate per 1,000 patient days at which patients experience an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment, including bedside mat). All falls are reported and described by level of injury or no injury, and circumstances (observed, assisted, restrained at the time of the fall). Include Assisted Falls (when staff attempts to minimize the impact of the fall, it is still a fall). *Excludes Intentional Falls: When a patient (age 5 or older) falls on purpose or falsely claims to have fallen, it is considered an Intentional Fall and is NOT included. It is NOT considered a fall according to the CALNOC definition.*		**QRR Reporting and Staff Validation**
Medication Errors	Joy Pao; Cheryl Reinking	Medication Safety Committee; P&T Committee	5 Rights MEdication Errors: [# of Med Errors (includes: Duplicate Dose, Omitted Dose, Incorrect Patient, Incorrect Medication, and Incorrect Route.) divided by Adjusted Total Patient Days (includes L&D & Nursery)]* 1,000 *Excludes: Wrong Time, ADR, Contrast Reaction, Incorrect Dose, "Not Yet Rated" Med errors, No risk identified and near miss*		**QRR Reporting and Staff Validation**
Mislabeled Specimens	Edwina Sequeira; Cheryl Reinking	QIPSC	Number of blood and nonblood Laboratory specimens collected by non-Lab staff that are unlabeled or contain incomplete or incorrect information for patient ID, specimen source/site, date/time, collector initials. Soft ID GoLive in May 2015 for select units, MCH full GoLive date after iCare implementation in Nov 2015.		**Staff Manual Tracking (Thara Trieu, Laboratory)**
Surgical Site Infection	Catherine Nalesnik; Joy Pao; Carol Kemper, MD	Infection Control Committee	(Number of Deep Organ Space infections divided by the # of all sugery cases)*100 counted by the month infection was attributed to and not by the month it was discovered. All Surgery Cases in the 29 Surgical Procedural Categories required by the California Department of Public Health.		**IC Surveillance and NHSN Data Reporting**
Communication with Nurses	RJ Salus; Meena Ramchandani; Cheryl Reinking	Patient Experience Committee	Percent of inpatients responding "Always" to the following 3 questions [% Top Box]: 1. *During hospital stay, how often did the nurses treat you with courtesy and respect?* 2. *During hospital stay, how often did nurses listen carefully to you?* 3. *During hospital stay, how often did nurses explain things in a way you can understand?* CMS Qualified values are pulled from the Avatar website.Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**
Responsiveness of Hospital Staff	RJ Salus; Eric Pifer	Patient Experience Committee	Percent of inpatients responding "Always" to the following 2 questions [% Top Box]: 1. *During hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?* 2. *How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted (for patients who needed a bedpan)?* CMS Qualified values are pulled from the Avatar website.Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**
Communication About Medicines	RJ Salus; Cheryl Reinking; Bob Blair	Patient Experience Committee	Percent of inpatients (who received meds) responding "Always" to the following 2 questions [% Top Box]: 1. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? 2. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? CMS Qualified values are pulled from the Avatar website. Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**
Average Length of Stay	Eric Pifer, MD; Mick Zdeblick; Joy Pao; Petrina Griesbach	LOS Rounds	The difference in days between the Medical-Surgical average length of stay and the DRG-weighted geometric mean length of stay for the current CMS fiscal year.		**EDW Data Pull, Department of Clinical Effectiveness**
30-Day Readmission (LOS-Focused)	Eric Pifer, MD; Margaret Wilmer; Joy Pao; Petrina Griesbach	BPCI Task Force	Percent of Medicare inpatient discharges return for an unplanned IP stay for any reason within 30 days, aged ≥65. Excludes patients who die, leave AMA or are transferred to another acute care facility; excludes admits to ECH Rehab and Psych admissions and for medical treatment of cancer.		**EDW Data Pull, Department of Clinical Effectiveness**

El Camino Hospital
THE UNIVERSITY OF BUSINESS WORKS

Department of Clinical Effectiveness

#	Priority *(Most Critical = 4)*	Date Presented to Committee	Medication Focused Issues	Patient Safety Impact *(Reached Patient, Near Miss, Potential)*	QRR	Ticket #	Identified Fix	How fixed	Responsible Party *(EPiC/iCare/other)*	Estimated Completion Date	EPiC Test in Environment / Validation (Date and Staff)	Note
			OPEN ITEMS									
1	4	12/3/2015	MDs can order home meds which are not on formulary-no alert fired - 3 patient in Nov	Reached Patient (Omitted Meds)	Y		1/20/16: For meds pulled in from Care Everywhere, did allow continue the med as pre checked option. Removed that option as of 1/18/16-requires MD to select NF. Rx provided therapeutic substitutions for known meds. Plan to close at next week's meeting if working correctly. Need to explore whether alert can fire at time of MD order off of home list to suggest therapeutic alternative/ 12/16: Notification to MD that MED is non formulary, require MD to verify s/he wants to order and will trigger NF request to RX. Will use same process for POM. 1/6/16: Still seeing in QRRs	EMR System Fix (Willow)	Lian Chang			
2	4	12/3/2015	Medication allergy noted in Care Everywhere	Reached Patient	Y		Med allergy information not brought in through Care Everywhere 12/16: Recommendation to have read receipt for all nurses on new workflow. Email sent to staff by Chris T in December. Update?	Retraining/ Tip Sheet	Chris Tarver	12/11/2015		
3	4*	12/10/2015	NICU TPN Rounding Issue. QRR on NICU TPN (fat to be more specific) because EPIC was not allowing the MD to enter a dose of 0.5 g/kg (resulting in a rate of 0.06 ml/hr) - it gave an error message that 0.06 ml/hr is not a deliverable rate and it rounded the rate to 0.1 ml/hr. I checked with the RN yesterday and 0.06 ml/hr is programmable on the pump. Despite the MD talking to the RN, entering and RN order and adding a note on the lipid order itself, the lipids were run at a rate of 0.1 ml/hr (the rate EPIC put on the label) until shift change this AM when it was caught. This is a 24 weeker who already had elevated TG. I don't know why EPIC is making all these rounding decisions. I'm not sure how to escalate this further since I already submitted a QRR because I though this might	Reached Patient	Y		12/11/15: Update: for all adult, round to 0.1mL/hour; for certain population (NICU) round to 0.01mL/hour - weight-based? age-based? concentration? location/unit-based? Dr. Sivakumar recommends: gestational age 44 weeks or birth up to 180 days, for all NICU infusions). 12/16: Need status update. 12/29: Need to verify and validate; Willow Team and Marisa	EMR System Fix	Deb Muro			
4	4	12/11/2015	TPN/Vanco Errors: pharmacy not getting the orders for management, delays in 8 patients when they did not cross over	Reached Patient (4)	Y		Research building Vanco/TPN Rx to Manage Specific Order Set. 12/29: to review next week with EPiC team 1/6/16: Cmte Discussion-EPIC present do not recommend consult in med verification queue. Explore whether system has ability to notify Rx via pop up/email. Plan to sit with EPIC to explore options, udpate next week.	EMR Sytem Fix	Alicia Potolsky			
5	2	12/3/2015	NICU Alerts: Birth age versus gestational age issue with First Databank	Near Miss	Y		Need neonates to use gestational age based on Neofax. FDB pushing out fix on 12/3. Need to test. 12/16: First Databank patch does not address all issues. Dr. Sivakumar wants custom build for other alerts. Drs. Pifer/Shin to address with MD plan. 12/29: Alerts off now, confirmed by Deborah. Long term plan?	EMR System Fix (Willow)	Maritza Lew Lian Chang			

#	Priority (Most Critical = 4)	Date Presented to Committee	Medication Focused Issues	Patient Safety Impact (Reached Patient, Near Miss, Potential)	QRR	Ticket #	Identified Fix	How fixed	Responsible Party (EPiC/iCare/other)	Estimated Completion Date	EPiC Test in Environment / Validation (Date and Staff)	Note
6	2	12/3/2015	Accuracy of Home Medication List	Near Miss	N		Group working on flow for physicians, Care Everywhere process and pulling in outside meds and identification of all fields for RN to complete. 12/16: Training for MDs being rolled out, not being completed well on front end. 12/29: Admission Med Rec at 45% from 19% this past week.	Retraining/ Tip Sheet	Susan Bukunt			
7	2	12/3/2015	L&D RN entered verbal order for mother on baby's chart	Near Miss	Y		Evaluate whether we can restrict ordering on neonates to ED, Pedi and Neo. 12/16: Evaluating whether we can visually display distinction between mom/baby	EMR System Fix	Susan Bukunt			
8	3	12/16/2015	ED Order Set: all should be once and stat order if MD used Order Set, but it is passing thru to other clinical setting (MD education?) – 1) Need to build system to either automatically dc or notify Pharmacy of those that did not use ED Order Set; 2) do MDs have appropriate access to ED Order Set?	Near Miss	Y		1/20/16:If they use non ED order set, ED MDs are not changing frequency/stat (continous meds do not drop off). ED MDs using orders not as part of ED preference list or quick list so need to manually change to once and stat. 1/6/16: ED physician need to order as needed, updating quick list as much as possible.	Training	Susan Bukunt			
9	3	12/16/2015	ED: Epic - PYXIS link is not synchronized - ordered in PYXIS is not the same as the one in Epic - not appearing at all if not matched	Reached Patient (Delay to patient)	Y		1/6/16: Need to validate what is in Pyxis and on autoverify list. Have IT manage process-run list periodically and fix					
10	2	12/16/2015	Zosyn would not scan barcode	Near Miss			Phuong Nguyen to research why item would not scan		Phuong Nguyen			
11	2	12/16/2015	hourly PCA not calculating max appropriately	Near Miss			Chris Tarver to bring examples of issue to next meting. 12/29: Hard stop		Chris Tarver			
12	2	12/10/2015	automatic stop orders (time-limited); if MD orders from home med list and says continue without a duration specified then there is no end date.	Near Miss			Sutter: mandatory field (exception codes) - screen shot - Dr. Phil Strong	EMR System Fix	Susan Bukunt			
13	2	1/6/2016	Need to validate what is in auto verify-should reflect only what can be available in Pxyis. If Rx to prepare, must show on Rx list to be aware.	Reached Patient (Delay to patient)	Y		1/6/16: Rx to review autoverify list. EPIC says possible to compound pediatric meds. EPIC says that possible that all autoverification queues can be configured to show in Rx queue.	EMR System Fix				
14	2	1/6/2016	Review ED override list to ensure that it encompasses emergency meds needed	Reached Patient (Delay to patient)	Y		1/6/16: Kris M and Dr. Davenport reviewed list for LG. Lotta needs to review for MV.	EMR System Ifx				
15	3	1/20/2016	Order for titration meds do not have administration orders for RN to follow (TJC)	Reached patient	Y		Fentanyl, insulin, vasoactive drips, hypothermia order set-admin instructions not entered by MD, indications. Will explore whether it can be mandatory for MDs. Re educate Rx to require administration instructions, evaluate with EPIC customized required fields for parameters	EMR System Fix	Maritza Lew			
16	3	1/20/2016	Therapeutic duplication-multiple meds for same indication (moderate) (TJC)	Reached patient			Narcotics, anti emetics. Orders group needs to review order sets for pain- only 1 for mild, moderate, severe. Can have PO and IV for same.	EMR System	Susan Bukunt/Jimmy Li			
			NEW ITEMS FOR DISCUSSION									
	4	new to committee	Potassium order in NICU is built using adult doses	Near Miss								
			COMPLETED ITEMS									
	3	12/3/2015	Ertapanem order defaulting to wrong dose	Reached Patient	Y		Fixed 1 order. Will do search and replace to identify all other potentials	EMR System Fix	Maritza Lew	12/16/2015		

#	Priority (Most Critical = 4)	Date Presented to Committee	Medication Focused Issues	Patient Safety Impact (Reached Patient, Near Miss, Potential)	QRR	Ticket #	Identified Fix	How fixed	Responsible Party (EPiC/iCare/other)	Estimated Completion Date	EPiC Test in Environment / Validation (Date and Staff)	Note
	3	12/3/2015	Zosyn extended infusion dose incorrect in system	Near Miss	Y		Fixed 1 order. Will do search and replace to identify all other potentials	EMR System Fix	Maritza Lew	12/16/2015		
	4*	12/10/2015	567540 t-PA calculated to 96mg but max is only 90 mg, but vial comes in 100mg. No alert fired	Near Miss	Y		Lian to work with Mojgan		Maritza Lew Lian Chang	12/16/2015		
	1	12/16/2015	ED (only?) code narrator sodium bicarb dose did not reflect actual given (documentation and) 1mEq, 1 amb, versus 50mEq	Near Miss	Y		Documentation fixed for sodium bicarb and calcium chloride	EMR System Fix		12/16/2015		
	3	12/16/2015	Home med list not showing up on AVS even after MD Med Recon (insulin sliding scale)	Reached Patient				EMR System Fix		12/16/2015		
	2	12/16/2015	Willow created wrong recipe card for Vanco 250mg over 5mL	Near Miss	Y			EMR System Fix		12/16/2015		
	2	12/16/2015	Ertapanem order cannot be ordered consistently by Sx, ID and Anes					EMR System Fix				
	4	new to committee	Omitted antibiotic doses-order confusing due to need to give with/after dialysis	Reached patient	Y		1/6/16: Proposed smart text added: Admin every *** hours. If scheduled dose is due immediately prior or during dialysis, primary RN to give after dialysis completed	EMR System Fix				
	4*	12/3/2015	Location specific orders not dropping off MAR	Reached Patient (Doses Given in Error)	Y		1/20/16: Only 1 QRR so far in January. Will close and monitor through QRR. Pt not being moved in system appropriately which will drop location specific meds (PACU, ED, MRI only). Group meeting to evaluate whether header can show location on MAR. 12/16: Sheetal/Chris T to review recent QRRs to identify potential gaps. 12/29: Need specific QRR/MRNs on cases for follow up and testing. 1/6/16: Sheetal emailed Susan/Chris on 12/16 that only 1 QRR reviewed QRRs up to 12/16 and only saw 1 QRR on 12/1/15.	Retraining	Susan Bukunt	1/20/2016		

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY
Department of Clinical Effectiveness

#	Priority *(Most Critical = 4)*	Date Presented to Committee	Who Reported	Other Safety Issue	Patient Safety Impact (Reached Patient, Near Miss, Potential)	QRR	Ticket #	Identified Fix	How fixed	Responsible Party	Estimated Completion Date	EPiC Test in Environment / Validation (Date and Staff)	Status *(Yellow In Process, Green Complete, Orange NEW)*
1		11/20/2015	Flex RN	Code Narrator for RRT does not have start and end times. Multiple RNs documenting on RRT form causing inconsistent	Documentation lapse	Email							
2	3	new to committee	Chris Tarver	blood transfusion (Friday 2B, Monday 4B, ISC)									
3	4	new to committee	Chris Tarver	9 omited med doses because of MAR hold/phases of care issues - if MD does not reconcilled the med at transfer, then order cannot be released (PACU Only [Dec] etc.)	Reached Patient	Y							
4													
5													
6													
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17													

ATTACHMENT 7

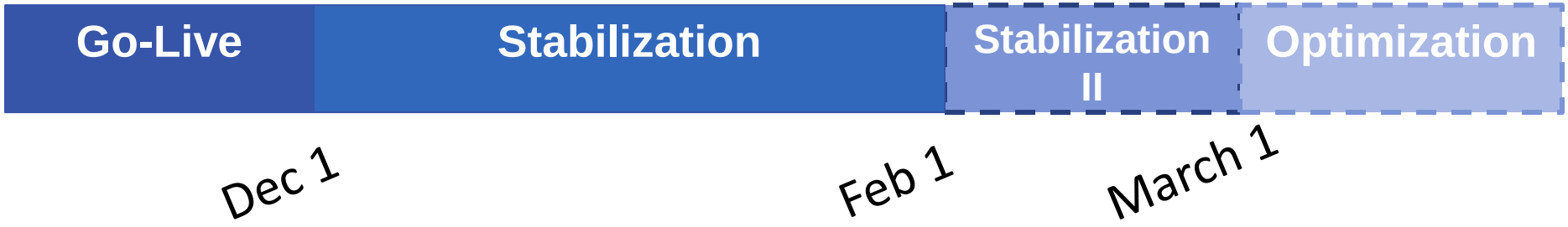
iCare
integrated care

Quality Committee Update

February 1, 2016

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

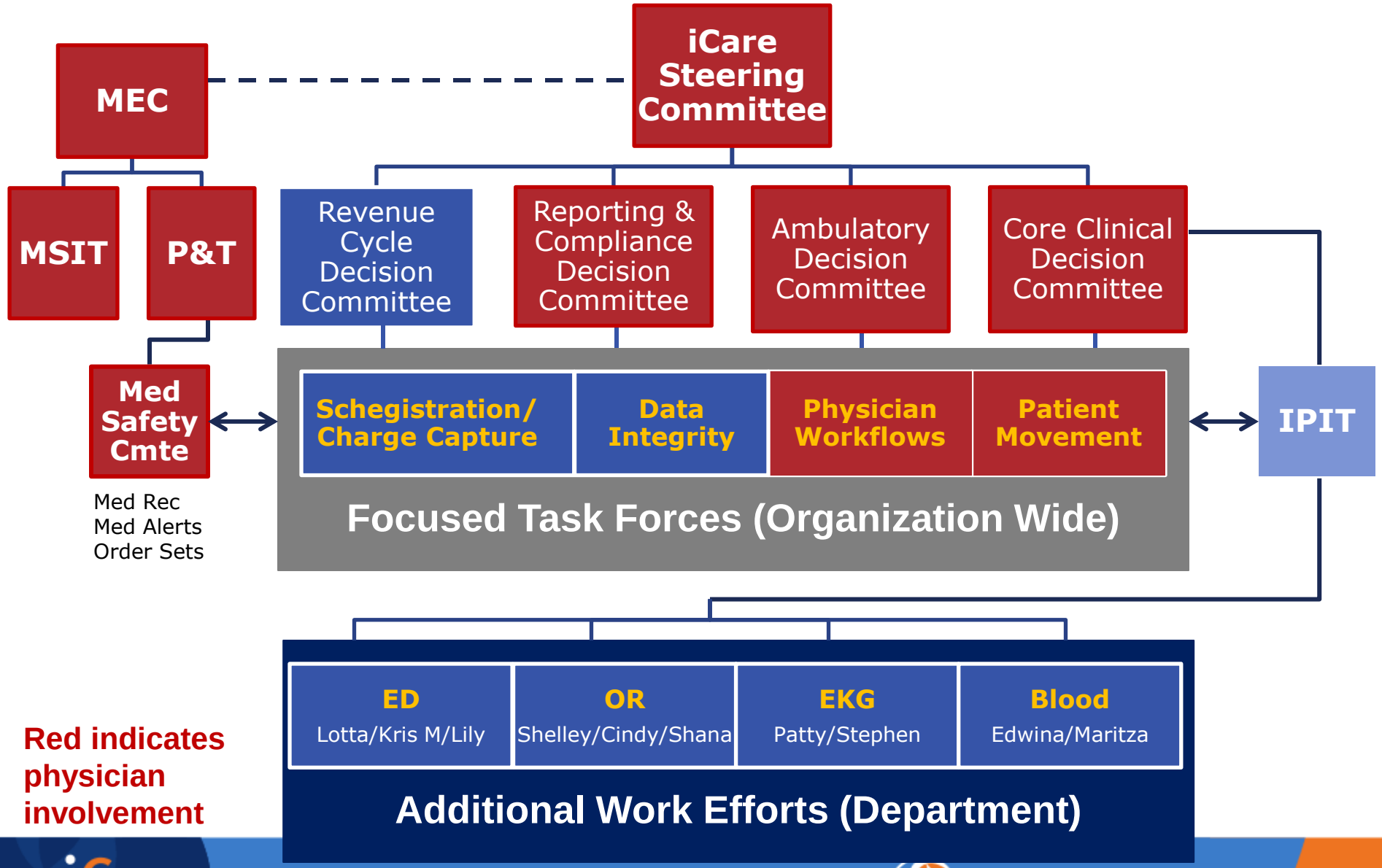
Looking Forward



Goal: Stable and Safe

- Using system as designed
- Training & workflow adjustments
- HelpDesk process & flow

Post Live Governance



Red indicates physician involvement

Task Force Updates

Patient Movement Task Force

- Workflow review complete with continued monitoring:
  - 2B blood transfusion workflow
  - 2B/IR workflow
  - Transfers to/from Peri-Operative Services
  - OB ED to ED transfer workflow
- Current focus:
  - Campus to Campus transfers versus discharge/readmission
  - Presentation at next Hospital Supervisor Meeting to review and reinforce patient movement workflows
- Top Areas of concerns from Post Live Visit:
  - 2B appointment workflow remains a challenge for nurses and physicians
  - Continued need for education on Patient Movement and the downstream effects if not done correctly

Physician Workflow Task Force

- Demonstrated improvements with continued monitoring:
  - **Alerts** – completed efforts to reduce erroneous alerts, continue to monitor.
  - **Physician Navigators** – refined Admission & Discharge Navigators. Monitoring usage of alternative navigator for proceduralists.
- Current focus:
  - **Medication Reconciliation** – identified need for additional RN training on using Care Everywhere and creating accurate prior to admission medication list. RN education to start in February.
  - **AVS** – continue to improvement patient medication list and patient care instructions post discharge
  - **SNF Discharge order process** – Investigating more efficient flow for post discharge order communication to SNF
- Top Areas of concerns from Post Live Visit:
  - Medication Reconciliation
  - SNF Discharge Process
  - Training and Support for physicians

Med Safety Committee Update

Weekly review of medication reported events with focus upon the following areas:

- Medication reconciliation at admission and discharge
- Newly implemented Heparin Protocol (still requiring oversight)
- Pharmacy consults for Vancomycin TPN
- Medication auto-verification process in the ED

Epic Post Live Visit #1

Epic Post-Live Visit & Assessment

Week of January 18

- First of three iCare Post-Live Visits
- Chance for our staff and leadership to give feedback on how the system is working in their areas
- Surveys distributed to assess support, training and general satisfaction with the system.
- Project team (including Epic) met with departments to discuss survey results, identify trends and help prioritize issues
- Scores consistent with other Epic organizations and shared with organizational leadership

The following common themes were found:

- Users are becoming accustomed to the system and increasing proficiency daily, and expect this to increase with time
- In some areas, users are commenting that the system is intuitive and that finding/reviewing the patient chart and access to external records is helpful

In addition, Epic noted areas in which we can focus our efforts in the next few months:

- Identifying areas for ongoing training of time-saving features, tools and tips
- Refinement and reinforcement of workflows
- Continued oversight of revenue cycle metrics and work queues
- Understanding and validating report data
- Practice and experience with downtime procedures

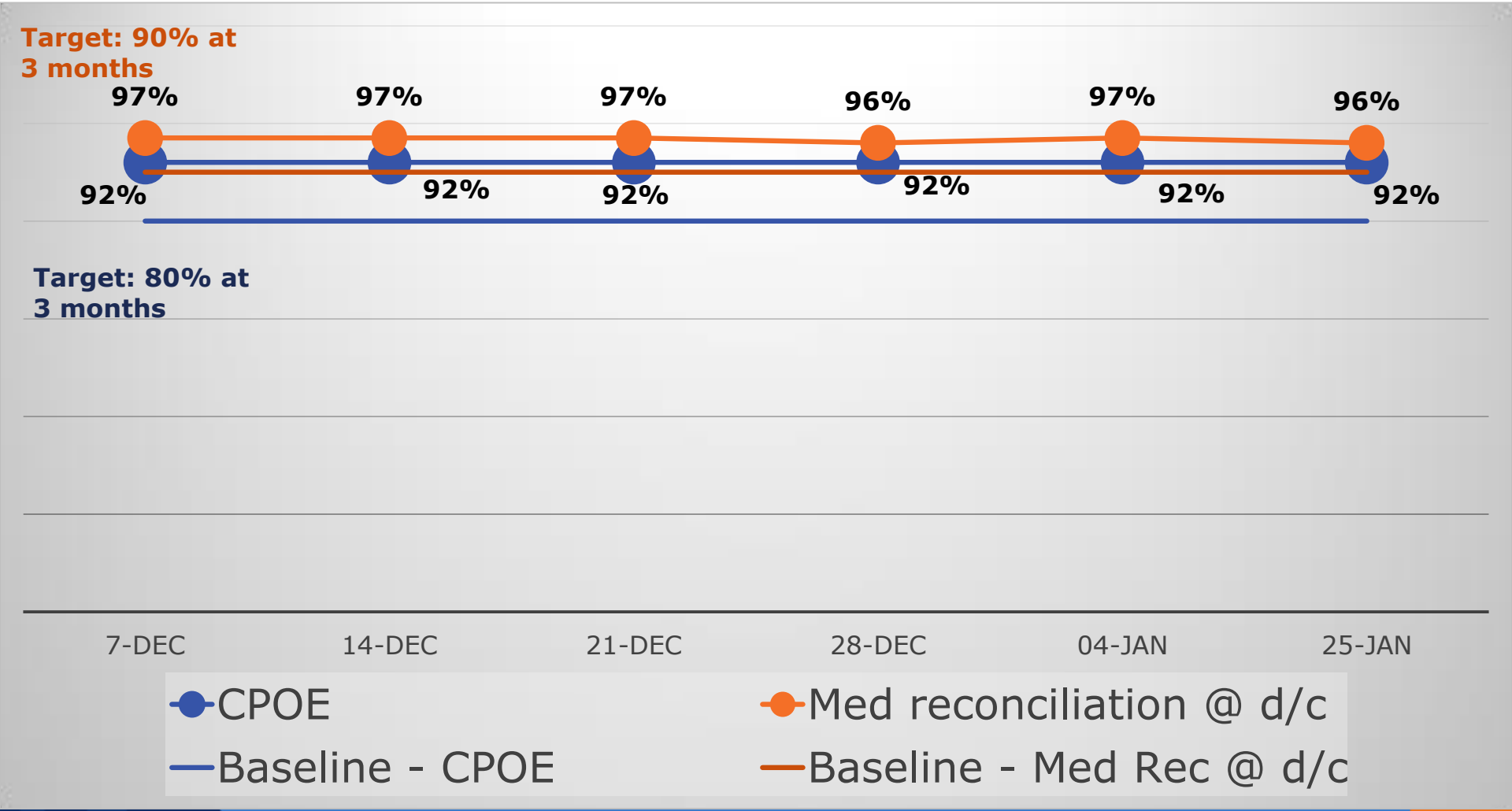
Key Performance Metrics

Physician Adoption

- **CPOE:** % of total orders enter by a physician or per protocol orders. Verbal or telephone orders count against CPOE.
- **Med reconciliation at discharge:** % of discharged patients that have full med rec done at time of discharge
- **Patients with problem in the problem list:** % of patients that have had problem list updated during the hospital stay
- **Use of order sets:** % of total physician orders from order sets

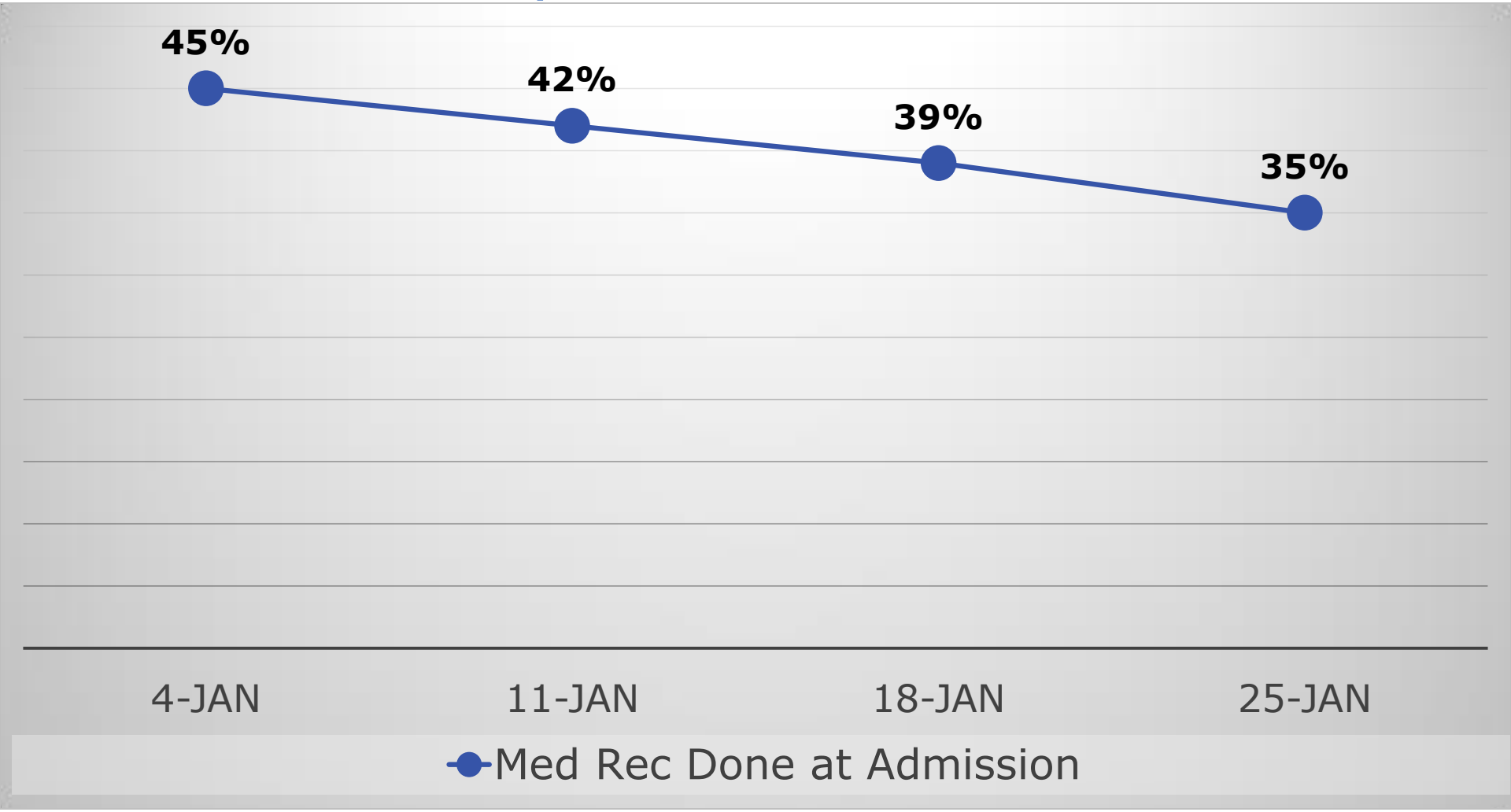
Physician Adoption

CPOE & Medication Reconciliation at Discharge



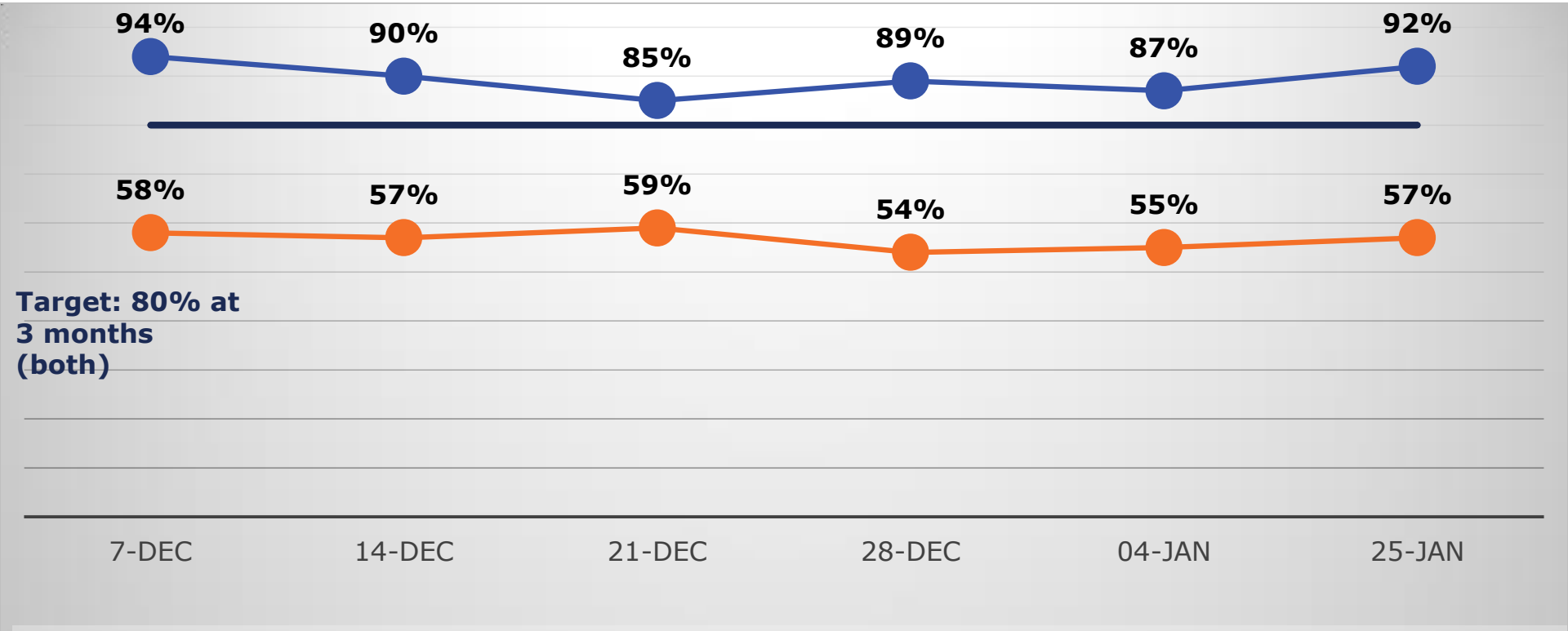
Additional Metric

Med Rec Completed at Admission



Physician Adoption

Problem List & Order Sets



- Patients w/ problem in problem list
- Use of order sets
- Baseline - Patients w/ problem in problem list
- Baseline - Use of order sets

Analysis of Medication Reconciliation Issues

- Problem:
  - Med rec is not consistently completed on admission due to challenges with entering and verifying the home medications list
  - Incorrect reconciliation of home meds lists creates downstream effects on discharge and AVS

- Mitigation Plan:
  - Nurses will receive training regarding the workflow to incorporate patient information via CareEverywhere and the process for updating the home medication list
  - Managers and educators will perform competency checks and chart review to monitor progress