NH Health Care
Quality and Safety Commission

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

June 1, 2023

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	**Rori Dawes-Dyment,** MS, RN, CNL Director, Center for Quality & Safety Southern New Hampshire Health, Nashua
Vice-Chair	**Karen Chandler,** RN, MSN, CPPS, CNML Senior Director of Quality Assurance and Safety Dartmouth-Hitchcock Medical Center, Lebanon
Past Chairs	**Natalie Gosselin,** MS, RN, CPHQ, CSSGB Executive Director, Quality & Performance Improvement Catholic Medical Center, Manchester
At Large	**Mallory Hamilton,** MSN, RN, CPHQ, CPPS Senior Director of Quality & Patient Safety Exeter Hospital, Exeter
	Kelly Hussey Director, Quality & Risk Management Cottage Hospital, Woodsville
	Sue Majewski, CASC Chief Operating Officer Bedford Ambulatory Surgery Center, Bedford
	Hannah Sharp, MS, RN, CNL, CPPS Patient Safety Officer Elliot Hospital, Manchester
	Helene Thibodeau, DNP, RN, CCRN, NEA-BC Chief Clinical Officer Northeast Rehab Hospital Network, Salem
	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.

- Ensure Health Equity, Diversity and Inclusion
  Incorporate the voice of the patient in adverse event investigation and root cause analysis, pro-active risk assessment and health care system design. Utilize REaL, and other equity data in quality improvement.

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. The 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 had 1 public member and received the appointment of another public member in May, who provided 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. This year, the public

member offered feedback and general observations about meeting topics and discussions and was impressed by the eager sense of collaboration and sharing amongst members.

In its eighteenth year, the Commission met five times on the following dates:
August 5, 2022
October 7, 2022
January 13, 2023
March 3, 2023
May 5, 2023
All meetings were in-person with a virtual Zoom option for extenuating circumstances. The Executive Committee met immediately after each meeting to debrief 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 top challenges affecting quality; sharing of success stories and identification of ongoing areas for improvement; and reflections on the value of the commission and desired topics and programming for the 2023-2024 year.

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

- ☑ 'Story Telling' presentations by all organizations that reported **Surgical Adverse Events** related to foreign objects in calendar year 2021. Information was provided on the national patient safety program to prevent retained foreign objects (https://nothingleftbehind.org/) as well as updated guidelines from AORN on adjunct technology to aide in accurate surgical counts. 8 members shared details of their events, root cause analyses and corrective action plans. A common thread identified amongst all events was breakdown in communication and teamwork, prompting TeamSTEPPS© education for the Commission described later in this report.

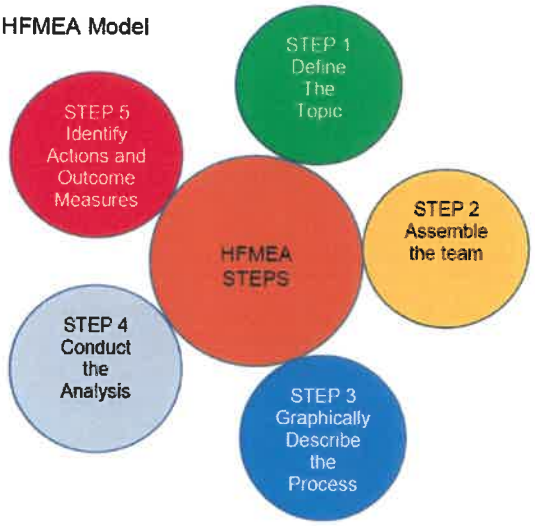
- ☑ Discussion on **Clinical Peer Support** programs, not just after serious adverse events, but proactively to promote health care worker (HCW) well-being and prevent burnout. The risk for burnout is exacerbated when clinicians are involved in medical error and when they are exposed to stressful events and environments. In these circumstances, HCWs often withdraw, feeling isolated, anxious, depressed, and questioning their future as healthcare professionals. Trained clinical peer supporters share the lived experience with the HCW in need and they listen to their colleagues' concerns and help validate their feelings. Ongoing, confidential 'check-ins' cultivate relationships and create critical connections to help re-build a sense of community and belonging. Many hospitals had started these programs just prior to COVID but were struck with staffing shortages and competing priorities.

- ☑ A member presentation outlining the hospital's **Patient Harm Journey During the Pandemic.** The organization had historically experienced decreasing trend of patient harm events and explained how an increase in COVID-19 cases correlated with an

increased harm reduction score. Member described how robust data collection, root cause analyses, and special cause analyses helped identify improvement opportunities and strategies to prevent hypoglycemic events, pressure injuries and catheter associated infections. Member shared a model for harm reduction influenced by culture, human factors and hardwiring safety, and a focus on 'back to basics' in clinical care.

☑ A presentation by the Manchester VA Medical Center on the Veteran's Administration **Healthcare Failure Mode & Effect Analysis (HFMEA).** HFMEA is a technique for conducting a proactive risk assessment to identify and account for potential vulnerabilities in systems and processes to ensure high reliability and safe patient care. Members were guided through the process of conducting an HFMEA, including real life examples to help them understand how to apply HFMEA framework in their organizations. Members familiar with HFMEA gave examples of processes they examined, including how the pharmacy handles and dispenses controlled substances. Members also discussed the importance of proactive risk assessments considering the recent criminalization of a nurse for medical error, and concern there may be a decrease in "near miss" and actual event reporting.

Diagram 1. HFMEA Model



☑ Ongoing **Collaboration with the State of NH Licensing and Regulations Services** staff regarding Adverse Events (AE), including quarterly reports and new summary demographic information on falls and pressure injuries, which provide members increased opportunity to validate data, ensure adherence to the adverse events reporting process, and plan for improvements to prevent future events. Debora Wyman, Licensing & Evaluation Coordinator, DHHS, and a member of her team attended a Commission meeting to discuss trends of events reported, including increase in sexual assaults of patients to staff and patients to patients, and they provided suggestions for members related to root cause analysis reporting.

☑ A presentation by the American Hospital Association Center for Health Innovation on **TeamSTEPPS© (Team Strategies and Tools to Enhance Performance and Patient**

Safety). TeamSTEPPS© is an evidenced-based teamwork system aimed at optimizing patient outcomes by improving communication and teamwork skills, and promoting psychological safety, among health care professionals. Members were particularly interested in this topic as a major theme across reportable surgical adverse events in calendar year 2021 was break down in effective communication. Members learned tools (i.e., SBAR, Brief, Huddle, Debrief, Hand-off, 2-Challenge Rule, CUS) and strategies and shared which TeamSTEPPS© interventions they were currently using, and which ones they would be implementing in the future.

☑ A member presentation on their patient falls reduction journey and implementation of the **HD Nursing Fall Prevention Program©.** Dr. Amy Hester, Chairwoman & CEO HD Nursing, joined the conversation and explained the importance of appropriately screening patients to predict fall risk, creating individualized patient care plans to ensure the right interventions are employed at the right time, and using data to drive actionable decisions and sustain gains over time. Specific fall prevention strategies for the most difficult patient populations (acute and chronic brain injury, isolation patients, and those with history of falling) were discussed and tools and resources were provided to members.

☑ **Patient Family Advisory Council Volunteer Rounding Program** presentation by member explaining their work to strengthen communications and collaboration among patients, families, caregivers, and staff to improve the patient experience, patient safety, and clinical quality. Patients were routinely surveyed on their care experience after discharge, thereby providing a retrospective view of care. Desiring to gain 'real-time' patient perspective, the organization recruited volunteers to round on patients during hospitalization. Data collection methodology was reviewed, and examples of service recovery and care improvements were shared.

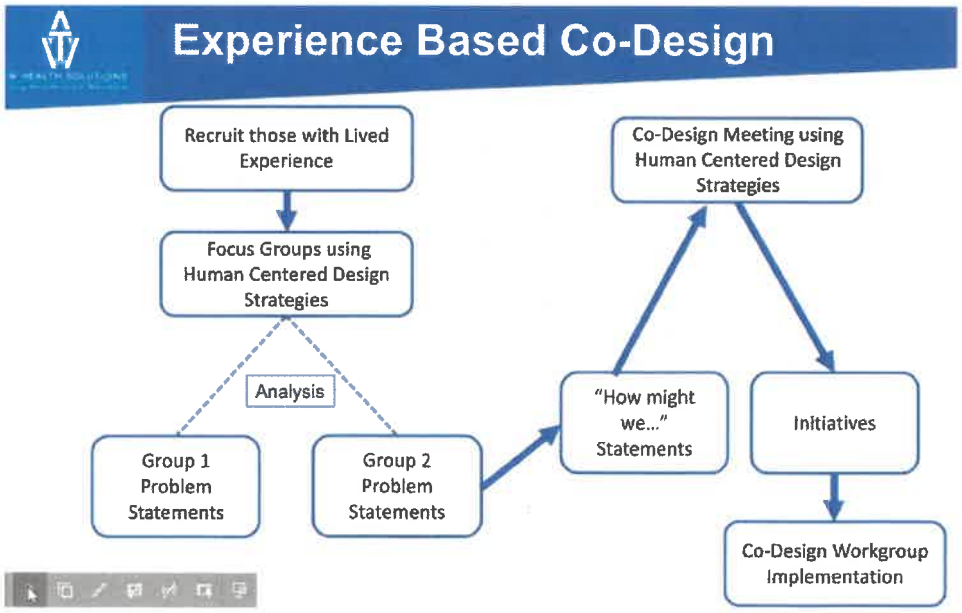


☑ Two members explained **Stay Interviews** as a process to proactively gather 'actionable' information about what the employee values, what keeps the employee engaged in the organization, and what may be causing them to become disengaged. With a focus on staff wellness and retention, stay interviews are designed to gather information on the employee's needs and values, not to discuss performance. After each interview, the manager and staff person create a 'Stay Plan' of actionable items they will work on together to address issues and ideas. Follow up is key, and the frequency of follow up is determined based on the needs of the employee.

☑ Ongoing focus on **Pressure Injury Prevention** with education to members on wound care fundamentals, including Wound Care Nurse certifications, National Pressure Injury Advisory Panel (NPIAP) guidelines (https://npiap.com/page/Guidelines), and the use of risk assessment and prevention bundles to drive care. A member shared new innovations deployed that are reducing pressure injuries in critically ill patients and explained the importance of an inter-disciplinary team in a robust wound prevention program.

☑ Round Robin sharing of **'One-off' Adverse Events** that occurred during this Commission year and are rare to NH hospitals and ASCs. These include burn, physical assault, patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results, and discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized individual. By sharing details of the events, event analyses, and improvement opportunities members provided valuable insights and tools to colleagues to assist them in preventing similar events in their organizations.

☑ A presentation by the Chief Innovation Officer, ATW Health Solutions, on improving quality using **Experience Based Co-Design (EBCD).** EBCD involves engaging two groups, each separately at first and then together at the end of the process, in conversations to identify problem statements and then to work jointly on problem solving. Human Centered Design Strategies are used in focus groups and senior leaders participate in the final 'co-design' focus group. Examples were shared where patients and staff partnered to improve care for patients hospitalized with substance use disorder, where nurses and physical therapists partnered to increase patient mobility, and where patients and physician office staff partnered to improve the check-in experience.



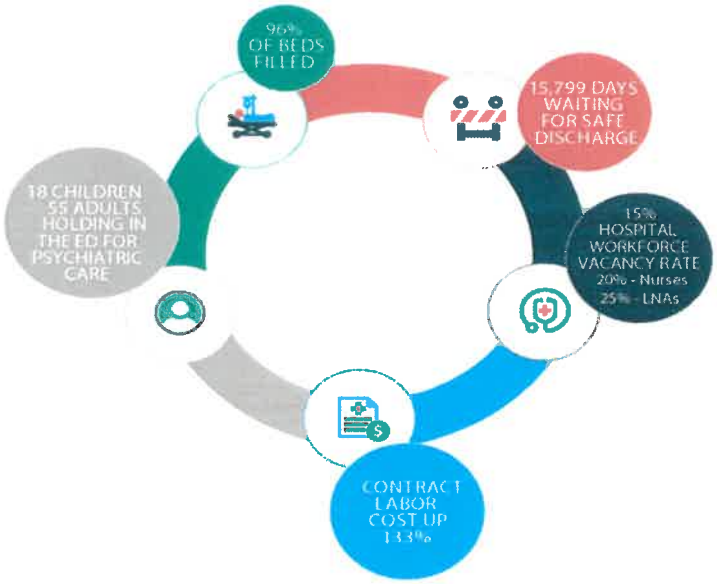
Public Health Updates and Information Sharing

Collaboration between healthcare partners and public health is essential for the quality and safety of patient care in NH. For this reason, there is dedicated agenda time at each Commission meeting for the NH State Epidemiologist to provide updates on relevant topics and for members to ask questions and provide feedback. Topics included:

- Updated CDC guidance on COVID-19 quarantine requirements and a shift toward pharmaceutical interventions and vaccinations, including booster doses.
- Monkeypox education including mode of transmission, testing options, and vaccine information.
- Health Alert Network notices reviewed as CDC updated COVID-19 infection prevention and infection control guidelines, community transmission metrics, and screening, testing, and treatment guidelines.
- Influenza levels and implications for NH healthcare system.
- Enterovirus update includes information on acute flaccid myelitis in children and mandatory reporting requirement.
- Sudan Ebola virus and management of travelers from Uganda.
- Ending of the Public Health Emergency and implications for data reporting and laboratory testing.
- Highly pathogenic Avian Influenza and risk to humans.

Unwinding of Pandemic Era- Impacts on Quality and Safety

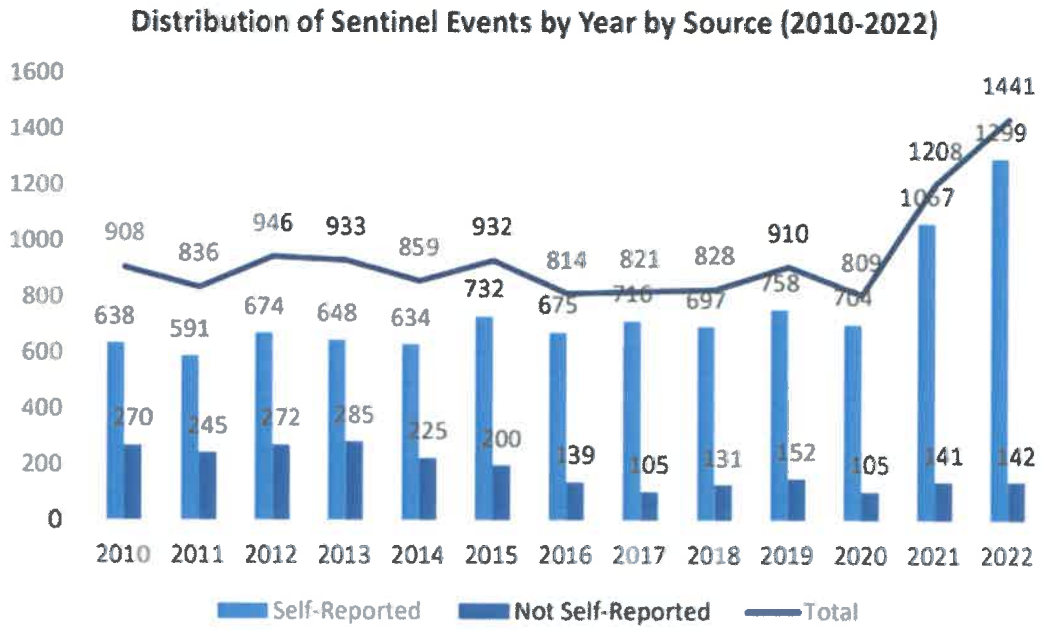
In year three of the COVID-19 pandemic the facilities represented by the Commission continued to operate in unprecedented circumstances. As illustrated in the graph below, multiple factors converged making the job of NH hospitals and caregivers incredibly challenging.[1]



[1] See NHHA's NH Hospitals Face a Difficult 2023 report for additional details

Of particular concern to the Commission, and a major contributor to the increased number of adverse events reported this year, was the health care workforce shortage. High vacancy rates meant increased contract staff with 'renter' versus 'owner' mentality, lack of experienced charge nurses to help lead quality improvement activities, and lack of clinical leaders without patient care assignments to round on patients and mentor new clinicians. This was particularly problematic for newly graduated nurses who were trained during the chaos of the pandemic and had less actual clinical experience and hands on patient care than is typically required.

A recent article in the New England Journal of Medicine explained how the COVID-19 pandemic put enormous strain on the health care system, disrupted normal operations for hospitals and other health care facilities, and caused safety concerns for patients and staff.[2] Years of national downward trend of adverse event rates and health care associated infections were reversed during the pandemic with both rising substantially in the post-pandemic era.[3] This trend is reflected in The Joint Commission's voluntary reporting of sentinel events by year from 2010-2022:[4]



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

---

[2] Fleisher, L. E., Schreiber, M., Cardo, D., & Srinivasan, A. "Health Care Safety during the Pandemic and Beyond-Building a System that Ensures Resilience." *New England Journal of Medicine* 386, no.7 (February 2022); 609-611.
[3] Bates, D.W, et al. "The Safety of Inpatient Health Care" *New England Journal of Medicine* 388, no.2 (January 2023; 142-153). DOI:10.1056/NEJMsa2206117.
[4] See Sentinel Event Data CY2023 Annual Summary (jointcommission.org) report for more details.

- Further incorporating non-traditional members (i.e., unlicensed patient care attendants) into the healthcare team to extend capacity and maintain safety.
- Expanding tele-health capabilities and exploring artificial intelligence to leverage technology to keep high fall risk and behavioral health patients safe and reduce pressure injuries.
- Welcoming back visitors and volunteers and partnering with patients and families to improve care.
- Addressing the unwinding of many policy changes and potential workarounds implemented during the pandemic and communicating impacts to staff.
- Sharing quality data, resetting and recommitting to clear improvement goals, and creating a culture of transparency and accountability.
- Implementing strategies and resources to increase healthcare worker resilience.

The Commission is hopeful that the end of the public health emergency allows for the healing and stabilization of a frail health care workforce, and it urges legislators to enact programs and policies to support and to rebuild this precious commodity in NH.

Summary

In its 18th year, the Commission operated during a time of tremendous stress and strain on the NH health care system including unprecedented workforce challenges and the unwinding of a plethora of pandemic-era policies. 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 19 in August 2023. Promoting high reliability organizations, cultivating 'Just Cultures' in hospitals and ASCs, adopting evidence-based best practices and incorporating the voice of the patient will remain a 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: Rori Dawes-Dyment, Commission Chair: (603) 281-6831 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
Partnering to improve health for all