NH Health Care Quality
Assurance Commission

Annual Report of the
New Hampshire Health Care Quality Assurance Commission

June 1, 2018

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, Paula Carr and Sara Meade served as the public representatives.

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	**Jennifer Costain**, MS, CPHQ, CPPS* Senior Director, Quality and Patient Safety Exeter Health Resources
	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 2018 meeting.
**Resigned from Commission due to assuming new role as CNO in November 2017.

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

- August 11 and October 6, 2017
- January 12, March 9 and May 4, 2018

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:

☑ 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 by contributing to the 2016 and 2017 Adverse Event Reports.

☑ Receiving updates about current legislation such as the proposed requirements to report Workplace Safety events and updates to the PDMP rule.

☑ 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 presentations by members and educational approaches used by all to reinforce the principles of a culture of safety.

- ☑ Presentation by a hospital that experienced an act of gun violence in their hospital and the response following the event to improve workplace safety.

- ☑ 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.

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 from members. All meetings were coordinated, and minutes were recorded by an administrative representative of the Foundation for Healthy Communities.

Through our public members, we are developing more meaningful ways to encourage patients to partner with their clinicians to ensure optimal health benefits. Their presence also improves our effectiveness in the messaging 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 have continued to work on reducing and eliminating opportunities for exposure to infection.

Katrina Hansen, MPH, Chief, Infectious Disease Surveillance Section, Bureau of Infectious Disease Control provided an overview of current program activities at our August 2017 meeting. Funding was made available in NH to support greater collaboration between emergency preparedness and HAI programs, which allowed expansion of infection control assessments to all acute care hospitals and an increase in education. NH completed Infection Control and Prevention Assessments in all acute care hospitals and a sample of urgent care centers, using a CDC tool. The domains of the assessment were described, and lessons learned were shared.

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 2016 Healthcare Associated Infection (HAI) Reports for Hospitals and ASCs were distributed to all members and results reviewed.

Overall results for NH include:

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 2016.

- The observed number of surgical site infections in New Hampshire ASCs was 33% fewer than predicted based on national data; however, this difference is not statistically significant and therefore considered similar to national data.

- Statewide ASC adherence to intravenous antibiotic prophylaxis timing guidelines to prevent surgical site infection was **99.1%** (compared to 98.5% in 2015) and the overall staff influenza vaccination rate was **83.3%** (an increase from 76.3% in 2015).

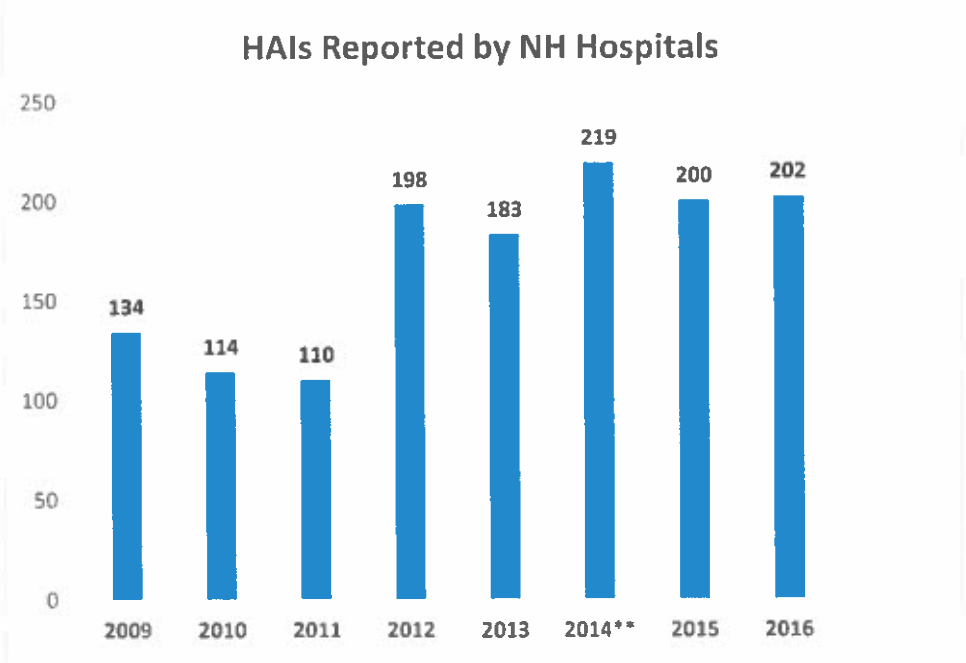
Hospitals:

- The observed number of HAIs in New Hampshire hospitals was 28% lower than predicted based on national data; there were also 61% fewer central line-associated bloodstream infections and 28% fewer surgical site infections than predicted. The number of catheter-associated urinary tract infections was 1% higher than predicted.

- Healthcare personnel influenza vaccination rate in hospitals was **94.2%**, which was the highest rate reported in the nine years of reporting. This exceeds the Healthy2020 goal of 90%.

The overall observed number of HAIs was 28% lower in NH hospitals and 33% fewer in ASCs than expected based on national data.

- The following chart shows the total number of HAI reported by NH hospitals since 2009, including central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI) and surgical site infections (SSI) following certain heart, colon, knee, and abdominal hysterectomy surgeries. In 2014 reporting definitions were expanded for some HAIs.



Source: 2016 Healthcare Associated Infection Report http://www.dhhs.nh.gov/dphs/cdcs/hai/publications.htm

Antibiotic Stewardship

In 1943, just before penicillin was available, Sir Alexander Fleming warned that misuse of antibiotics could cause organisms to develop resistance to the drugs and render them ineffective. Antimicrobial resistance has become widespread over the past several decades and the time between the year of approval for a drug coming on the market to its first clinical report of resistance has shortened. The Commission has considered this topic a high priority focus area during this commission year.

The Infectious Disease Society of America defines antibiotic stewardship as

"coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration. Antimicrobial stewards seek to achieve optimal clinical outcomes related to antimicrobial use, minimize toxicity and other adverse events, reduce the costs of health care for infections and limit the selection for antimicrobial resistant strains."

A strong antimicrobial stewardship program is the cornerstone for addressing the challenges of increased resistance patterns in hospitals and surrounding communities.

"Avoidable costs after antibiotic misuse range from $27 billion to $47 billion per year in the United States."

(Avoidable Costs in US Healthcare, IMS Health 2013)

At Commission meetings there were presentations that reinforced the importance of an antibiotic stewardship program and offered outstanding examples of best practices, including lessons learned that could be shared with all members. They included:

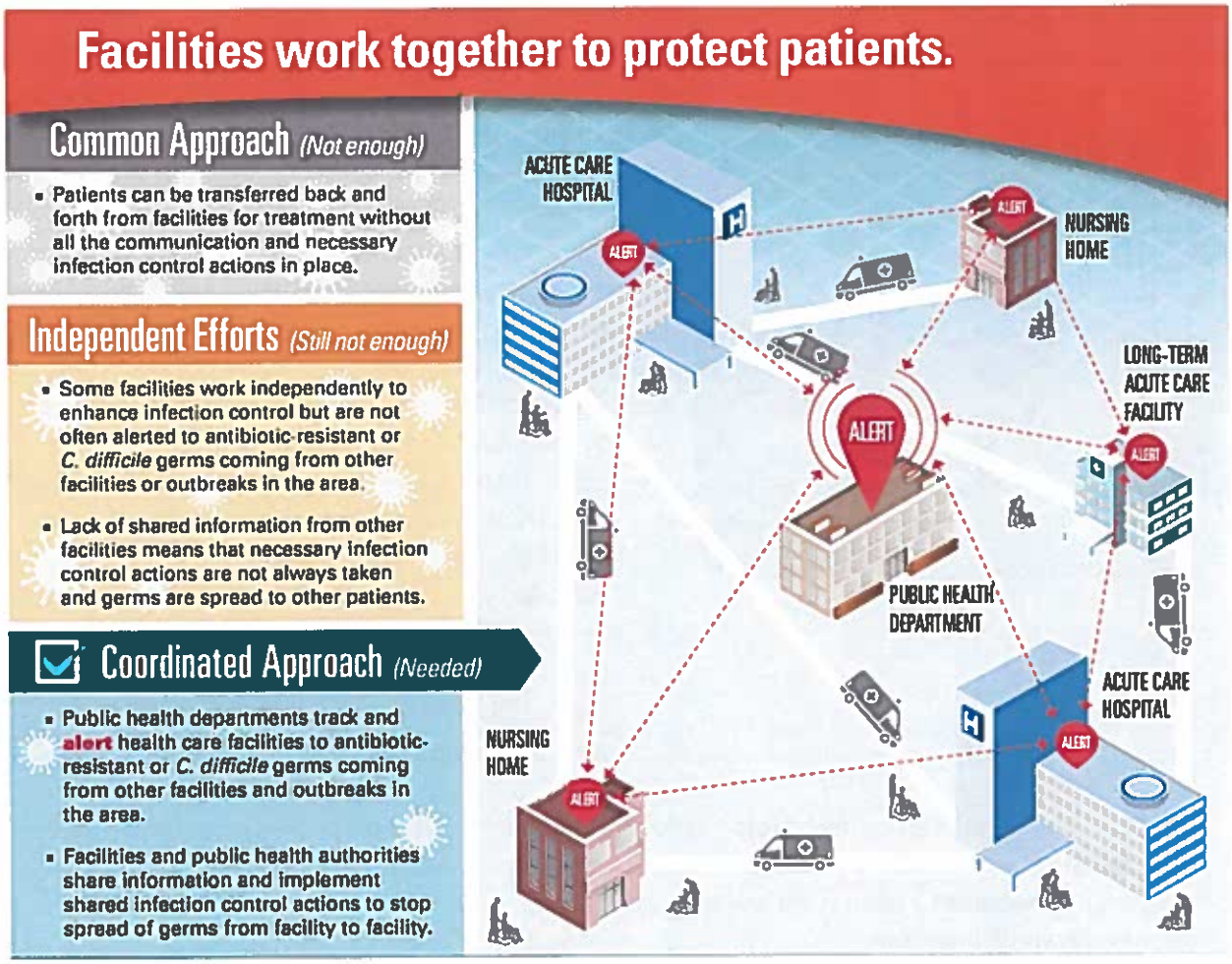
- Presentation of the First NH State Antibiogram by Hannah Leeman - Centers for Disease Control and Prevention, Public Health Associate with the Bureau of Infectious Disease Control - NH Division of Public Health Services. This included an overview of the 1st statewide antibiogram, its uses and applicability in a community setting. The clinical implications of the results and examples of clinical highlights were reviewed.

- Dr. Ben Chan, State Epidemiologist for NH, regularly offered updates of antimicrobial resistance activities including an Antimicrobial Resistance Advisory Workgroup which is well represented from a variety of organizations, roles, sectors, disciplines and geographic locations.

- A description of a Pharmacist Driven Antibiotic Stewardship Program at a 2-hospital system by Paul Santos, Pharm. D., Director, Clinical Pharmacy Services, LRGHealthcare, who reviewed the 'birth of antimicrobial stewardship, the history, current definition and the CDC – Core Elements of Antimicrobial Stewardship Program as a practical tool for organizations to use.

- An overview by Apara Dave, MD, Infectious Disease Physician and Epidemiologist of Exeter Hospital's antibiotic stewardship program including: where they started; where they stand now; how they got there; where they are headed, and lessons learned along the way. She also highlighted the CDC Core Elements of an ASP and used those elements to describe the Exeter experience, emphasizing the benefits of this program.

To be successful, antimicrobial stewardship must be a coordinated effort to improve the way antibiotics are used and prescribed, and to improve patient outcomes while reducing the development of bacterial resistance. Through many statewide efforts, including the focus of the NH Health Care QA Commission, NH can demonstrate a solid coordinated approach. Public and patient / family-oriented education is one area that has been identified as a top priority moving forward.



Establish a 'Just Culture' / Culture of Safety

The concept of a Just Culture and importance of actively promoting a Culture of Safety are frequent topics of discussion at the Commission meetings. This occurs through presentations as well as "Storytelling" and sharing of harm events by members. Just Culture is also about encouraging nonpunitive reporting of events and distinguishing amongst fallibility and at risk or reckless behaviors. It fosters reporting of defective processes and unsafe conditions that allow human error to occur.

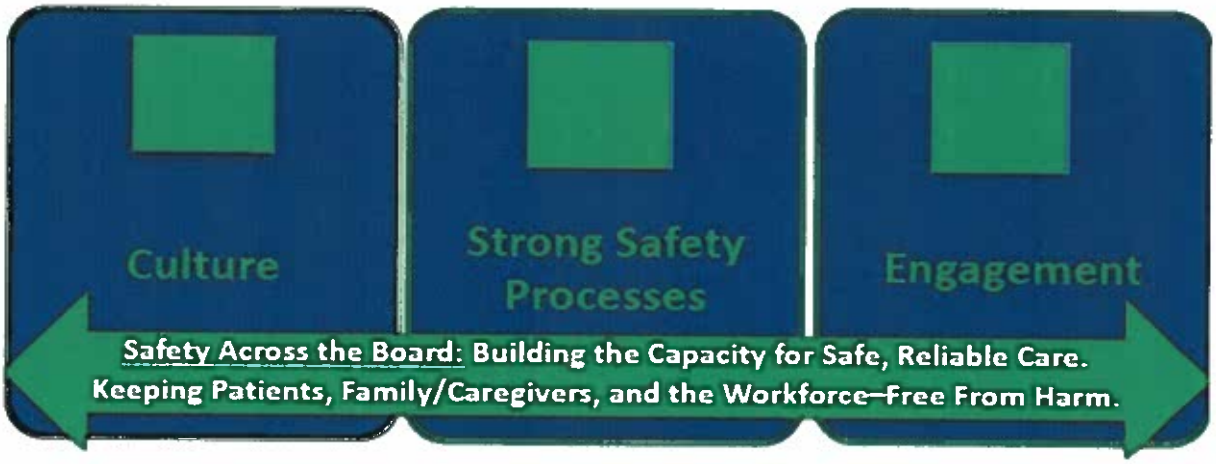
- A Review of Just Culture & Role of the Commission was presented at our August 2017 meeting by Jean A. Corvinus, RN BSN MS CPHQ CPPS, Director of Quality and Patient Safety, Frisbie Memorial Hospital. She linked the guiding principles of the Commission as well as Commission projects from 2016 to Just Culture concepts, emphasizing that it always "runs in the background". This included a review of each inherent duty and examples:
    - Duty to produce an outcome
    - Duty to follow procedural rule

- Duty to avoid causing unjustifiable risk or harm

A handout was shared with all – "Guidelines & Tools: Just Culture and Employed Staff Documentation Management Tools" that can be used as an ongoing reference.

- Several NH hospitals have instituted leadership safety rounds / daily huddles that incorporate aspects of a Just Culture with the goal of improving patient safety and quality as well as a promoting a focus on staff safety and overall safety culture. A survey was sent to those that have presented their experience with leadership rounds and huddles at past Commission meetings and others who have begun doing this, with results summarized and distributed to assist members who are exploring developing similar models in their hospitals.

- The practice of using an "All Harm" or "Total Harm" approach to reporting Patient Safety was shared by two of our members, Hannah Sharp, MS, RN-BC, CNL, Patient Safety Officer, Elliot Hospital and Jennifer Costain, MS, CPHQ, CPPS, Senior Director, Quality and Patient Safety, Exeter Health Resources at the May 2018 meeting. While they used different approaches to display total harm, they used many of the same categories of events, sources of data, and definitions. Data is published regularly and distributed in a variety of ways to different constituents such as the Board of Trustees, leaders, staff and committees. The noise created by a tsunami of data and scorecards reinforced the need to present data in the simplest terms possible to staff. Promoting transparency is an important goal and this approach has generated a greater level of engagement from front line leaders. It is designed to keep the conversation going and ensure everyone is more aware of events that happen and to encourage everyone to work on solutions.



Workplace Safety

Emerging research is showing that there is a direct relationship between patient safety and worker safety. Organizations that have successfully adopted a just culture also find this

encourages employees to report unsafe conditions and adverse events, including unsafe working conditions. Reducing workplace violence and injury continued to be a priority for the Commission this year and there were several activities focused on this topic.

- Data Collection of Workplace Harm Events A meeting with Commission members and Dr. Lisa Mistler, of New Hampshire Hospital included a review of existing definitions, challenges of data collection, importance of data, barriers and suggestions for finding common definitions. Since there are no clear measure definitions, the hope is for NH hospitals (and other health care settings) to agree on basic definitions. It was recommended that all hospitals consider adopting a slight modification of the WHO definition:

    - Modified WHO definition: Violence is the use of physical / verbal force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.

  Members offered general feedback and shared their ongoing experiences. It became clear there was substantial variation in interpretations of current reporting requirements. The emphasis is to demonstrate the level of employee harm that is occurring, not to look at it as a punitive approach to patients, who may be identified as the perpetrators. Members expressed many challenges of getting staff to report verbal threats / assaults, including fear of retaliation.

> *"According to Occupational Safety and Health Administration (OSHA), approximately 75% of nearly 25,000 workplace assaults reported annually occurred in health care and social service settings and workers in health care settings are four times more likely to be victimized than workers in private industry."*
>
> *Joint Commission Sentinel Event Alert, Issue 59 (April 17,2018).*

- Preventing Violence in Healthcare Gap Analysis: The purpose of the gap analysis is to offer an overall state snapshot of practices and help determine additional resources that may be useful. All 26 hospitals and some ASCs completed this analysis. Results will be summarized and shared in upcoming meetings.

- S.E.C.U.R.E Training for Staying Safe (Safer Environments via Collaborative, Unified Response to Emergencies workshop). This workshop was developed by staff at NH Hospital and is being offered to all hospitals thru Partnership for Patients funding. It is an integrated and proactive way to bring many community partners together to help meet the new CMS Emergency Preparedness Rule. It also fosters improved relationships with local law enforcement agencies, as well as hospital security, when dealing with challenging patients that may be at risk for aggressive / violent behaviors.

- DHMC ICU Shooting Event – Organization Response Lori Key, RN, MBA, Director QA & Safety, Dartmouth Hitchcock Medical Center, provided an overview of the event which involved a visitor shooting a patient. Immediate actions were described in response to the event, including additional EAP resources for staff that were made available. The Code Silver Corrective Actions Task Force was created to identify issues with the response, identify corrective actions, and oversee implementation of those corrections. In the first 10 weeks there was a major effort by leadership to solicit feedback from staff to learn from the people directly affected and they spoke with other organizations similarly impacted. Building a more coordinated response with other agencies was a significant focus as well and have since done a lot of collaborative work with area agencies. One strategy was to encourage each employee to develop a personal safety plan should they need to react / respond to an event in the future. Members were very grateful for the opportunity to hear first-hand about this very difficult situation so that all could learn from the DHMC experience.

Promote High Reliability Organizations

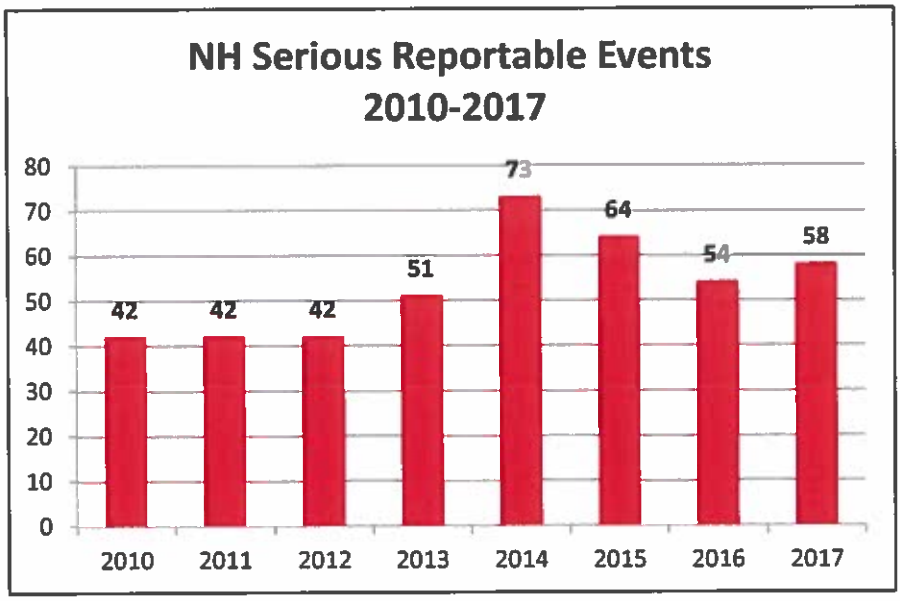
Serious Reportable Events / Adverse Events

Since January 2010, all NH hospitals and ASCs, except for New Hampshire Hospital, have been required to report every **serious reportable events (SREs)** as defined by the National Quality Forum's (NQF) Serious Reportable Event report. The NQF definitions were broadened and additional event types were added to the list of SREs by NQF, in 2011, which resulted in an increased number of NH reports starting in 2014, when the NQF SRE list was adopted for NH use. This list serves as the standard for identifying patient safety events. The list of events with complete descriptions can be viewed here:
http://www.qualityforum.org/Publications/2011/12/Serious_Reportable_Events_in_Healthcare_2011.aspx
In NH, there is an additional event related to the exposure of a patient to a non-aerosolized blood borne pathogen by a health care worker's intentional, unsafe act, that is required to be reported by RSA 151: 38, which was revised in 2013.

All hospitals and ASCs must submit an initial report to the Bureau of Health Facilities Licensing within 15 days of becoming aware of the event. The notification is filed in a format specified by the DHHS and does not include any identifying information of the healthcare professionals, facility employees, or patients involved. They must conduct a Root Cause Analysis (RCA), which is a structured method to identify and analyze any systemic issues or processes

that may have contributed to the event or could create risk of a future event if they are not addressed and corrected. Recognizing the importance of a Just Culture, identifying underlying issues is the focus rather than blaming individuals. A Corrective Action Plan (CAP) is developed and submitted that outlines action steps to address findings, assigns responsible persons to ensure actions are completed, delineates time frames for completion and describes measurable outcomes to demonstrate completion of corrective actions. The RCA and CAP must be submitted within 60 days of identification of event.

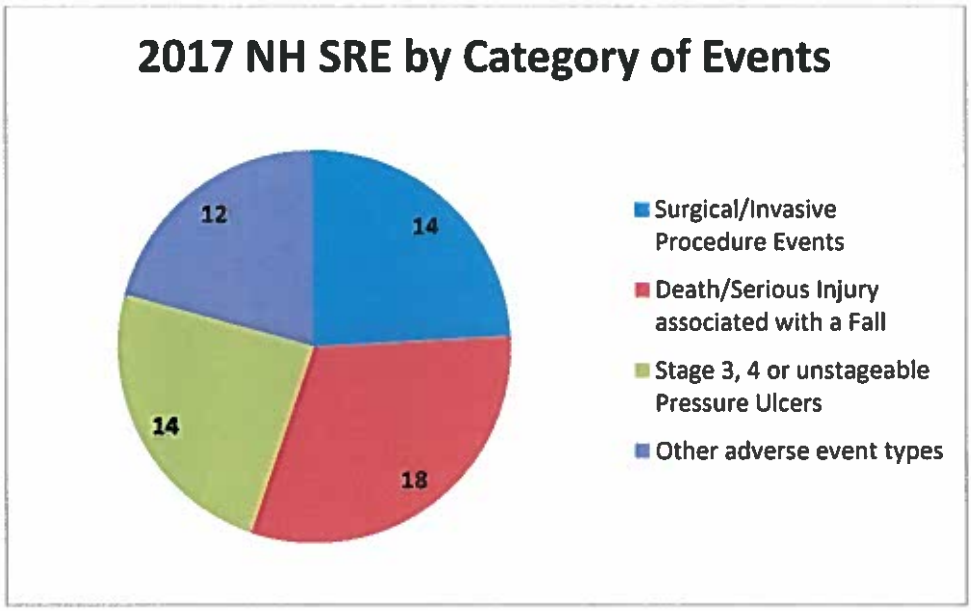
The bar graph below shows the total number of events reported in NH, since the statute was effective in 2010.



It is notable to report that in 2016 there was a **16% decrease** in total SREs since 2014, with a slight increase in 2017.

In analyzing the events reported in CY 2017, there continue to be three major areas responsible for 79% of the events reported. These areas were as follows:

Falls	**31%**
Pressure Ulcers	**24%**
Surgical Events	**24%**



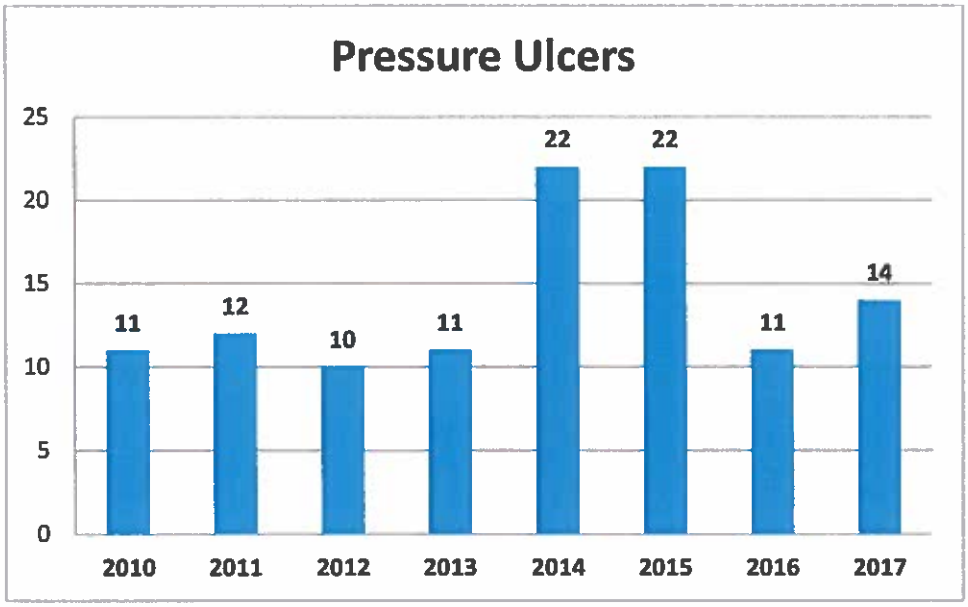
Considering that these event types represent 79% of the total events, it is important that we focus on these and address what the NH hospitals are doing in these areas to improve outcomes. Organizations have used their root cause analyses to learn about the weaknesses in their systems, to identify opportunities in systems and processes, and implement new approaches to improve the quality of care the patients receive within their hospitals and ASCs.

In addition to strategies specific to Falls, Pressure Injuries and Surgical Events, outlined in the next section, other overall approaches have included:

- Initiation of a Safety Champion program which provides for focused training on tactics to reduce falls and pressure injuries through education and peer to peer support. The safety champions are trained to evaluate their peers on how well they can complete the falls and pressure injury prevention bundles and apply their advanced subject matter expertise to help peers problem solve on complex or high-risk patients and share new advances for prevention and management.

- Sharing lessons learned from case reviews throughout the organization

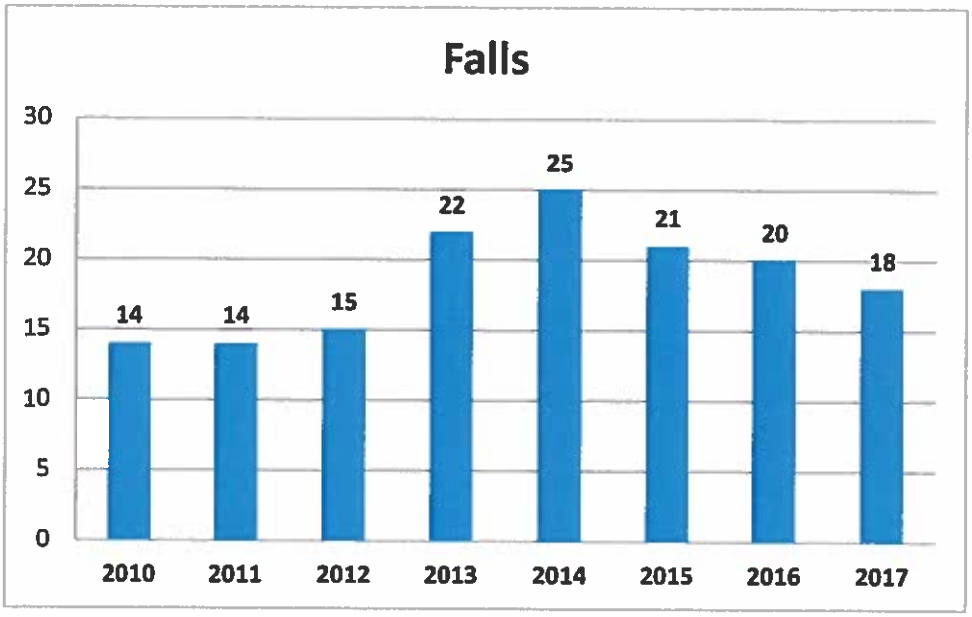
- Utilizing Culture of Safety data to identify areas at risk for falls, HAPU, & surgical events



Strategies utilized by NH hospitals and ASCs include:

- Complete a Skin Assessment upon admission to identify pressure injuries at the time of admission so that prompt care can be initiated and reassessed every 8 hours to detect early development of pressure injuries to prevent progression. Include a review of skin condition and risk in daily multidisciplinary rounds with the care team.
- Use of Braden Scale and similar tool for predicting pressure injury risk to determine other risk factors such as poor nutrition, dehydration, and hygiene issues so that high risk patients can be promptly identified, and preventative interventions can be implemented before a pressure injury occurs.
- Operative procedures which necessitate the patient's position be maintained in a single place for extended periods of time.
- Inspection of equipment and devices that touch skin such as nasal oxygen prongs, ear loops and vascular access ports. Use of preventative padding of skin areas at risk for skin breakdown from medical equipment. Involve Respiratory Therapist to daily assess the skin at potential for breakdown in patients using noninvasive ventilation pressure masks.
- Adoption of new evidence-based practices including new wound care treatments for faster healing.
- Education on wound dressing application and specialty beds.
- Use of smooth soft surfaces and special pads for surgical patients undergoing lengthy procedures and add positioning policies for any surgical case that goes over 4 hours, the patient is to be repositioned and checked for any redness or breakdown. The circulating RN documents the time of repositioning and any findings if applicable.
- Development of protocols for cleaning and treating wounds, use enhanced protocols for wound debridement (removal of dead tissue to allow for healing).

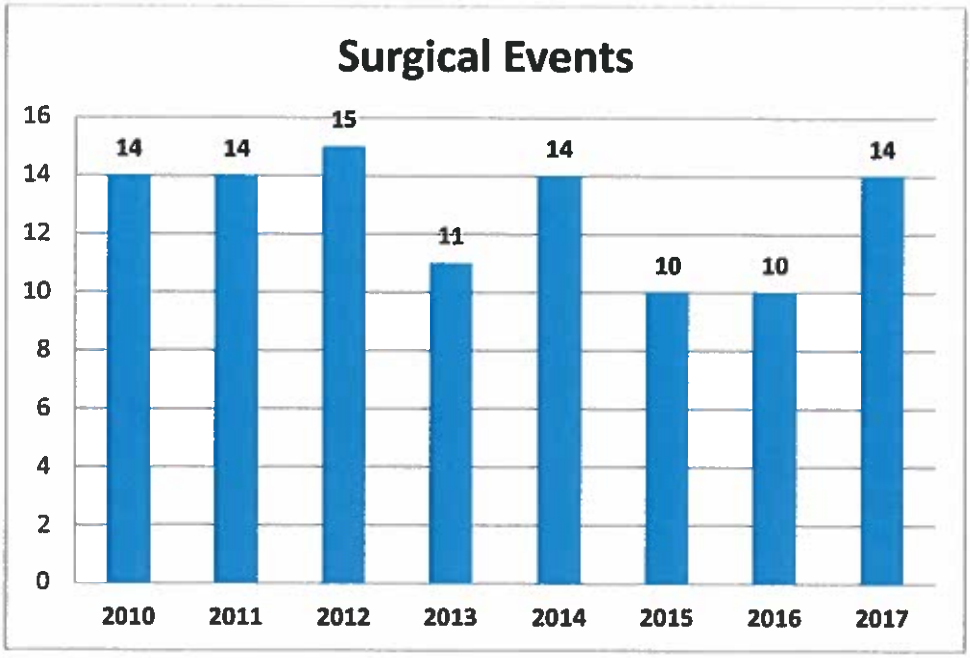
- Clinical staff education / training on wound care at orientation, with refresher classes offered at least every 2 years, on skin inspection / assessment and documentation of any sign of pressure injury development.
- Addition of Certified Wound Care Nurse to round and assess patients at risk for skin breakdown and patients with pressure injuries.
- Allow Nursing the ability to order Wound Care Nurse consult.
- Use of a valid tool to measure nutritional status and increase role of Registered Dietitian Nutritionist to create care plan to address improving hydration and nutritional status.
- Increase Provider engagement in early detection and planning for risk of skin breakdown during hospitalization.
- Standardize the hand off/huddle reports to communicate pressure injury risk or presence, including current treatment plan.
- Engagement of local provider practices and home care agencies in inspections, assessments, and preventative treatment and patient/family education.



Strategies utilized by NH hospitals and ASCs include:

- Educate patients (and caregivers) of their fall risk due to medications that may interfere with mobility and judgment, such as post-operative pain medications, medical conditions and impact of femoral nerve block.
- Focus on purposeful rounding to determine the safety and comfort of patients at least every hour and expand the act to include toileting at least hourly, as indicated.
- Use a standardized Fall Risk Assessment upon admission, expanded to include a history of falls at home (including asking family members or caregivers) as well as assessing for evidence of falls such as bruising. Fall Risk Assessment will be updated every eight hours and re-evaluated after every fall.

- Link specific interventions to prevent falls to the fall risk assessment score. Staff education orientation/refresher on fall prevention including the content of assessment and making changes in interventions as needed to address the changes in fall risk.
- Staff debriefing (huddles) immediately after every fall to determine contributing factors to learn how to prevent further falls.
- Re-evaluate and improve use of dedicated sitter programs and incorporate patient family engagement in the process, by providing human companionship and help alert nurses in a timely manner when a patient is trying to get up creating a risk for potential fall.
- Regular training and technology to improve the uses of motion sensors - pads and alarms activated by patient movement that alert staff to movement.
- Revitalize Fall Prevention Teams, rotating new staff and clinicians into committees for a fresh approach in reviewing the events and determining organizational strategies.
- Increased use of Gait Belts and other mobility aids, to help maintain balance and give staff more control if patient demonstrates weakness while walking.
- Keep patients needed personal items such as tissue, eye glasses, tv controls within reach.
- Nurse to nurse reports which would include patient care unit to unit reports; adding interdepartmental communication of fall risk. Communication of changes in condition to providers and hand off discussion when patient is moved from unit to unit.
- Work with skilled nursing facilities to develop and implement transfer forms noting patient's fall risk status, any recent falls, ambulatory status, and assistive devices used.
- Promote early mobility, with appropriate physical and occupational therapy consults, to maintain functional status. Plan and develop mobility assessment training for nursing to improve identification of patients at risk in between fall risk assessments, and more quickly update plans and interventions to prevent falls.
- Use Nursing Dashboards so staff will see fall outcome data and fall prevention process measures to further engage clinicians and improve reduction of harm.
- Engaging patients and families through information exchange and education about the patient's specific risks during the stay and after discharge.



Strategies utilized by NH hospitals and ASCs:

- Improve consistency in hand-offs of information during the continuum of care from the time of the original diagnosis of the issue requiring surgery to the actual team preforming the procedure; to ensure vital information is accurately and appropriately communicated.
- Measure adherence to policies that address supply counts, time-outs, consents and other processes deemed to be contributing causes to the event.
- Continue to educate staff in the use of the checklist and time out process including the awareness of potential limitations of these tools to prevent all surgical errors.
- Enhance high reliability performance of the surgical team by including the patient's goals of care in the safety checks or briefings, ideally including the patient prior to induction of anesthesia.
- Explore and consider the implementation of pauses during the procedure prior to critical steps to assure all team members understand the plan and their role in executing it.
- Utilize practice guidelines and resources for achieving optimal perioperative practice from professional organizations such as the Association of periOperative Registered Nurses (AORN) and others.
- Reinforce all components of the Surgical Safety checklist, to include the pre-operative area in the time out and then follow through all during all phases, advocating for the patient always.

Throughout the Commission year there was regular contact with the staff from the Bureau of Health Facilities Licensing to promote open and ongoing communication about events; provide data of adverse events report for validation of number of events to ensure accuracy; and to improve processes of report notification to include closed loop communication of receipt of initial event report form, RCA and CAP. Meetings were held with the Bureau and representatives of the Commission, to clarify reporting rules and address areas of confusion. A flowchart was created to describe the reporting process and overall education provided to all Commission members at the May meeting. In addition, a tool that was developed at Frisbie Memorial Hospital, "Consideration and Evaluation in Determining State Reporting of Adverse Events" was reviewed and shared with all as a guide. The DHHS Bureau and the representatives from the NH Healthcare Quality Assurance Commission will plan to meet again in August to review the Adverse Events of 2018.

NH hospitals and ASCs continue share their experiences via Storytelling at Commission meetings, thereby ensuring we can all learn from their identified root causes and Corrective Action Plans (CAPs) that can enhance patient safety. The Hospitals and the ASCs remain committed to educate their personnel and professional staff about patient safety to promote the best outcomes for their patients.

Patient Experience and Engagement

Incorporating the Patient Voice / Experience

The Members believe value in healthcare is created when patients and providers work together to meet the patient's goals. An activated patient is more likely to receive the care they want and stick to the care plan when they develop it with their provider. Some hospital examples include:

- Patient/provider focused campaign to reduce the unnecessary use of antibiotics.
- Patient/provider education in the risks of narcotic exposure and alternative pain management techniques.
- Patient engagement boards in patient rooms in which patients and their families partner with caregivers to establish the safety plan to prevent falls.

Patient Safety Bright Spots

17 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 in March. A sampling of individual hospital achievements in quality and / or patient safety activities that were highlighted include:

- Reduction in hospital onset c. difficile infections by 58% through development of order criteria.
- Reduction in falls by 39% through implementation of safety rounds on 3 targeted units.

- Increase in event reporting by 24% through implementation and promotion of a new event reporting system.
- AHRQ Culture of Safety Survey demonstrated top quartile performance in overall patient safety after implementing CUSP on eight units.
- Reduced noise level at night to the lowest in the state by improving staff awareness using a Yacker Tracker.

Summary

Year 13 continued to bring NH hospitals and ASCs together to focus on the prevention of medical harm and continuous learning. Our topics have aligned with other efforts in the state including the work of many divisions within the Department of Health & Human Services, the NE Quality Innovation Network, Partnership for Patients and other professional organizations, to complement 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.

The Commission will begin Year 14 in July 2018 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.org.

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

Respectfully submitted,

Anne Diefendorf

Anne Diefendorf
Administrator,
NH Health Care Quality Assurance Commission

Foundation *for*
Healthy Communities

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