NH Health Care
Quality and Safety Commission

Annual Report of the
New Hampshire Health Care Quality and Safety Commission

June 1, 2022

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 New Hampshire Health Care Quality and Safety Commission (NHHQSC) include one representative from each 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.

Members of the Executive Committee include:

Chair	**Lori Underwood,** OTR, MBA, CPHQ Chief Operating Officer New London Hospital, New London
Vice-Chair	**Rori Dawes-Dyment,** MS, RN, CNL Director, Center for Quality & Safety Southern New Hampshire Health, Nashua
Past Chairs	**Lori Key**, RN, MBA Associate Chief Quality Officer - Quality Assurance & Safety Dartmouth Hitchcock Medical Center, Lebanon
	Natalie Gosselin, MS, RN, CPHQ, CSSGB Executive Director, Quality & Performance Improvement Catholic Medical Center, Manchester
At Large	**Jennifer Costain**, MS, CPHQ, CPPS Senior Director, Quality and Patient Safety Exeter Health Resources
	Melissa Howard, MHA, BS, RN, CPHQ Director of Quality, Infection Prevention and Service Excellence Speare Memorial Hospital, Plymouth
	Sue Majewski, CASC Chief Operating Officer Bedford Ambulatory Surgery Center, Bedford
	Christopher Tkal VP, Operations, Quality & Patient Safety Cheshire Medical Center/Dartmouth-Hitchcock, Keene
	Carlene T. Whitcomb, RN, BSN, MBA Director of Quality Services Littleton Regional Healthcare, Littleton

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 timely topics that support those principles.

Guiding Principles:

- **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.

- **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 involve differentiating system and human failures from reckless behavior.

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

- **Incorporate the Voice of the Patient**
  Creating a forum for patients to have open conversations about their experiences and needs and wants as invaluable information in the design and improvement of care and service delivery.

Organizational Structure and Activities

The Commission is working under the protection of RSA 151:13a and RSA 329.29A. Commission membership includes one representative from each of the 26 acute care hospitals, the 4 specialty hospitals and 20 free standing ambulatory surgical centers (ASC); a designee of the Commissioner of the Department of Health and Human Services and three "at large" public members. Average number of attendees at Commission meetings is 35-40 members.

All new members received an orientation and signed confidentiality agreements to allow for free exchange of sensitive information among members. All meetings were coordinated, and minutes recorded, by an administrative representative of the Foundation for Healthy Communities.

The Commission increased its public member representation from 1 to 3 individuals, who provide the unique perspective of healthcare consumer in the realm of healthcare delivery and quality improvement. Their presence improves the richness of our learning and our effectiveness in what we are trying to accomplish. Public members offered feedback and

general observations about meeting topics and discussions and were impressed by the eager sense of collaboration and sharing amongst members.

In its' seventeenth year, the Commission met five times on the following dates:
2021: August 6 and October 1; 2022: January 14, March 4, and May 6
All meetings were via the virtual meeting platform of ZOOM due to the COVID-19 Pandemic and meeting restrictions.

The Executive Committee met immediately after each meeting to debrief meeting content and to set agendas for future meetings with suggested topics that reflected current priorities focused on eliminating harm and improving quality.

This year we utilized a combination of Ice Breaker and Round Robin tactics to elicit feedback and sharing from all members on priority issues. Topics included investigation of suspected drug diversion; workplace safety events and initiatives; patient safety success stories; adverse events trends; and 'getting back to basics' to re-engage frontline staff in quality focused patient care.

Prevention of Harm Topics the Commission Focused on this Year Included:

- ☑ An in-depth overview and discussion on the **Safe Use of Opioids and Benzodiazepines** from a clinical, regulatory, and public health perspective. Members were educated on the Eastern US Quality Improvement Collaborative's 'ROADE' (Reducing Opioid Adverse Drug Events) initiative and its associated tools and resources. 31 members completed an Opioid Gap Analysis Survey to compare best practices to avoid opioid adverse drug events, to current practice, and to identify improvement opportunities.

- ☑ An update on **COVID-19 Prevalence, Infection prevention strategies, and Implications of Mandatory Vaccinations** for all hospital and health system employees. Members shared ideas on how to address staff concerns and provide education recognizing the potential impact of mandates on an already stressed workforce dealing with staffing shortages in the face of COVID surge.

- ☑ A presentation by the Disaster Behavioral Health Coordinator about **Redefining Resilience and Self-Care for the Healthcare Worker**, including the role of organizational culture in addressing individual stress. Practical resources were shared for members to bring back to their organizations. Members shared tactics and initiatives to promote resilience in staff in their organizations.

- ☑ The **Impact of Health Inequities on the Quality of Patient Care** were explored, particularly focused on the LGBTQ patients. Scenario based learning described suboptimal patient experiences when interfacing with the healthcare system and discussion ensued on how members are improving the design and delivery of care for this population.

- ☑ Ongoing collaboration with the State of NH Licensing and Regulations Services staff regarding **Adverse Events (AE),** including new quarterly reports which provide members increased opportunity to validate data, ensure adherence to the adverse events reporting process, and plan for improvements to prevent future events. **The State of NH Adverse Event Report for 2020** was shared with all members and trended data for overall reports, Falls, Pressure Injuries and Surgical events were shown. Adverse event data collected for 2021, compared to 2020, shows a decrease in the number of overall events, with Falls, Pressure Injuries and Surgical events continuing to be the opportunities for greatest improvement. The Bureau Chief for the Medicare Certification Unit, Kristie Holtz, and a member of her team attended a second Commission meeting to discuss trends of events reported and suggestions for members to improve event root cause analysis and corrective action plans.

- ☑ The **2020 Healthcare Associated Infection Reports for Hospitals and ASCs** executive summaries were shared with members. Both NH hospitals and ASCs had statistically significant lower numbers of healthcare-associated infections (HAI) than predicted compared to national benchmarks. National trends during this time-period showed significant increases in catheter-associated urinary tract infections (CAUTI) and central line-associated blood stream infections (CLABSI) in hospitals, but NH data showed 46% fewer CAUTI and 38% fewer CLABSI than predicted, and 25% fewer surgical site infections (SSI) than predicted. There were zero SSIs in the 12 NH ASCs who performed reportable procedures. Members discussed their robust surveillance and reporting systems for these infections, the potential impact multiple demands on infection control preventionists during pandemic response had on HAI rates, and whether the decrease in SSIs could be attributed to cancellation of elective surgeries during certain surges in COVID hospitalizations.

- ☑ In-depth discussion on **Workplace Safety** including NH Hospital Association President, Steve Ahnen. Hospital data demonstrates violence against health care workers is increasing with a significant number of workplace harm events reported. Members talked extensively about creating a clear definition of workplace violence and were encouraged to connect with their security departments about this data. Members shared specific incidents they experienced, with lessons learned including alerts to staff of patients at risk for violent behavior; de-escalation and self-defense training programs; enhanced real time communication of threats; and post-harm event reviews.

- ☑ A member shared work done on **Enhanced Recovery After Surgery (ERAS)** in a low volume hospital. Discussion on the role of opioid sparing/ opioid free anesthesia and how this can prevent addiction after surgery, patient factors that increase risk for addiction, and details on the patient plan of care in the pre-operative, intra-operative, and post-operative periods. ERAS involves a culture change, and many NH hospitals and ASCs are embarking on this journey.

- ☑ A presentation by the Granite State Health Care Coalition on the **COVID-19 Extended Response** and overview of after-action report. Strengths and opportunities for improvement discussed in the domains of community resilience 'preparedness', incident management, information management, surge information, and countermeasures and

mitigation. Dr. Benjamin Chan, State Epidemiologist, highlighted specific instances of communication barriers and sought examples from members to help inform process improvement.

- ☑ Member presentation on **3 Safety Events Involving Fire**, including review of root cause analysis of each event and lessons learned. The need to increase education to patients and staff on the risk of vape pens in an oxygen rich environment was identified and members shared education and communication strategies. Information was shared with the NH State Fire Marshal.

- ☑ **Patient Safety Success Stories** shared demonstrating significant focus on prevention of medication errors, pressure injuries and patient falls. Many discussions ensued around patient falls and trends in staffing and visitation rules, as well as the impact of staffing shortages on all quality improvement initiatives.

- ☑ A presentation by the Vice President of Nursing at a NH community hospital on **Re-engaging Staff in Quality Improvement**. For the past two years, healthcare workers have been working in necessity mode, many in non-traditional staffing models and care areas, doing more with less. The impact on front line staff disengagement in quality was explained with the imperative that those doing the work must be involved in improving it. Redesign of multidisciplinary quality and practice councils was shared as well as practical approaches to re-educate clinicians on core strategies to prevent error and adverse events. Discussion by members on how quality professionals can partner with, and support, front line clinicians.

- ☑ A Round-Robin exercise for members to share ideas for **Re-focusing Bedside Staff on Best Practice Bundles** (falls, delirium care, pressure ulcer prevention, sepsis, surgical checklist) and getting 'back to basics'. Ideas included creative communication strategies such as GroupMe and electronic communication boards in staff workstations and lounges; releasing culture of safety survey and setting up 'safe tables' for staff to share concerns with senior leadership; re-invigorating Patient Safety Grand Rounds; and including 'Quality Update' (including data and patient stories) as a standing topic of all meetings.

Opioid Gap Analysis Survey- Subcommittee Findings

Members reviewed the Opioid Gap Analysis Survey results and created a Priority Matrix to rank best practices according to ease of implementation and impact to patients. Findings include:

- There are 26 best practices in the survey, several of which hospitals and ASCs have fully met. Prioritizing the remaining, beginning with 'true wins' (easy to implement with big impact to patients) will incentivize participants while simultaneously doing the most to increase patient safety.
- Most ASCs do not routinely prescribe opioids and there is a high level of standardization for patient history and assessments among them. Protocols that define evidence-based patient monitoring practices and emergency procedures are common.

- Hospital leadership and oversight for safe opioid practices are essential, as is commitment to an opioid safe environment.
- Trending and tracking opioid usage and adverse events can vary depending on the sophistication of the organization's IT system and resources.
- Like ASCs, a strength for hospitals is obtaining patient history and performing assessment of current medications and pain. Standardization of patient risk assessments could be more widely adopted among various clinical units.
- The development and implementation of comprehensive protocols and order sets incorporating all the best practices is resource and time intensive, involving a robust interdisciplinary team.
- Ensuring a standardized 'hand-off' for patients receiving opioids at points of transition is very challenging, especially with high numbers of contract staff in hospitals. Discharge from post-anesthesia care routinely involves a well-defined stabilization period.
- Discharge planning for patients with opioid use disorder varies across the state based on available medication assisted therapy services and behavioral health resources.
- Hospitals endeavor to avoid or limit opioids at discharge, based on patient need, and to involve pharmacists in creating pain management plans of care.

Members discussed the reality that larger hospitals have more resources and may be further along than smaller critical access hospitals, and that sharing robust outpatient plans of care for opioid dependent patients as well as opioid order sets and prescribing policies could be very impactful. Rapid Response Team (RRT) protocols, including criteria for monitoring respiratory depression for patients receiving opioids as well as defined emergency responses, were circulated among members. Many of these protocols include a mechanism for patients and families to activate the RRT. Our public member provided valuable perspective on the importance of a clearly defined mechanism for families to raise care concerns citing the complexity of the healthcare system. Assuring the safe use of opioids and benzodiazepines is a priority for the Centers of Medicare and Medicaid (CMS) and hospitals will be reporting on this as a newly required electronic clinical quality measure. Members agreed to develop a library of resources and educational materials on this topic in the upcoming year.

Workplace Safety - Role of the NHHQSC

The Commission started addressing workplace safety in 2015, recognizing that workplace violence and safety harm events against healthcare workers negatively impacts patient care and quality and there were no other forums for these discussions. For the past 6 years members presented specific harm events and lessons learned, shared best practices and policies and procedures, and voluntarily collected data on harm events. Standardizing the definition of harm and violence was a challenge and the data collected was very basic and did not provide significant, actionable, insight into the details surrounding the events. In 2021, Senate Bill 100 established the Committee to Study Workplace Safety in Healthcare Settings. Members discussed the following:

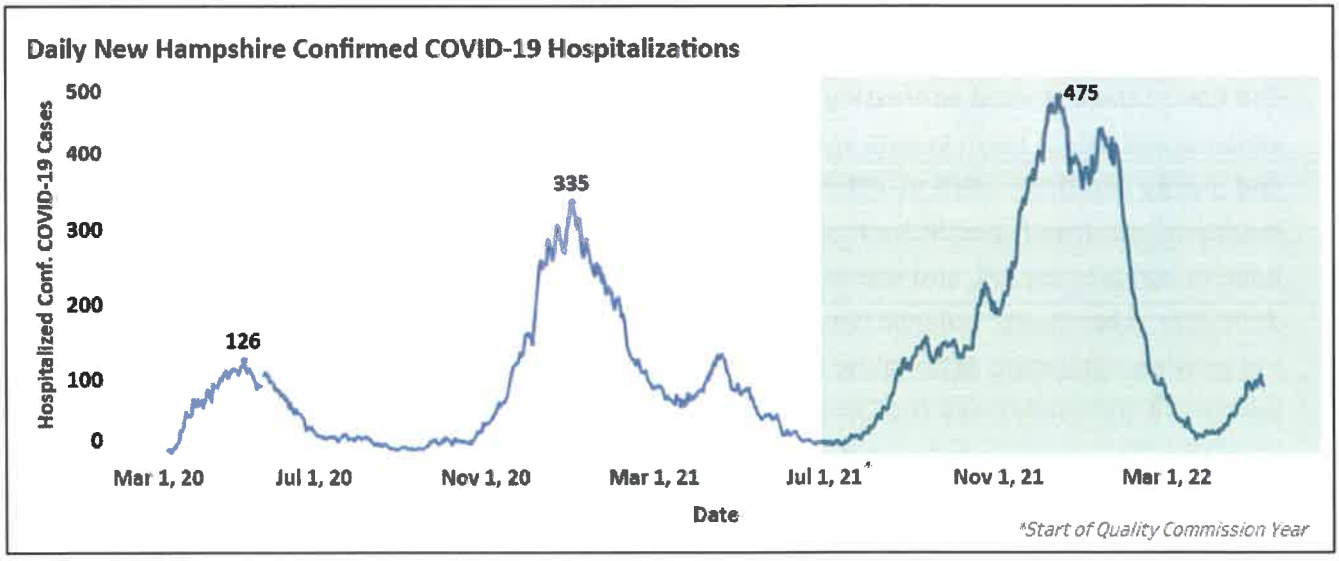
- ASCs are not experiencing the levels of violence that hospitals are experiencing.

- Violence is increasing in hospitals, especially in emergency departments, which continues to demoralize the healthcare workers who are already struggling with the burden of the COVID-19 pandemic.
- The Commission's primary focus is on patient safety, and not workplace safety, and quality professionals do not have primary responsibility for their organizations' safety programs.
- The creation of a new commission, modeled after the NHHQSC with its confidentiality protections, is necessary to give healthcare workplace violence the attention it requires and to allow healthcare agencies to share openly and learn from each other. At a minimum, membership should include safety directors, security officers and emergency management professionals.
- There must be a mechanism for the new commission to inform, and partner with, the NHHQSC.
- A standard definition of workplace harm and mandatory reporting requirement by the NH Department of Health and Human Services (DHHS), like Adverse Events, would ensure workplace violence data is complete and actionable.

The NHHQSC Chairperson and Administrator presented an overview of Commission activities relative to workplace safety to the Committee to Study Workplace Safety in Healthcare Settings. The Committee established a subgroup to determine the details of what data would be collected, which healthcare organizations would participate, who would house and report the data, and who would review it and make best practice recommendations which the NHHQSC Administrator helped inform.

Ongoing COVID-19 Pandemic - Impacts on Quality, Safety, and the Patient Experience

In year two of the COVID-19 pandemic the facilities represented by the Commission operated in, and were significantly impacted by, unprecedented circumstances. As illustrated in the graph below, COVID-19 hospitalizations spiked to an all-time high with the Delta variant in December 2021, dwarfing the spikes of early surges.



This high COVID burden, coupled with high acuity patients who had previously delayed care, pushed hospitals beyond capacity. Hospital beds, especially those in critical care units, were inadequate for the number of patients requiring admission and patients experienced extended stays in emergency departments or were transferred to hospitals beyond New England for care. Hospital and State leaders met daily to strategize bed management and patient placements, DHHS authorized the operation of Temporary Acute Care Centers in most NH hospitals to allow patient care in non-traditional settings, and hospitals moved to 'team nursing' models to meet patient care needs while facing significant staffing shortages. Overall quality initiatives were impacted as healthcare workers and quality professionals:

- Were reassigned to surge units, assumed new roles and responsibilities, and managed increased workloads.
- Provided training and mentorship for large numbers of contract staff hired to fill open positions.
- Learned new models of care to extend the healthcare team to meet patient needs and maintain quality of care and patient safety.
- Stayed current with continuously changing regulations and clinical practice guidelines.
- Had fewer interactions and supports from families as they were required to limit visitors to the facilities
- Faced increasing anger and hostility from patients and families frustrated with visitor restrictions, masking requirements, and longer wait times.
- Struggled with increased stress, fatigue, mental and physical exhaustion, burnout, and vaccine mandates.

Throughout the Commission year, members shared how they were maintaining critical elements of their quality and safety programs and how they were supporting their healthcare workforce including:

- Introducing non-traditional members (i.e., unlicensed patient care attendants) into the healthcare team to extend capacity and maintain safety.
- Redeploying management staff and non-clinical staff to support patient care and the clinical teams.
- Expanding tele-health capabilities to leverage technology requiring fewer staff to keep high fall risk and behavioral health patients safe.
- Loosening visitor restrictions to allow at least one support person per patient per visit and utilizing tele-health options to include family in daily rounds and discharge planning.
- Addressing staff concerns about vaccine mandates with education and empathy including creating confidential email boxes for questions,
- Implementing strategies and resources to increase healthcare worker resilience.
- Enhancing strategies to improve communication and training to improve workplace safety and security.

It is important to acknowledge that our hospitals operated outside typical business operations this past year and that they demonstrated great collaboration and creativity to ensure NH residents received the care they deserved. There is concern about the recovery of what was already a fragile healthcare workforce, and the Commission recognizes the need for a collective 'deep breath' and a return to the basic tenets of evidence-based care bundles, every patient, every time, to prevent and reduce adverse events going forward. This will involve our hospitals and ASCs collaborating with frontline healthcare workers and patient and family advocates to assess current state and identify potential workarounds that developed during surge; sharing quality data and resetting and recommitting to clear improvement goals; re-education and monitoring for accountability; reviewing results and rejoicing in successes; and hard-wiring improvements for sustainability.

Summary

In its 17th year, the Commission operated during a time of unprecedented stress and strain on the NH healthcare system. Despite this, attendance at meetings was high, as was teamwork among members, as they engaged in learning, sharing, and problem-solving to prevent medical harm during a pandemic. Commission topics continued to align with other efforts in the state including the work of many divisions within the Department of Health and Human Services, the Eastern US Quality Improvement Collaborative, Centers for Medicare & Medicaid Quality Improvement Organizations, and other professional organizations, to avoid redundancy and maximize efficient use of resources and to compliment work.

The Commission recognizes that one Adverse Event or Hospital-Associated Infection is too many and it will continue to focus to reduce preventable harm as it begins Year 18 in August 2022. Promoting high reliability organizations, establishing 'Just Cultures' in hospitals and ASCs, adopting evidence-based best practices and incorporating the voice of the patient will remain priority as we also consider the role diversity, equity and inclusion play in harm reduction. All public documents related to the Commission can be found at www.healthynh.org.

For questions, please call:
Lori Underwood, Commission Chair: (603) 526-5055 or Kris Hering, Administrator: (603) 415-4271.

Respectfully submitted,

Kris Hering

Kris Hering
Administrator, NH Health Care Quality and Safety Commission

Foundation *for*
Healthy Communities