NH Health Care Quality
Assurance Commission

Annual Report of the
New Hampshire Health Care Quality Assurance Commission

June 1, 2017

RSA 151-G: 1 established the New Hampshire Health Care Quality Assurance Commission. Its intent is *to enable health care providers to share information about adverse outcomes and prevention strategies in learning environments which foster candor and self-critical analysis while maintaining the confidentiality of the information submitted to the Commission, the proceedings of the Commission, and the results of the Commission's deliberations.*

Members of the Commission include one representative from each acute care hospital and free standing ambulatory surgical center (ASC), a designee of the Commissioner of the Department of Health and Human Services and three "at large" public members. During the past year Thomas Bunnell served as the public representative, appointed by Governor Lynch in 2012, and we welcomed two new public members. Paula Carr was appointed by the President of the Senate and Sara Meade was appointed by the Speaker of the House. They joined the Commission at the March 2017 meeting, after receiving an orientation to the Commission.

Members of the Executive Committee include:

Chair	**Lori Key**, RN, MBA Director QA & Safety, Dartmouth Hitchcock Medical Center, Lebanon
Vice-Chair	**Natalie Gosselin,** MS, RN, CPHQ, CSSGB Director, Center for Quality & Safety Southern New Hampshire Medical Center, Nashua
Past Chairs	**Marge Kerns,** RPh VP Clinical Services, LRGHealthcare, Laconia
	Jean Corvinus, RN, BSN, MS, CPHQ, CPPS Director, Quality & Performance Improvement, Frisbie Memorial Hospital, Rochester
At Large	**Melissa Howard,** BS, RN, CPHQ***** Director of Quality, Infection Prevention and Service Excellence Speare Memorial Hospital, Plymouth
	Martha Leighton, MS, RN, CPPS Patient Safety Officer Elliot Health System, Manchester
	Sue Majewski Chief Operating Officer, Bedford Ambulatory Surgery Center, Bedford
	Christopher Tkal VP Quality & Patient Safety Cheshire Medical Center/Dartmouth-Hitchcock, Keene

*Elected to the Executive Committee at the March 2017 meeting.

During its twelfth year, the Commission met five times on the following dates:

- August 8 and October 14, 2016
- January 13, March 10 and May 5, 2017

Executive Summary

The following principles were utilized as a guide by the Commission in our efforts to promote high quality and safe care to all patients seeking services in our organizations. Agenda planning incorporated these principles, including topics that are timely and would support them.

Guiding Principles:

☑ Adopt Evidence-Based Best Practices to Improve Outcomes
Using scientific studies to select interventions that are proven to improve outcomes and avoid harm.

☑ Establish 'Just Cultures' within our Organizations
Creating cultures of safety where staff and providers involved in an error are treated fairly in the investigation process and we clearly understand contributing factors that involves differentiating system and human failures from reckless behavior.

☑ Promote High Reliability Organizations
Improving systems and standardizing processes to yield best outcomes and to detect and manage unexpected events before they escalate into situations resulting in harm to patients or employees.

☑ Patient Experience
Creating a forum for patients to have open conversations about their experiences and what they need and want is invaluable in the design and improvement of care and service delivery.

Prevention of Harm topics the Commission focused on this year included:

☑ Learning about implementation strategies for the new Opioid Prescribing Rules and changes in the Prescription Drug Monitoring Program.

☑ Shared discussions and understanding of how organizations are implementing best practices to address pain management through appropriate treatment, incorporating practice changes into work flows and reliable adherence to new regulations.

☑ Meeting with the State of NH Licensing and Regulation Services staff to share feedback about the process of reporting Adverse Events and optimizing shared learning from events to contribute to the 2015 Adverse Event Report.

- ☑ Receiving updates about current legislation such as the Medical Technician Registry and Employee Indemnification Law.

- ☑ Education on antimicrobial resistance and current efforts on both a statewide and community level focused on antibiotic stewardship.

- ☑ Shared learning, resources and best practices from the National Partnership for Patients initiative with ongoing communication about educational offerings focused on harm prevention topics.

- ☑ Continued encouragement of the adoption of a 'Just Culture' in our organizations and ongoing education using practical examples of its application through a comprehensive presentation by a hospital and educational approaches used by all to reinforce the principles of a culture of safety.

- ☑ Presentations by two hospitals on their approach to workplace safety and its role in promoting a culture of safety through comprehensive programs that involved developing strong employee safety policies, training and education, encouraging safety event reporting and leadership modeling of desired behaviors via rounds and huddles demonstrating that workplace safety is a strategic priority.

- ☑ Sharing and learning by all members of Patient Safety Bright Spots that occurred at their organizations in the past year, to celebrate National Patient Safety Awareness Week.

- ☑ Timely communication of new DCYF rules about Plan of Safe Care for infants born with neonatal abstinence syndrome; a CDC alert about contaminated heater-cooler devices used in cardiac surgery and the new State of NH Reportable Diseases Rules.

Organizational Structure and Activities

The Commission is working under the protection of RSA 151:13a and RSA 329.29A. All new members received an orientation and signed confidentiality agreements, to allow for free exchange of sensitive information amongst members. All meetings were coordinated and meeting minutes were recorded by an administrative representative of the Foundation for Healthy Communities.

With our expanded membership of two additional public members, we are confident we will continue to develop more meaningful ways to encourage patients to partner with their clinicians to assure optimal health benefits. The presence of our public members also improves our effectiveness in communicating the message of what we are trying to accomplish. They add tremendous insight and value by bringing the voice of the public to our discussions.

The Executive Committee met or held conference calls prior to meetings to set agendas and to suggest topics that reflected current priorities focused on eliminating harm and improving quality.

Adopt Evidence-Based Practices to Improve Outcomes

Management and Prevention of Healthcare Associated Infections

NH healthcare organizations continue to work hard to reduce and eliminate opportunities for exposure to infection. As required by law, all Hospitals and ASCs are submitting infection data to the National Health Safety Network (NHSN) or the NH Healthcare Associated Infection program. The 2015 Healthcare Associated Infection (HAI) Reports for Hospitals and ASCs were distributed to all members and results reviewed.

Overall results for NH include:

Hospitals:

- A total of 200 HAIs were reported by hospitals in 2015, compared with 219 in 2014, 183 in 2013, 198 in 2012, 110 in 2011, 114 in 2010, and 134 in 2009. More infections were reported beginning in 2014 due to an expansion of hospital reporting requirements.
- The observed number of HAIs in New Hampshire hospitals was 27% lower than predicted based on national data; there were also 48% fewer central line-associated bloodstream infections and 18% fewer surgical site infections than predicted. There were 44% fewer catheter-associated urinary tract infections than predicted, a significant decrease from 2014.
- Statewide hospital adherence to four infection prevention practices during central line insertions was 98.2% (compared to 98.3% in 2014).
- Healthcare personnel influenza vaccination rate in hospitals was 93.7%, which has shown continuous improvement since 2008 (when it was 59.9%) and exceeds the Healthy2020 goal of 90%.

The overall observed number of HAIs was 27% lower in NH hospitals and 53% fewer in ASCs than expected based on national data.

Ambulatory Surgery Centers:

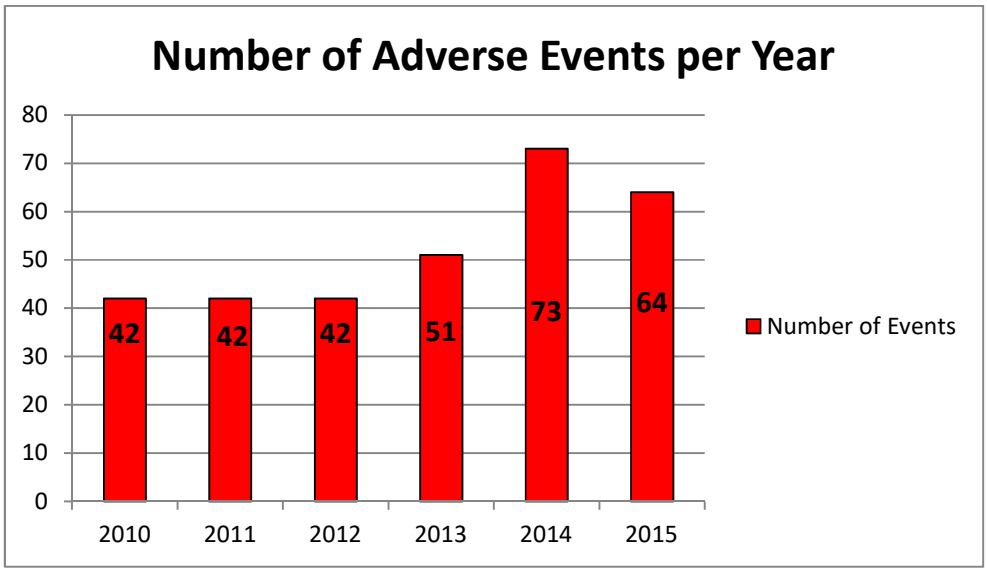
- Statewide infection rates in ASCs are similar in comparison to national data. A total of three surgical site infections were reported by ASCs for 2015, compared with four in 2014.
- The observed number of surgical site infections in New Hampshire ASCs was 53% fewer than predicted based on national data; however, this difference is not significant and considered similar to national data.
- Statewide ASC adherence to intravenous antibiotic prophylaxis timing guidelines to prevent surgical site infection was 98.5% (similar to 2014) and the overall staff influenza vaccination rate was 76.3% (a significant decrease from 85.7% in 2014 due to four ASC reported vaccination percentages that were significantly lower than the overall State vaccination percentage.)

Source: 2015 Healthcare Associated Infection Report http://www.dhhs.nh.gov/dphs/cdcs/hai/publications.htm

Serious Reportable Events / Adverse Events

Since January 2010, NH hospitals and ASCs have been reporting adverse events to the Bureau of Health Facilities Licensing as required by RSA 151: 38, which were revised in 2013. The list of events are based on the National Quality Forum's (NQF) revised list of twenty-nine discrete adverse medical events, known as **serious reportable events (SREs).** In NH, there is an additional event related to transmission of blood borne pathogens that is required to be reported. The NQF definitions were broadened and additional event types were added to the list of SREs by NQF, which resulted in an increased number of NH reports starting in 2014. This has been particularly evident in the category of pressure ulcers, whose definition was expanded to include "unstageable", which resulted in a doubling of pressure ulcer reports between 2013 and 2014, from 11 to 22, but stabilized in 2015.

It is notable to report that in 2015 there was a **12% decrease** in total SREs. Organizations have scrutinized their root cause analyses to learn about the weaknesses in their systems to identify opportunities to improve the quality of care the patients receive within their hospitals.



Hospitals contributed data on total beds, ICU beds, admissions, patient days, and inpatient and outpatient surgical volumes to the state adverse event report. This year, the number of *staffed* beds was also included to more accurately describe the level of activity, acuity and the relative size of NH hospitals. ASC volumes were not included since there was only one reported event in an ASC.

Discussion about experiences with adverse events and what organizations did to respond to them provided invaluable learning for others to mitigate potential risks that may exist at their own organizations. Staff from the State of NH Bureau of Health Facilities Licensing attended our August meeting to have a general question and answer session about the process

of reporting SREs. Commission members requested ongoing communication and feedback from the department when they have questions about determining whether an event meets the definition of an SRE. Members continue to be very diligent about ensuring the high integrity of reporting these events in a timely manner.

Another focus continues to be on educating the public at large on the importance of having a high level of engagement in their care and working together with their healthcare team. How we partner with patients and family was included as a key part of the report. The report was presented on November 18, 2016 to the Health & Human Services Oversight Committee by the staff of Health Facilities-Certification. The publication of the report generated a lot of interest by media outlets resulting in many news stories with attention to the efforts that are occurring at the hospitals and community level to improve safety for our patients.

Adverse Drug Events: Medication Safety & Pain Management

There has been a significant focus on the appropriate pain management of patients due to the associated risks of opioid diversion, overdose deaths and addictions. How NH is addressing this growing concern was a topic at every Commission meeting. Members were provided with regular updates about the Prescription Drug Monitoring Program (PDMP), including software improvements, who can query the data base, use of delegates, expectations of use prior to any narcotic prescriptions and workflow suggestions. Requirements of the new opioid prescribing rules that went into effect on January 1, 2017 were regularly shared, followed by question and answer sessions. The feedback of Commission members was then communicated via staff of the NH Hospital Association (NHHA) to the NH Medical Society, who developed Opioid Prescribing Rules FAQs. Additional questions resulted in ongoing revisions and updates to the FAQ document and brought back at each meeting. Members had ongoing discussion and sharing of best practices, policies and procedures. Use of Risk Assessment tools, prescribing practices, provider education and changes in workflows were shared. A Checklist for the Prescribing of Opioids for the Management or Treatment of Pain was distributed to all members, as a guiding tool for helping organizations implement and adhere to the new rules. An update of the activities of the NH Board of Medicine and other involved regulatory health care licensing boards was also regularly offered. The Commission would like to acknowledge with gratitude the regular attendance by the NHHA's Kathy Bizarro-Thunberg to keep members informed.

Members were also provided with:

- Handouts from a webinar explaining the CDC Guidelines for Prescribing Opioids for Chronic Pain, 2016.
- Information from the Pain Assessment and Management Initiative (PAMI): A Patient Safety Project - a free online resource whose goal is to improve pain recognition, assessment and management in patients of all ages including special populations. They offer learning modules, a Discharge Planning toolkit, a Distraction Toolbox for Pain and Anxiety and a Pain Management and Dosing Guide.

Members were also informed of other legislative updates that were a response to the significant drug diversion event that occurred in 2012. They included:

Medical Technician Registry

Medical Technician Registry materials were sent to Commission members about the website with the application and information for criminal background checks. Although it is not proscriptive as to "who" the term "Medical Technician" applies, the Commission recommendation was to broadly interpret that any role should be included in which practice includes management and exposure to narcotics as part of their duties and activity. The Board is phasing the requirement in over a 6-7 months period.

Employee Indemnification Law

This bill declares that any health care provider facility licensed under RSA 151 shall provide certain employment information to any other health care provider facility regarding an employee or prospective employee if the information was provided in good faith. It became effective January 1, 2017. Although Human Resource Departments will primarily be involved in this, Commission members are supportive of the law because they had raised this as an issue years ago, as a risk to patient safety if concerns related to employee's behavior were not disclosed.

Antibiotic Stewardship

Antimicrobial resistance has become widespread over the past several decades and residents of NH have been impacted by this trend. The Commission established this as a high priority focus area for this year. Dr. Ben Chan, State Epidemiologist, provided an educational presentation at the January meeting on this topic. He reviewed how antimicrobial resistance happens. Multidrug resistant organisms (MDROs), predominantly bacteria, are usually resistant to all but one or two commercially available antimicrobial agents. MDROs cause infections that result in hospitalizations, incur significant costs, prolong hospital stays and result in complications. The CDC published a document called "Antibiotic Resistance Threats in US 2013" used to determine prioritization of work efforts by classifying them as: 'Urgent', 'Serious' or 'Concerning' threats. 'Urgent' includes clostridium difficile (C.Diff), Carbapenem-resistant Enterobacteriaceae (CRE) and drug resistant gonorrhea, the second most reportable sexually transmitted disease in the USA. Dr. Chan provided an overview of the prevalence of these diseases in NH as well as challenges in diagnosis and treatment. The role of public health in preventing Antibiotic Resistance involves leading the coordination and improving antibiotic use in healthcare settings by knowing the antibiotic resistance threats. NH activity included forming a workgroup in coordination with the Foundation for Healthy Communities and others.

"Each year in the United states, at least 2 million people become infected with bacteria that are resistant to antibiotics and at least 23,000 people die each year as a direct result of these infections"

(Centers for Disease Control and Prevention 2013)

A strong antimicrobial stewardship program is a cornerstone to address the challenges of increased resistance patterns in hospitals and surrounding communities. In May, a presentation was made by a member about their work in developing a community wide approach to antibiotic stewardship. The initial focus was on acute bronchitis and providers were given guidelines and data about prescribing practices. They developed a commitment letter to patients explaining that because they have a virus an antibiotic will not be helpful and outlined suggestions for symptom relief. This letter was signed by the hospital CEO and president of the medical staff. They also created an instruction sheet about the role of antibiotics and the importance of taking the full dose as prescribed. They created posters for clinics and not only educated the providers but gave them tools to support them in their efforts to educate their patients and the public.

All members received and were encouraged to complete the CDC Checklist for Core Elements of Hospital Antibiotic Stewardship Programs.

Establish a 'Just Culture' / Culture of Safety

Workplace Safety

The concepts of a Just Culture offer our organizations a means to fairly evaluate systems issues while ensuring personal accountability. An organization with a just culture encourages employees to report unsafe conditions and adverse events. Rather than assigning blame for medical errors they seek to understand the underlying cause of variability that may have contributed to the event. There is an increasing recognition that hospitals and health care organizations must go beyond patient safety and foster a culture of safety for all, including its employees. Reducing workplace violence and injury was another priority focus area for the Commission this year. It is difficult for health care workers to make the care they provide safer to patients if they do not feel safe in the environment that they work in. As a continuance to a model we began three years ago, we used presentations by members who shared their approaches on how they have focused on improving workplace safety.

> *"Both patients and health care workers sustain injuries at relatively high rates. U.S. Hospitals recorded 6.8 work related injuries and illnesses for every 100 full-time employees in 2011. Additionally, assaults comprise 10-11 percent of workplace injuries involving days away from work. These assaults result primarily from violent behavior or patients, clients or residents."*
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> *Health Research & Educational Trust (May 2017). Culture of Safety Change Package: 2017 Update*

One organization gave a very comprehensive overview of their approach towards reducing workplace violence. They shared historical trended national data from 2002-2013 which showed healthcare ranks in the highest occupational category of workplace violence incidents, as measured in days away from work. The majority of incidents (80%) are patients causing injuries to employees. This does not include verbal threats or abusive behavior. In response to issues observed at their hospital, they initiated a coordinated effort in 2008 to focus on this area, and embarked on the following activities:

- Created a Workplace Violence Intervention & Prevention Policy.
- Formed a Workplace Violence Committee that reviews all events and provides data to managers on a monthly basis. This shows leadership commitment to a zero tolerance for these acts and reinforces the importance of reporting.
- Are proactive regarding things that need to be done to improve safety.
- Reviewed their process for reporting, response and investigation. They create a synopsis, by types of events bimonthly, and share quarterly reports with all department managers. They have noted that the number of incidents is higher due to comfort of people reporting. They discussed initial barriers to reporting.
- Provide support & treatment for victims, stressing that violence is NOT "part of my job" and should not be tolerated. The Employee Assistance Program is available 24 hours a day so there is a focus first on employee safety and post traumatic response.
- Established training protocols and annual education for all staff in a Stay Safe program as well as other targeted programs for security staff.
- Huddles are extremely important as well as the importance of sharing stories to help each other learn. All workplace violence events are reported. This helps get the message out. These activities help staff recognize events that should be reported.

Another hospital offered their experiences on the journey to improve workplace safety, triggered by an event involving a staff member assaulted in the ED four years ago. At that time there was no real process to respond to the event and a lack of understanding that the situation could have been controlled. They began by implementing a policy of zero tolerance. They posted signage for patients about behavior expectations. They developed an 'Aggressive Act on Campus – Response Work Flow' outlining actions and an 'Action Worksheet' which provides a standardized approach to these events.

They also created a pamphlet 'Coping with the Unexpected' which is given to staff who may be involved in an incident. It provides suggestions for managing symptoms of stress and reinforces that an aggressive or assaultive incident is not part of "business as usual" and reinforces the supports that are available to them.

For particularly challenging patients who may have frequent encounters with their system, staff create a Containment Plan which provides a mechanism to guide staff in optimal treatment approaches that have been successful for the patient in the past. The hospital works closely with community partners who may also be involved providing services to patients who have been deemed as a "complex case." They also expanded education and training for security and front line staff members.

Culture of safety rounds (monthly rounds with senior leaders) and daily rounds and huddles all have a focus on staff safety. 'Days since last staff injury' is reported on at leadership huddles.

Commission discussions have focused on how we might increase reporting of these types of events to the state, since there is an applicable SRE: Death or serious injury of a patient or staff from physical assault (battery) within or on the grounds of a healthcare setting. The definition of serious injury is hard to apply when one considers emotional harm. Members agree that having more information about these events publicly available will help raise awareness.

Promote High Reliability Organizations (HROs)

Many of the topics that are discussed at the Commission meetings result in members sharing specific approaches they have taken to ensure that the system improvements they are making truly become "hard wired." Presentations have been made over the years about educational efforts and ongoing programmatic changes in how daily work is approached. This year we learned about one hospital's journey to improve reliability, with a focus on resilience.

The presentation included a review of the Five Principles of HROs, per Weick and Sutcliffe:

- Three Principles of Anticipation
  - Preoccupation with Failure – Regarding small, inconsequential errors as a symptom that something's wrong
  - Sensitivity to Operations – Paying attention to what's happening on the front-line
  - Reluctance to Simplify - Encouraging diversity in experience, perspective, and opinion
- Two Principles of Containment
  - Commitment to Resilience –Developing capabilities to detect, contain, and bounce-back from events that do occur
  - Deference to Expertise – Pushing decision making down and around to the person with the most related knowledge and expertise

> *"By promoting the core attributes of trust, report and improve, high-reliability organizations create safety cultures in which team members trust peers and leadership; report vulnerabilities and hazards that require risk-based consideration; and communicate the benefits of these improvements back to involved staff."*
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> *Sentinel Event Alert, Issue 57, March1, 2017. Published by The Joint Commission*

Organizations need to be relentless in their desire to learn from events and defects, must respond to failures in a timely manner and find new solutions, and help staff connect to the "why" of each improvement effort. Standard work involves the use of evaluation tools with setting of stretch goals; investment in leader skill development; use of real-time scenarios - "on-the-spot" teaching and fostering the celebration of any "good catch."

The six domains of personal resilience (vison, composure, reasoning, health, tenacity and collaboration) were reviewed. Recognizing and fostering the growth of these traits in our work force is critical to developing their capabilities to address events in an effective manner. It also recognizes that clinicians and staff involved in events may often be at risk of becoming the "second victim" so an awareness of these traits and their impact on one's ability to recover from an event is important. Members participated in an exercise of self- identifying which traits they thought they were especially strong in, and described behaviors associated with those traits that other members might find useful.



Eliminate Harm: Partnership for Patients

In 2010 the CEOs and Board of Trustees at every acute care hospital in NH agreed to support the goal of eliminating harm by 2015**.** The Eliminate Harm Initiative work was aligned with the efforts of the Partnership for Patients, a national initiative known as the Hospital Engagement Network, that took place from 2012-2016. In September of 2016, the Hospital Improvement Innovation Network was launched, continuing the work of the FHC NH Partnership for Patients. All 26 NH acute care hospitals committed to participate and others were welcome to participate. Two levels of a Quality Improvement Fellowship and a new Patient Family Engagement Fellowship, (developed and offered by NH resident and FHC staff member Tanya Lord), were offered. Free topic specific resources, virtual trainings and in-person events, with CME / CEU have also been made available.

The Partnership for Patients focus on making hospital care safer, more reliable, and less costly is through the achievement of two goals by 2019:

- Making Care Safer: Reducing all-cause patient harm by 20%
- Improving Care Transitions: All hospital readmissions to be reduced by 12%

The goals of the Partnership for Patients are aligned with the Commission's principles of high reliability, adoption of evidence based practices, patient experience and encouragement of a culture of safety in our organizations. Patient and family engagement is an essential component as well as addressing health care disparities.

Resources include evidence based guidelines, change packages, webinars and presentations to assist in implementation, which are shared with hospitals, ASCs and all partners along the continuum of care.

Areas of focus include:

- Adverse Drug Events
- Catheter Associated Urinary tract Infections
- Central Line Blood stream Infections
- Clostridium Difficile
- Injuries from Falls and Immobility
- Pressure Ulcers / Injury
- Readmissions
- Sepsis and septic shock
- Venous Thromboembolism
- Ventilator Associated Events

Data collection requirements allow us to compare performance nationally as well as statewide, in a timely manner. Results for the September 2015 – September 2016 activity indicated NH hospitals avoided **168** patient harms and saved **$1.12M** in healthcare costs.

Patient Experience

Incorporating the Patient Voice / Experience

Looking at our work through the lens of the patient and family is one way that we are able to attain meaningful and permanent success in ensuring patients receive the safest care possible with optimal outcomes based on evidence based practices.
Examples of our approach are reflected in the topics that were presented this year and include:

- Distribution of Get Smart About Antibiotics Patient / Public handouts from the CDC
- Sharing of a letter from the CEO and CMO to the community raising awareness of the importance of appropriate prescribing of antibiotics to help establish realistic expectations when visits are made to a provider
- Seeking feedback from members of Patient Family Advisory Councils in developing communication to patients about the new Opioid Prescribing Rules
- Distributing CDC / American Hospital Association handout: Prescription Opioids: What You Need To Know
- Ensuring dignity and respect for the patient is a main focus as organizations apply the principles of high reliability organizations and seek to learn from an untoward event

- Bringing forth patient and family concerns into daily safety rounds / huddles with staff and leadership
- Incorporating family suggestions and guidance in developing safe plans of care for patients at risk for harm to themselves or others

Patient Safety Bright Spots

35 hospitals and ASCs shared over 50 examples of Patient Safety Bright spots that occurred in the past year, as a prelude to recognizing Patient Safety Awareness Week, March 12-18. A sampling of achievements in quality and / or patient safety activities that were highlighted include:

- Steps taken to reduce infections such as improving sterilization of equipment, standardizing products, changing cleaning methods, purchasing new equipment and implementing new protocols resulting in a 75% reduction in central line associated bloodstream infections and a 52% reduction in catheter associated urinary tract infections.
- Seeking feedback from patients via surveys and direct comments that helped drive development of new education for surgical patients and greater attention from staff to areas that patients had voiced concerns about.
- Improving the physical environment to ensure safety for those experiencing a behavioral health crisis and to reduce risk of falls outside surgical centers by repairing / painting curbing in the parking area.
- Establishing a new system of care delivery for patients who are pregnant with substance use disorders and ensuring their needs are addressed throughout their birthing experience.
- Investing in strengthening the culture of safety thru expansion of Team STEPPS training, leadership rounds, tiered huddles, checking the daily safety temperature, visual management boards and establishing a goal of zero preventable harm.
- Learning from defects through post fall huddles.
- Improving a medication reconciliation process from zero % accuracy to 78% accuracy.
- Creatively using media and music by holding a flash mob dance focused on engaging staff in improving patient safety and creating a You Tube video for demonstrating hand hygiene practices.

The pride of storytelling was evident and this was a great way to share with our public members the exciting and meaningful work being done every day in NH to improve patient safety!

Summary

Year 12 continued to bring NH hospitals and ASCs together to focus on the prevention of harm and continuous learning. Our topics have aligned with other efforts in the state including the work of many departments in the Department of Health & Human Services, the NE Quality Innovation Network and Partnership for Patients as well as other professional organizations, to complement our work and avoid redundancy. We are especially appreciative of our members who so willingly share their experiences, programs and methods for promoting the best patient safety practices.

We welcomed two new public members who, in addition to our other public member, readily made their voices heard on behalf of patients and their families.

The Commission will begin Year 13 in July 2017 with a continued focus on decreasing preventable harm by promoting high reliability organizations, adopting evidence-based best practices and continuing work to establish 'Just Cultures' within each institution. All public documents related to the Commission can be found at www.healthynh.com.

For questions, please call:
Lori Key, Commission Chair: 653-1063 or Anne Diefendorf, Administrator: 415-4271.

Respectfully submitted,

Anne Diefendorf

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NH Health Care Quality Assurance Commission

Foundation *for* Healthy Communities