SCHNEIDER REGIONAL
MEDICAL CENTER

ROY LESTER SCHNEIDER HOSPITAL | MYRAH KEATING SMITH COMMUNITY HEALTH CENTER | CHARLOTTE KIMELMAN CANCER INSTITUTE

Monthly Report
To:

Senior Leadership
&
The Board Performance Improvement Committee

From:
Quality & Performance Improvement Department
&
Organization Wide Performance Improvement Committee
Infection Prevention & Control Committee

Chief Executive Officer:	**Alice Taylor**
VP Quality & Performance Improvement:	**Elizabeth Harris**
Reporting Date:	**December 20, 2010**

Board Performance Improvement Committee Meeting
Wednesday, December 22, 2010
Hospital Boardroom
11 AM – 1:00pm
Agenda

1. Call to Order

2. Acceptance of meeting minutes

3. Matters arising from meeting minutes

4. Legal/Regulatory update

5. Quality and Infection Prevention Activity Summary – October 2010 Reporting
   - PI Priorities – Patient Flow & Operational Efficiencies in the OR
   - Core measures dashboard and report
   - Patient Safety dashboard and report
   - Patient Satisfaction report
   - Infection Prevention report with Infection Rates
   - Hemodialysis Progress Report

9. Adjournment

Next meeting: *January 26, 2010*

Report Contents

Topic	Page
October 2010 Quality Activity Summary & Document Key	4
October 2010 Quality Indicators and Action Plans	
Core Measures Dashboard and Report	5-10
Patient Safety Report	11
Patient Satisfaction & HCAHPS Report	12
Infection Prevention Report with Infection Rates	13-15
Employee Health Report	16
Hemodialysis Progress Report	17-20
Monthly Summaries for:	
Organization Wide Performance Improvement Committee & Infection Prevention Committee Meeting Summary Meeting Dates: December 15 & 16, 2010	22
Acknowledgements:	23

October FY2010
Quality & Infection Prevention Activity Summary

Strengths	**Publicly Reported Quality Indicators**
• 82% of staff completed Annual Education, which includes the Code of Conduct and I AM SRMC focused customer service initiatives. • Annual education also included the mandatory education on MDRO, SSI, and Central Line Bloodstream Infections required by clinical staff. • No Hemodialysis patient infections related to access for the month of October 2010. • Employee Incident Report form was revised and disseminated to all departments.	Core Measures: • AMI – One (1) case for the month of October, with 100% compliance in all indicators (See page 5). • HF – All indicators at 100% compliance for October (See page 6). • PN – All indicators at 100% compliance for October (See page 7). • SCIP – 7 of 9 indicators at 100%, Prophylactic Antibiotic Start Within 1 Hour indicator at 82%, above regional but below national average; Prophylactic Antibiotics End Within 24 Hours indicator at 91%, above regional and at national average (See page 9)
Opportunities / Initiatives	**Process Improvement Activities**
• Patient Safety Survey to be conducted 12/10 • VHA Mock Survey report on Joint Commission Compliance received. Reports have been disseminated to Senior Leaders and Department Heads for corrective action. Target date for all corrective actions to be completed by January 31, 2011. • The PI Department weekly patient tracers are in process for monitoring and corrective action. • Rapid Response Team data correlation with Code Team Data expected January 2011. • All units are expected to post PI and Patient Safety education boards, which display 12-months of data on organizational and unit PI initiatives. • Hemodialysis opportunities for improvement (see report from QAPI) • Process for documentation of the withholding and withdrawal of life support under review by legal and Bioethics Committee. • 2011 Employee Health Plan and Risk Assessment completed – reporting in January 2011 • 2011 Infection Prevention Plan and Risk Assessment completed – reporting in January 2011, with Dashboard. • 2011 Organization Wide Performance Improvement Plan completed – reporting in January 2011	• Organizational Performance Improvement Initiatives - FY2010-2011 **I. Patient Flow** **1.** ER patient flow – the committee has resumed meeting; additional resources have been allocated to collecting, analyzing, and reporting the data to the committee by January 2011. Data analysis will help to identify areas of focus. **II. Operational Efficiencies** **1.** OR start times: September 2010 – 62% October 2010 – 71% **2.** OR turn-around times: October 2010 - 32.9 Minutes

Quality Indicators and Action Plans
Core Measures - AMI (Acute Myocardial Infarction)

Indicator	Indicator Description	Top 10%	Regional Avg.	Nat'l Avg.	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	AVG to Date
AMI-1	Aspirin at arrival	100%	87%	95%	100%	100%	NA	NA	100%	100%
	Numerator				3	2	0	0	1	6
	Denominator				3	2	0	0	1	6
AMI-2	Aspirin prescribed at discharge	100%	91%	94%	100%	100%	NA	NA	100%	100%
	Numerator				2	2	0	0	1	5
	Denominator				2	2	0	0	1	5
AMI-3	ACEI or ARB for LVSD	100%	85%	93%	NA	100%	NA	NA	100%	100%
	Numerator				0	1	0	0	1	2
	Denominator				0	1	0	0	1	2
AMI-4	Smoking cessation advice/counseling	100%	88%	97%	100%	NA	NA	NA	NA	100%
	Numerator				1	0	0	0	0	1
	Denominator				1	0	0	0	0	1
AMI-5	Beta blocker prescribed at discharge	100%	83%	94%	100%	100%	NA	NA	100%	100%
	Numerator				2	2	0	0	1	5
	Denominator				2	2	0	0	1	5
AMI-7	Fibrinolytic Therapy Agent Received Within 30 Minutes of Hospital Arrival	100%	45%	46%	NA	NA	NA	NA	NA	NA
	Numerator				0	0	0	0	0	0
	Denominator				0	0	0	0	0	0
AMI-8a	PCI received within 90 minutes of hospital arrival	97%	*81%	84%	100%	0	NA	NA	*100%	66%
	Numerator				1	0	0	0	1	2
	Denominator				1	1	0	0	1	3
AMI-10	Statin Prescribed at Discharge								1	100%
	Numerator								1	1
	Denominator								1	1

* Discussing with Thomson Reuters technical support regarding arrival time as EKG was performed well before the logged arrival time.

Regional Averages: Calculated using Healthcare Cost and Utilization Project 2008- latest data with comparison amongst rural public hospitals in the South Atlantic Region

AMI-8a: PCI within 90Min
Numerator: 1
Denominator: 2
Target: 80%
Current status 66%
ACTION PLAN

1. Met with key stakeholders to review all cases from Jan 2010
2. Re-assessed current ER triage tools and process
3. Developed flow sheet to document and assess delays between arrival and PCI time
4. Cardiologists provided in-service on current AMI protocol and guidelines
5. Consensus to use fibrinolytics if cardiologist not available within 15min
6. Currently investigating more economical alternatives to TPA
7. Implemented delay of "full" triage to expedite EKG assessment

Quality Indicators and Action Plans
Core Measures - Heart Failure

Indicator	Indicator Description	Top 10%	Regional Avg.	Nat'l Avg.	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	AVG to Date
HF-1	Discharge Instructions	96%	68%	80%	80%	100%	100%	86%	100%	93%
	Numerator				4	6	6	6	5	27
	Denominator				5	6	6	7	5	29
HF-2	Evaluation of LVS Function	100%	85%	91%	100%	100%	100%	100%	100%	100%
	Numerator				5	6	6	7	5	29
	Denominator				5	6	6	7	5	29
HF-3	ACEI or ARB for LVSD	100%	83%	90%	100%	100%	100%	100%	100%	100%
	Numerator				3	5	3	3	3	17
	Denominator				3	5	3	3	3	17
HF-4	Adult Smoking Cessation Advice/Counseling	100%	90%	93%	100%	100%	NA	NA	100%	100%
	Numerator				1	1	0	0	1	3
	Denominator				1	1	0	0	1	3

Regional Averages: Calculated using Healthcare Cost and Utilization Project 2008- latest data with comparison amongst rural public hospitals in the South Atlantic Region

Quality Indicators and Action Plans
Core Measures - Pneumonia

Indicator	Indicator Description	Top 10%	Regional Avg.	Nat'l Avg.	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	AVG to Date
PN-2	Pneumococcal Vaccination	99%	79%	88%	75%	66%	0	100%	100%	85%
	Numerator				3	4	0	3	4	14
	Denominator				4	6	2	3	4	19
PN-3b	Blood Culture in Emergency Department Before First Antibiotic	100%	87%	93%	75%	71%	100%	50%	100%	79%
	Numerator				3	5	4	1	1	14
	Denominator				4	7	4	2	1	18
PN-4	Adult Smoking Cessation Advice/Counseling	100%	88%	91%	100%	50%	NA	NA	100%	83%
	Numerator				1	1	0	0	1	3
	Denominator				1	2	0	0	1	4
PN-5c	Initial antibiotic received within 6 hours of hospital arrival	100%	93%	94%	75%	75%	75%	100%	100%	85%
	Numerator				3	6	3	2	1	15
	Denominator				4	8	4	2	1	19
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	97%	83%	89%	75%	60%	NA	NA	100%	78%
	Numerator				3	3	0	0	1	7
	Denominator				4	5	0	0	1	10
Pn-7	Influenza vaccination	100%	80%	86%	NA	NA	NA	NA	100%	100%
	Numerator				0	0	0	0	4	4
	Denominator				0	0	0	0	4	4

Regional Averages: Calculated using Healthcare Cost and Utilization Project 2008- latest data with comparison amongst rural public hospitals in the South Atlantic Region

PN-3b Blood Culture Prior to Antibiotic
Numerator: 14
Denominator: 18
Target: 87%
Current Status:79%
ACTION PLAN

1. Nursing clinical reminders were developed
2. Need to intensive re-education of ER nursing staff on the indicator and re: documentation in including military time
3. On call physician should be notified early during pt's stay in ER so that ER physicians and nurses can start PN admission orders while in ED

Challenges:

1. Lack of adequate staffing of ER nurses during busy periods can cause delays in care and or documentation
2. On call physician delay in initiating orders or ER awaiting admission floor to carry out orders

PN-2 Pneumococcal Vaccine
Numerator: 14
Denominator: 19
Target: 80%
Current Status: 85%
ACTION PLAN

1. Nursing clinical reminders were developed-provided nursing education
2. Re-educate nursing staff on documentation, assessment
3. Implemented flagging system for core measure pts
4. Implemented checklist upon discharge

Quality Indicators and Action Plans
Core Measures - SCIP

Indicator	Indicator Description	Top 10%	Regional Avg.	Nat'l Avg.	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	AVG to Date
SCIP-Card-2	Patients on Beta Blockers PTA Who Received Beta Blockers Perioperatively	100%	*	*	100%	100%	100%	100%	100%	100%
	Numerator				2	2	3	1	2	10
	Denominator				2	2	3	1	2	10
SCIP-10	Surgery Patients with Perioperative Temperature Management	97%	*	*	96%	100%	100%	77%	100%	95%
	Numerator				26	17	13	10	11	77
	Denominator				27	17	13	13	11	81
SCIP 1	Prophylactic Antibiotic Start Within 1 Hour - Overall Rate	99%	80%	93%	88%	87%	90%	85%	82%	86%
	Numerator				23	13	9	11	9	65
	Denominator				26	15	10	13	11	75
SCIP-2	Prophylactic Antibiotic Selection for Surgical Patients - Overall Rate	100%	78%	95%	100%	100%	100%	100%	100%	100%
	Numerator				26	15	10	13	11	75
	Denominator				26	15	10	13	11	75
SCIP-3	Prophylactic Antibiotics End Within 24 Hours - Overall Rate	100%	86%	91%	81%	80%	80%	85%	91%	83%
	Numerator				21	12	8	11	10	62
	Denominator				26	15	10	13	11	75
SCIP-6	Surgery Patients with Appropriate Hair Removal	100%	93%	89%	100%	100%	100%	92%	100%	98%
	Numerator				27	17	13	12	11	80
	Denominator				27	17	13	13	11	81
SCIP-9	Patients with urinary catheter removed on POD1 or POD2	100%	NA	N/A	89%	89%	100%	100%	100%	96%
	Numerator				16	8	7	7	10	48
	Denominator				18	9	7	7	10	51
SCIP VTE-1	Patients with Recommended VTE Prophylaxis Ordered	100%	83%	89%	89%	75%	100%	100%	100%	93%
	Numerator				8	6	4	5	4	27
	Denominator				9	8	4	5	4	30

SCIP-VTE-2	**Patients Receiving VTE Prophylaxis within 24 Hours Prior to or After Surgery**	98%	79%	74%	89%	86%	100%	100%	100%	95%
	Numerator				8	6	4	5	4	27
	Denominator				9	7	4	5	4	29

**** not available on 2008 comparison results***

Regional Averages: Calculated using Healthcare Cost and Utilization Project 2008- latest data with comparison amongst rural public hospitals in the South Atlantic Region

SCIP-3 Prophylactic Antibiotic End within 24hrs
Numerator: 62
Denominator: 75
Target: 85%
Current Status: 83%
ACTION PLAN

1. Formalize Pharmacy 24hr automatic stop time
2. Education re: start of antibiotics based on pre-op dose time and start while in PACU
3. Identification of SCIP pts starting from OR check in nurse

Quality Indicators and Action Plans
Patient Safety Report
December 2010

Summary

- Met with OR to discuss their role in Patient Safety
- Risk assessments ongoing, action plans in progress
- FDA Drug Recall- Darvocet/Darvon-medication in stock and sequestered
- Attending staff clinical staff meetings to discuss goals and objectives of PS and encourage incident report filing or calling PS hotline
- Code Pink/Infant Abduction Unannounced drill upcoming December 2010
- VIMI Patient Safety Survey tentatively scheduled for December 15, 2010 thru January 3, 2011
- Scripts for PS PSA completed; approval pending
- Met with HN Medical to coordinate Fall Prevention Program Planning
- VIMI patient safety survey active thru January 31, 2010

Ongoing

- Patient Safety rounds continue staff will continue to be questioned on safety & work practices
- Simulation is being researched to reduce patient safety incidences
- Patient Safety Hands-On Fair planning 1st quarter 2011
- NSPG's compliance monitoring
- Case Reviews ongoing per request for quality of care and patient safety perspectives
- Dashboard data input
- Clinical Incident Report Intervention
- Working with Materials in an effort to ensure all supplies ordered for patient care are equipped with safety measures
- Reviewing submitted risk assessments for risk points and follow up

Note

PSC will be looking at Sentinel Events that TJC collects data on. In the event any of the occurrence occur here at SRMC, we will add them to the NSPG sheet of the dashboard.

Patient Safety Dashboard (attached)

Quality Indicators and Action Plans
Patient Satisfaction and HCAHPS Report

- Sample size and survey return rates continue to be low.

- During the month of November, the organization initiated public service announcements using the Sam Topp Show on Radio 1000 WVWI, in print, and in electronic media to try to improve sample size.

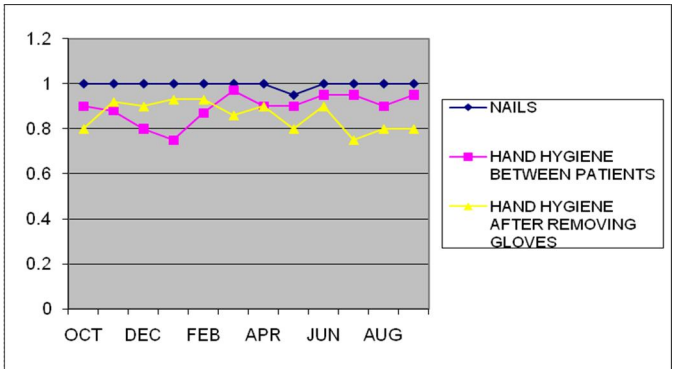
- Additionally, a PI communication board containing this information was placed in the Cafeteria.

- Staff is continually educated to encourage patients to complete and return surveys. This education was provided in the Annual Education, which reached approximately 82% of the employee population.

- A focused review of the option of surveying patients by telephone was conducted. Press Ganey submitted their quote, which, if implemented, would significantly save costs and should garner enough responses to have a statistically significant sample, which we do not currently have at this time. The internal activities required to undertake this change in survey methodology would require approximately 45-60 days. This would mean that telephone surveying could begin in March of 2011.

Quality Indicators and Action Plans
Infection Prevention
Hand Hygiene Reports
Surgical Unit

Surgical	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	YTD
Nails (n = 120)	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	99% (119/120)
HH btw Pt's (n=265)	90%	88%	80%	75%	87%	97%	90%	90%	95%	95%	90%	95%	89% (237/265)
HH removing gloves (n=275)	80%	92%	90%	93%	93%	86%	90%	80%	90%	75%	80%	80%	88% (241/275)



Benchmark 2010

- Artificial Nails- 100%
- Hand Hygiene between Patients- 90%
- Hand Hygiene after removing gloves- 90%

Population observed includes Medical and Nursing Staff

Areas of Concern:

Issue: Goal not met for all indicators monitored.

Findings:

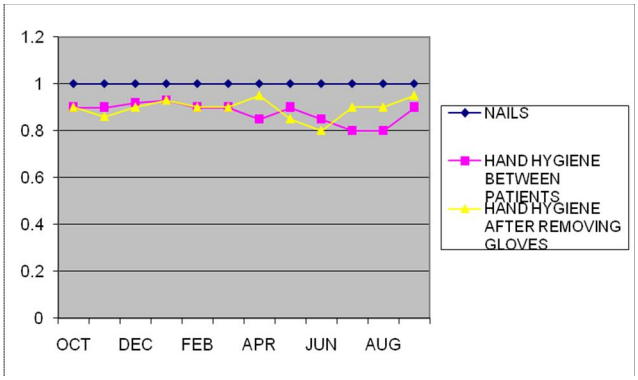
- Artificial Nails - An employee was observed with artificial nails. They were removed prior to her next schedules shift.
- Hand Hygiene between patients & removing gloves - Individuals observed not in compliance with Hand Hygiene practice.

Action Plan:

- Artificial Nails: The employee removed the artificial nails prior to next schedule shift and was re-educated on Hand Hygiene policy regarding artificial nails.
- Hand Hygiene between patients & removing gloves - Each employee was individually counseled on their HH practice. The information was also reinforced during the Annual education week.

Medical Unit

Medical	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	YTD
Nails (n=120)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0% (120/120)
HH btw Pt's (n=255)	90%	90%	92%	93%	90%	90%	85%	90%	85%	80%	80%	90%	88% (225/255)
HH removing gloves (n=230)	90%	86%	90%	93%	90%	90%	95%	85%	80%	90%	90%	95%	98% (225/230)



Benchmark 2010

- Artificial Nails- 100%
- Hand Hygiene Between Patients- 90%
- Hand Hygiene after removing gloves- 90%

Population observed include Medical and Nursing Staff

Areas of Concern:

Issue: Goal not met for Hand Hygiene between patients

Findings:

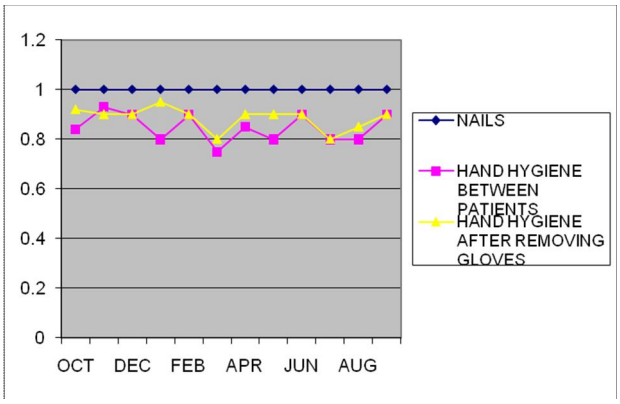
Hand Hygiene between patients - Individuals observed not in compliance with Hand Hygiene practice.

Action Plan:

Hand Hygiene between patients - Each employee was individually counseled on their HH practice. The information was also reinforced during the Annual education week.

ICU

ICU	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	YTD
Nails (n=120)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100% (120/120)**
HH btw Pt's (n=253)	84%	93%	90%	80%	90%	75%	85%	80%	90%	80%	80%	90%	**86% (217/253)**
HH removing gloves (n=255)	92%	90%	90%	95%	90%	80%	90%	90%	90%	80%	85%	90%	**87% (226/255)**



Areas of Concern:
Issue: Goal not met for Hand Hygiene between patients and after removing gloves

Findings:
Hand Hygiene between patients & after removing gloves - Individuals observed not in compliance with Hand Hygiene practice.

Action Plan:
Hand Hygiene between patients & removing gloves - Each employee was individually counseled on their HH practice. The information was also reinforced during the Annual education week.

Quality Indicators and Action Plans
Occupational Health and Safety
Employee Health Report

	October	**November**
Lost work days	74	129
M/S Injuries	0	2
Needle stick injuries	2	1
Falls	3	2
Total # Injuries	**8**	**9**

The injuries sustained by staff included the following: facial burn, needle stick, aggressive patient, falls (step ladder, hallway, and cafeteria), laceration from edge of metal pipe and injury due to spring retractor. Several employees remain out on Workmen's compensation, and / or restrictive duties.

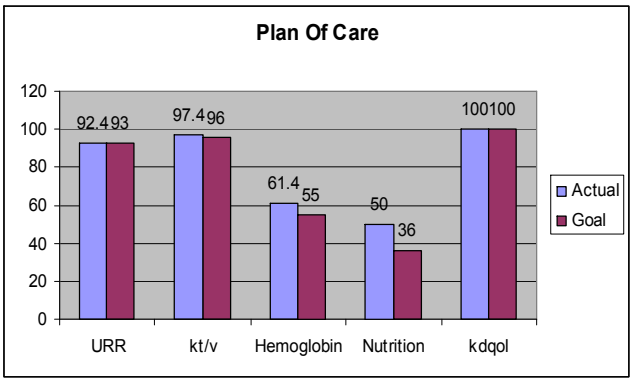
Corrective Action Plan:

- Employee Health will continue to monitor, track and trend musculoskeletal injuries that are related to patient care, in order to identify areas for concern and action planning.
- In order to ensure that lost work days are being properly reported, it was recommended that this data be presented with monthly and year to date statistics in tabular and chart form.
- The PATRAN sliding sheet introduced to Value Analysis was approved. This tool should reduce injuries related to patient transfer. The company is being contacted for further information and the possibility of training for staff.
- A total of 180 staff members have received the Influenza Vaccine at SRMC. MKS is conducting its own vaccinations, annual assessments, and physicals.

Quality Indicators and Action Plans
Hemodialysis Progress Report

*	Update	Objective	Plan
	PERSONNEL		
***	Per settlement agreement the Implementation Team was appointed and is functioning to ensure timely implementation of the approved plan of correction. Team composition: Primary Team: MD Richard Schluessel, Wishburne Hunt MD, HN Reba Williams, QM Gala Garcia, Dietician Cathryn Stauffer, SW Denise Torres-Hodges, Biomed Vashdi Pinney, Procedures Monica Bet, Facilitator Bonnie B Greenspan, QA Elizabeth Harris, Standing Consultants: Pt Relations Christine DeJongh-Lewis, IC Charlene Hewitt-White, Biomed Peter John Baptiste, Psychologists Lori Thompson/ Sheena Walker The primary team meets daily to track all elements of SRMC's commitments to CMS and Quality Insights Renal Network Three. As well as general operation requirements of the unit.	Continue to achieve compliance with settlement agreement.	Continue daily meetings at least through the end of 2010
	Reba Williams has submitted her resignation as Head Nurse of the facility effective December 31st, 2010 but will continue as a charge nurse and has agreed to continue as a member of the Implementation team.	Short term goal is to operate "office of the head nurse" designating specific responsibilities of the Head Nurse position to the core group of four experienced facility RNs. The ultimate goal is to identify an appropriate candidate either from within or from outside the facility for the position The Head Nurse position has	Continue "office of the head nurse" until appropriate candidate is identified

		been posted in Human resources	
	Monica Bet, RN, will begin prioritization of clinical procedure revision using "model" procedure manual provided by DCI and training of new procedures will follow	Identify top ten procedures needed by unit for clarity and consistency and initiate training and return performance with all staff	Prioritization by January 7, 2011 and complete five procedures per month December and January
**	Social Worker is completing KDQOL testing on patients 90 days post admission An excel spreadsheet incorporating lab values, patient assessment, and psychosocial assessment has been developed for use during unstable plan of cares	Integrate IDT member specific information into unstable patient review monthly and stable patient care plan annually Better integrate psychosocial patient data during IDT review of patient care plans	Beta Test document for incorporation of KDQOL data December and January
**	Considerable effort has been put into addressing aggressive patient issues involving conflict resolution and team building Dr. L. Thompson has met with staff to discuss conflict resolution on two occasions. However, aggressive patient behavior persists among a small group of the patient population	A Letter will be distributed to patients outlining resources available to address their concerns and guidelines for acceptable behavior within the unit Offer CPI training for both clinical staff and security	Staff to formulate and distribute letter by January 6th, 2011 Offer training by January 30th, 2011
Plant and Equipment			
*	**Update**	**Objective**	**Plan**
***	RO 1 continues to demonstrate small correctable problems (spontaneously reports in metric system and off US). RO1 has been taken offline	Install New RO	Install the week of January 10th, 2011

*	Auditing of charts has revealed incomplete documentation on the patient flow sheet. It was noted that training on the new flow sheet was inadequate.	Have complete and accurate records	Additional training was provided on complete documentation of flow sheet Auditing of charts will continue
	Medications are now being profiled on a weekly basis allowing nursing staff to access an efficient system when giving medication	Reduce errors through simplifying drug selection aspect of procedure, re-do written procedure, and provide MAR from system as opposed to current manual record	New process/procedure has been implemented as of December 21st, 2010. Written procedure to follow
Performance			
***	**Outcome Measures**  	Monitor and continuously improve URRs, and KDQOLs Specific targeting of hemoglobin below 10 will be addressed individually with every patient and when epogen is available (post FDA recall) transition from aranesp to epogen will be undertaken Hemoglobin values have become more stable with laboratory testing performed on Wednesdays and Thursdays reducing inconsistency due to volume shifts	Ongoing monitoring Dr. Bonner to notify QAPI team when epogen available New Wednesday Thursday schedule to be continued

	CIPA and POC will utilize new laboratory download forms. First use January	Utilize the laboratory capabilities to implement a CIPA and POC that incorporates all biometrics and patient input	First use of new CIPA POC January and a long term system by March
Prevention Of Infection			
**	PPE use and Hand hygiene between equipment contact still have small potential for improvement Hooks have been placed and significant improvement of proper donning of gowns has been noted	Attempt to increase accessibility of hand sanitizer to machines (1% improvement)	Increase in accessibility of hand sanitizer by February, 2010

Monthly Organizational Performance Improvement & Infection Prevention Committee Meeting Summary
Meeting Date: December 16 & 17, 2010

- Organizational Performance Improvement Meeting Summary:
    1. The regular monthly meeting of the OWPI Committee occurred on December 16, 2010. Several presentations were made by the departments listed below. Resulting identified areas of opportunity for corrective action, which are summarized by departmental reporting area:
        a. Hemodialysis
            i. See Hemodialysis progress report.
        b. MKSCHC
            i. MKS presented data on Medication Management and Storage, Critical Values, Pain Management, IV Therapy, Medication Administration (1st Dose), and Precision Glucose Monitoring. All monitors met 100% compliance. The newest PI study will be on Anticoagulation Therapy, to include the Warfarin Protocol, and clinician handling of Coumadin patients. This study is under continued development, and will be reported back to committee in March 2011.
        c. Rapid Response
            i. Rapid response team data was reported for the fiscal year of 2010. Rapid response team data will be correlated with Code Team data to determine if Rapid responses have reduced the frequency and severity of codes.
        d. Infection Control
            i. See Infection Control report (page 13-15 and below).
        e. Engineering and Maintenance
            i. The E/M department requires additional staff to improve the responsiveness of the department to the preventative maintenance needs of the organization. Additional brown water was identified, the hot water tank was identified, taken offline and isolated, cultured and the source was determined to be rust. The system was drained, and does not pose a risk to patient care other than aesthetics. Due to the disconnection of the system, users may experience slight discoloration and possible air in the line, which should dissipate within 48 hours. The system will be monitored daily for discoloration.
        f. Performance Improvement Plan for 2011
            i. Presentation in January 2011

- Infection Prevention Committee Meeting Summary:
    1. The regular monthly meeting of the Infection Prevention Committee occurred on December 17, 2010. Resulting identified areas of opportunity for corrective action, which are summarized by departmental reporting area:
        a. The committee received an update on the installation of the HEPA Filter in the OR, for Pulmonology use. The equipment is expected to be cleaned, mounted and installed by January 2011.
        b. The committee noted that the Fan Policy is still under development with a draft expected by January 2011.
        c. An update was provided on the glove dispenser installation project. The items have been ordered.

d. The Perfect Clean system is under consideration for improved mopping throughout the facility. Materials management is obtaining a quote for this system, for decision making by the committee.
e. All departments received training on the correct use of sanitizing wipes for cleaning of the PCX machines.
f. Several different bleach wipe products are under review for use throughout the facility. These include Dispatch and Clorox industrial strength wipes. MSDS documents are being reviewed to ensure they are safe for staff to use, with minimal PPE, while providing appropriate disinfection of equipment. Grenadier will continue to be the official disinfectant used.
g. The OR is reviewing the use of an alcohol based scrub system, Sterilium. The OR is setting up a trial with physicians and will provide the IP control committee a report of the results, accompanied by a cost analysis, by the January 2011 meeting of the committee. R. Gray is expected to develop an executive comparison summary for presentation and approval.
h. Hand hygiene rates have improved over the last quarter. The organization is closer to our goal of 90%. Kudos to medical unit, as their area, as their performance on all three areas of the hand hygiene indicators has improved. Medical unit met the goal for hand hygiene between patients, at 98%. Other areas are between 87-98%. Our target goal is 90%. Medical, surgical, ICU, and Hemodialysis are being monitored. Hemodialysis has also shown significant improvement. Hemodialysis indicators differ slightly.
i. 2011 Hand Hygiene indicators being monitored, include between contact, after gloves, and additionally after contact with equipment, or patients surrounding, hand-washing steps, gloves being worn, use of PPEs for patients on isolation precautions. A “weekly hand hygiene audit” collection tool will be shared across the organization for data collection and monitoring. The Hemodialysis tool will vary slightly. The form will need to be completed by the unit, and then turned in to IC for data collection purposes. This will go into effect January 1, 2011.
j. The CEO recommended that the reporting structure for communication from the Infection Prevention and Control Committee to the Organization Wide Performance Improvement Committee will occur bimonthly. This will lead to monthly reporting at Board PI on alternate topics. Communication to the full hospital Governing Board will occur as provided by that committee representative.
k. Infection Prevention and Control is in the process of developing a dashboard for simplified data presentation.
l. A revised Infection Prevention and Control plan will be forwarded to the committee in January 2011.
m. VHA Mock Survey - Direct impact standards were forwarded to senior leadership for review. Ms. Elizabeth Harris will be responsible for VHA / Joint Commission activities, and tracers will incorporate direct impact standards. Ms. Adeline Connor will be responsible for all education related to survey readiness and will be responsible for policies and procedures. Ms. Taylor is reviewing the indirect standards report, was posted Monday, December 20, 2010.
n. Open discussion – Physicians recommended as chairpersons of the Infection Prevention and Control Committee for 2011 include Dr. Reva Richardson and Dr. Cecilia Penn. The IPC requested that Dr. Penn advocate ensuring that the committee is regularly attended by an internist and a surgeon to participate regularly. Meetings will continue to be communicated to physicians via their personal emails with follow up phone calls.

Respectfully submitted,

Performance Improvement Team,
Christine deJongh-Lewis, MPH, Director of Patient Relations, for
Elizabeth Harris, VP of Quality & Performance Improvement

Acknowledgements:
Charlene White-Hewitt, RN, BSN, Infection Control Coordinator
Noreen Fletcher, RN, BSN, Employee Health Coordinator
Cereese Lewis-Smith, RN, MHA, MSN, Patient Safety Officer
Cecilia Penn, MD, MPH – Performance Improvement Physician
Christine deJongh-Lewis, MPH, Director of Patient Relations
Administrative & Support Staff, Performance Improvement:
Marisa Rogers, Executive Assistant
E. LaVerne Moorhead, Executive Assistant
Shanique Woods, Regulatory Analyst / Executive Assistant
Vennisha Wilson, Certified Nursing Assistant
Adlah Donastorg, III – PI Data Analyst

Additional thanks to Interdepartmental team members for report submission, including:
Georgiana Phillip – Executive Assistant to the Chief Operating Officer
Pamela Martin, RN – Emergency Room, Patient Flow Project Data Analyst
Deborah Brown, RN – Emergency Room, Head Nurse
Bonnie Greenspan, RN, MBA – BBG Consulting, LLC, Hemodialysis
Reba Williams, RN – Hemodialysis, Head Nurse
Gala Garcia – PI Analyst, Hemodialysis

Attachments:
Patient Safety Dashboard