Two-thousand thirteen was a year of significant accomplishments for St. Francis. Quality, safety, and patient care experience reflect a culture dedicated to achieving and sustaining excellence for the patients we serve. St. Francis is committed to data transparency and sharing performance results to empower stakeholders to make informed health care decisions.

The quality, safety, and service work completed in 2013 is a strong foundation for the strategic initiatives and health care reform challenges which lie ahead in 2014. This work is representative of a comprehensive quality and safety program through the united efforts of physicians, staff, and leaders.

Mike McMahan
President
St. Francis Regional Medical Center

The Quality & Safety Department works in partnership with St. Francis leadership, physicians and staff to improve care, safety, service and performance across the organization. The department provides direction and leadership in areas of performance improvement, accreditation and certification, patient safety, patient experience, patient advocacy, workplace/employee health and safety, risk prevention, infection prevention, medical staff peer review and medical staff services.

The department identifies and abstracts clinical, demographic and financial data and organizes, analyzes and translates this data into useful information which:

- Meets customer’s needs for performance enhancement;
- Promotes evidence based practice;
- Assists in strategy deployment and organizational goal achievement and;
- Supports the systems and processes necessary to maintain regulatory compliance.

The St. Francis Quality & Safety Council provides over site for the organization's quality, safety and service programs. This interdisciplinary council supports and monitors the progress of strategic initiatives and performance improvement strategies.

The Quality & Safety Department partners with leaders and staff to improve patient care outcomes. The department has been instrumental in building the infrastructure to support organizational goal achievement, assure goal sustainment and achieve state and national award recognition.

Nancy Wolf, MSN, RN, CPHQ
Director, Quality & Safety
St. Francis Regional Medical Center
2013 Honors and Awards

NATIONAL ACCREDITATION AND CERTIFICATION

Hospital accreditation by The Joint Commission

Heart Failure Disease Specific Program certification by The Joint Commission

Commission on Cancer accreditation by the American College of Surgeons

Cardiac Rehab Program certification by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)

Laboratory accreditation by the College of American Pathologists (CAP)

Diabetes Self-Management Education Program Certification by the American Diabetes Association

American College of Radiology Accreditation: CT Scan, MRI, Ultrasound general & breast, Mammography, Nuclear Medicine

Sleep Center accreditation by the American Academy of Sleep Medicine

ORGANIZATION HONORS – PROFESSIONAL

Prior Lake-Savage Area Schools Partnership Award

Shakopee Chamber of Commerce Member Business of the Year-Large Business

Highest Value Based Purchasing “total performance score” of all the Allina hospitals, second highest hospital in the state of Minnesota

2013 Allina Best Care (ABC) Culture Award

2013 IBCLC (International Board of Consultant Lactation Care) Award

March of Dimes Early Elective Delivery Recognition Award

Consumer Reports-Highest safety surgery rating

2013 Healthgrades Outstanding Patient Experience Award

2013 Health Information and Management Systems Society (HIMSS) Stage 6 award for EMR Adoption

2013 Minnesota Business Ethics Award-Large Company

2013 Star Tribune Top 100 Workplace-Large Company

2013 Valley Rehab Services Top 100 Workplace-Small Company (3rd consecutive year)

2013 HealthStrong Best in Strength Award-Top 100 Hospital

2013 Joint Commission Top Performer on Key Quality Measures

Women’s Choice Award-Best Hospital for Patient Experience in Emergency Care

INDIVIDUAL HONORS

Jimly Harris Diagnostic Services Manager, and Juan Queberin, Transport Aide, received the Allina Uncommon Caring Award

Colleen Roethke RN, Diabetes Educator, was a finalist for Mpls/St. Paul's Outstanding Nurses Award

Karen Sonnenburg RN, Elizabeth Cantrell RN, received the 2013 March of Dimes Rising Star Nurse of the Year Award

Sher Stiles RN, received the 2013 March of Dimes Staff Nurse-General Care Nurse of the Year Award

Helen Orso, Med/Surg nursing assistant, Georgia Baer RN, Same Day Surgery nurse, and Cortney Ginthier, Laboratory, received a Minnesota Hospital Association Good Catch for Patient Safety Award

Dr. Anthony Spagnolo received the Twin Cities Medical Society’s Charles Bowles Bowles-Rogers Award

Dr. Edwin Bogonko was named the 2013 president of the Twin Cities Medical Society

Michael Morris was named 2013 Minnesota American College of Healthcare Executive Early Careerist Award
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Core Measures - Optimal Care

Measure: Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), Stroke (STK) and Surgical Care Improvement Project (SCIP) Optimal Care

Definitions:

Core Measures — A uniform set of measures based on best practice guidelines which are nationally accepted standards of care across all hospitals.

Optimal Care — Percent of patients receiving all interventions appropriate to their care.

Inclusions: Inpatients with a principal discharge diagnosis of AMI, HF, PN, STK, or specific surgical procedures as defined by the Centers for Medicare and Medicaid Services (CMS).

Exclusions: Outpatients with the same diagnoses; patients <18 years of age, and other measure-specific exclusions as defined by CMS.

Goal: ≥ 96.3%

Data Source: Allina Enterprise Data Warehouse.

Summary:

- Achieved optimal care score of 98.2% which exceeded the goal and surpassed Allina’s score of 97.3%.
- Sustained concurrent case monitoring with real time feedback and education to nurses and physicians to assure measure compliance.
- Updated order sets to reflect best practice and CMS core measure requirements.
- Quality Improvement Specialist and RN Care Coordinators partner to assure measure compliance and identify appeal opportunities.

Lead: Erin Kiernan-Johnson, Quality Improvement Specialist

In 2013 St. Francis received the highest CMS Value-Based Purchasing (VBP) “total performance score” of all Allina hospitals, higher than the state or national benchmark and second highest of all Prospective Payment System Hospitals in the state of Minnesota. The VBP model rewards physicians, hospitals, medical groups, and other healthcare providers for meeting certain performance measures for quality, patient satisfaction and efficiency. Core measure rates are one component of the VBP calculation.
ED Patient Flow Core Measures

**Measure:** Median Time from ED Arrival to ED Departure Time for Discharged Patients

**Inclusions:** ED patients discharged from the Emergency Department.

**Exclusions:** Patients who expired in the emergency department, mental health, observation and transfer patients.

**Goal:** < 134 minutes

**Measure:** Median Time from ED Arrival to ED Departure Time for Admitted Patients.

**Inclusions:** ED patients admitted to an inpatient status.

**Exclusions:** Patients who expired in the emergency department, mental health, observation and transfer patients.

**Goal:** < 264 minutes.

**Measure:** Median Time from ED Decision Time to ED Departure for Admitted Patients.

**Inclusions:** ED patients admitted to an inpatient status.

**Exclusions:** Patients who expired in the emergency department, mental health, observation and transfer patients.

**Goal:** < 91 minutes.

**Data Source:** Allina Enterprise Data Warehouse.

**Summary:**

- Median time from ED arrival to ED departure for discharged patients (Total time patient spent in the ED): Exceeded national benchmark goal at 112 minutes.

- Implementation of immediate bedding initiative decreased ED average length of stay and time from patient arrival to time seen by a physician.

- Median time from arrival to departure for admitted patients: Far exceeded national benchmark at 199 minutes.

- Median time from ED decision time to ED departure for admitted patients: Slightly above national benchmark at 105 minutes.

- Operation Ruby Slippers initiative focused on discharging inpatients earlier in the day which positively impacts flow of ED patients to inpatient admit status.

**Lead:** Jamie Stolee, ED Manager, and the Emergency Department Team
St. Francis was awarded the Joint Commission Top Performer on Key Quality Measures designation for superior performance in pneumonia and surgical care. Top Performer hospitals represent the top 33 percent of all Joint Commission-accredited hospitals that reported measure data for 2012.

In addition, St. Francis was acknowledged by Consumer Reports as having one of the highest safety surgery ratings in the nation.

**Surgical Care - Optimal Care**

**Measure:** Surgical Care Improvement Project (SCIP) Optimal Care

**Definitions:**

**Core Measures** — A uniform set of measures based on best practice guidelines which are nationally accepted standards of care across all hospitals.

**Optimal Care** — Percent of patients receiving all interventions appropriate to their care.

**Inclusions:**

**Inpatient SCIP** — Antibiotic administration timing prior to incision, appropriate antibiotic selection, and timely discontinuation of antibiotic (for surgical case types: hip and knee arthroplasty, colon resection, and abdominal/vaginal hysterectomy); beta blocker administration for patients on beta-blockers at home, VTE prophylaxis, urinary catheter removal and perioperative temperature management for selected surgical populations.

**Outpatient SCIP** — Outpatient surgical procedures (sample of all outpatient procedures).

**Exclusions:**

**Inpatient SCIP** — Surgical procedures other than those identified above.

**Outpatient SCIP** — Inpatient surgical procedures.

**Goal:** ≥ 96%

**Data Source:** Allina Enterprise Data Warehouse.

**Summary:**

- Goal met with optimal care rate of 99.0%.
- Overall optimal care score for outpatient SCIP was 98.3% for antibiotic timing and 100% for antibiotic selection.
- Implemented system changes such as order set modifications, Best Practice Alerts (BPAs) and flow sheet redesign.
- Utilized Excellian workbench reports for concurrent case monitoring, allowing real time feedback to staff and physicians.

**Lead:** Karen Ortberg, OR Manager, and the Surgical Services Team.
ED Outpatient Core Measures

**Measure:** Outpatient AMI/Chest Pain Core Measures

**Inclusions:** AMI/Chest Pain - Patients presenting to the Emergency Department (ED) with chest pain and acute myocardial infarction (AMI) who are not admitted for inpatient care. The chest pain measure is a sample of all chest pain patients.

**Exclusions:** AMI

**Goal:** ≤ 8 minutes

**Data Source:** Allina Enterprise Data Warehouse

**Summary:**
- Median time to EKG is 9.75 minutes for chest pain patients.
- Implemented Respiratory Therapy process improvement work to decrease time for EKG download into the MUSE system thereby increasing EKG Excellian availability for physician documentation.
- Collaborated with Abbott Northwestern and Methodist Hospital cardiologists, ED physicians and call center to improve patient services via case reviews and continuous process monitoring.

**Lead:** Jamie Stolee, ED Manager, and the Emergency Department Team
Stroke Optimal Care

**Measure:** Stroke Optimal Care

**Definitions:**

*Core Measures* — A uniform set of measures based on best practice guidelines which are nationally accepted standards of care across all hospitals.

*Optimal Care* — Percent of patients receiving all interventions appropriate to their care.

**Inclusions:** Inpatients with a principal discharge diagnosis of ischemic or hemorrhagic stroke as defined by the Centers for Medicare and Medicaid Services (CMS).

**Exclusions:** Outpatients with the same diagnoses; patients <18 years of age, and other measure-specific exclusions as defined by CMS.

**Goal:** ≥ 95%

**Data Source:** Allina Enterprise Data Warehouse

**Summary:**

- Achieved stroke optimal care rate of 91.7% with a national average of 83%.
- Successful transition of code stroke leadership and processes within the Allina system.
- Improved dysphagia screening over the past two years from 43.1% to 72.7%.
- Provided education to emergency and critical care nursing staff regarding subtle stroke cases, early recognition in triage, and code stroke timing measures.
- Continued hospital wide newsletter on code stroke timing measures.
- Successful implementation of inpatient neurology consultation via telestroke.

**Lead:** Brianna Thompson, Med/Surg Supervisor and the Stroke Program Team
VTE Core Measures - Optimal Care

Measure: Venous Thromboembolism (VTE) Optimal Care

Definitions:

Core Measures — A uniform set of measures based on best practice guidelines which are nationally accepted standards of care across all hospitals.

Optimal Care — Percent of patients receiving all interventions appropriate to their care.

Inclusions: All Inpatients that are > 18 years of age and have a length of Stay (Discharge Date - Admission Date) <= 120 days as defined by the Centers for Medicare and Medicaid Services.

Exclusions: Outpatients with the same diagnoses; patients <18 years of age, and other measure-specific exclusions as defined by CMS.

Goal: New core measure set. No goal established.

Data Source: Allina Enterprise Data Warehouse

Summary:

- Achieved optimal care score of 89.9% which surpassed Allina-wide optimal care score of 84.9%.
- Sustained concurrent case monitoring with real time feedback and education to nurses and physicians.
- Multiple Allina order sets were updated with VTE hard stops to assure measure compliance.
- Quality Improvement Specialist and RN Care Coordinators partner to assure measure compliance and identify appeal opportunities.

Lead: Erin Kiernan-Johnson, Quality Improvement Specialist, and the VTE Team
Readmission Reduction

Measure: Potentially Preventable Readmissions (PPRs).

Inclusions: The potentially preventable methodology measures the readmission rate to the same hospital for all eligible discharges. Readmissions must be clinically related as defined by a clinical review panel. PPR reflects chain of readmissions occurring within 30 days of any prior discharge. PPR includes all ages past newborn, all payers, and counts few planned readmissions. PPR is adjusted for acuity differences using state data for an actual-to-expected performance ratio.

Exclusions: Left against medical advice, medical treatment of cancer, some cancer diagnoses, rehabilitation care, burns and major multiple trauma (Source: New CMS 30-day readmissions criteria).

Goal: < 0.98 actual/expected ratio

Data Source: Allina Enterprise Data Warehouse

Summary:
- Goal was not realized with a difference of 10 potentially preventable patient readmissions.
- Implemented transition conferences for patients identified at risk for readmission.
- Developed workgroup to standardize and improve transition conference processes.
- Implemented inpatient depression screening (PHQ-9 tool) for patients with heart failure and anxiety screening (GAD-7 tool) for patients with COPD. Depression screening prompts an inpatient psychiatric referral process, as mental health comorbidities are linked to increased readmissions.
- “Recommendations for Outpatient Provider” orders to communicate a specific transition plan for the outpatient provider and improve coordination of care.
- Implemented After Visit Summary (AVS) patient discharge instructions; concise and relevant information to promote patient self-management post-hospitalization.
- Participated in the Allina system Patient Education standardization work group.
- Participated in an American Lung Association “COPD Readmissions Learning Collaborative”.
- Implemented a Pulmonary Rehabilitation program and support group.
- Promoted and referred to “Living Well with Chronic Conditions” evidence-based workshop for patients living with chronic illness.

Lead: Sarah Amendola, Med/Surg/SCU Manager, and the Readmission Reduction Team
Patient Experience of Care

**Measure:** Overall Patient Experience

**Inclusions:** Returned adult (Med Surg, Intensive Care Unit, and Family Birth Place) HCAHPS surveys (patients admitted to the hospital).

**Exclusions:** Outpatient services other than those identified as inclusions, inpatient pediatric unit. Surveys are sent to patients based on the inpatient unit they were discharged from.

**Goal:** ≥ 76.7%

**Data Source:** HCAHPS survey; Allina Enterprise Data Warehouse

**Summary:**
- Goal met with an annual rate of 77%.
- Active pain management and communication with physician teams worked to improve these two survey composites.
- Environmental Cleanliness team launched to address this survey composite.
- Targeted patient care rounding questions established to focus on specific survey questions and composites.
- Positive deviance initiative launched, focusing on environmental cleanliness.
- Staff, leader and medical staff training initiated to transition from percent to percentile data display in 2014.
- Avatar outpatient department percentile goals established for 2014.

**Lead:** Nancy Wolf, Patient Experience Site Lead

St. Francis received national recognition in 2013, receiving the Healthgrades Outstanding Patient Experience Award and the Women’s Choice Award-Best Hospital for Patient Experience in Emergency Care.

Patient experience at St. Francis Regional Medical Center is measured by responses received from patient satisfaction surveys. The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is a national, standardized, publicly reported survey of patients’ perspectives of hospital care. Patient survey responses are shared with staff on an ongoing basis to affirm the positive impact caregivers have on the patients’ experience.

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**Inpatient Overall Patient Experience**

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>67.0%</td>
</tr>
<tr>
<td>2009</td>
<td>68.0%</td>
</tr>
<tr>
<td>2010</td>
<td>71.7%</td>
</tr>
<tr>
<td>2011</td>
<td>72.1%</td>
</tr>
<tr>
<td>2012</td>
<td>76.10%</td>
</tr>
<tr>
<td>2013</td>
<td>77.5%</td>
</tr>
</tbody>
</table>

**2013 Goal - 76.7%**

**Percentage of patients selecting 9 or 10:** Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
Communication with Doctors

**Measure**: Communication with Doctors

**Inclusions**: Returned adult (Med Surg, Intensive Care Unit, Family Birth Place) HCAHPS surveys (patients admitted to the hospital).

**Exclusions**: Outpatient services other than those identified as inclusions, inpatient pediatric unit. Surveys are sent to patients based on the inpatient unit they were discharged from.

**Goal**: ≥ 85.87%

**Data Source**: HCAHPS survey; Allina Enterprise Data Warehouse

**Summary**:
- Achieved rate of 84.2%.
- Utilized hospitalist and Physician Assistant business cards as a patient communication tool.
- Continued emphasis on the “four C’s” (Connect, Chairs, Care Boards, and Cards).
- Completed new hospitalist shadowing by system patient experience manager.
- Discussed Communication with Doctors newsletter at all medical staff department meetings.
- Recognized exceptional physicians with the Hospital Outstanding Patient Experience (HOPE) award.
- Identified physician by name on care boards.
- Implemented hospitalist scribe program, creating dedicated communication time for hospitalist and patient.

**Lead**: Nancy Wolf, Patient Experience Site Lead

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*St. Francis implemented a Hospitalist scribe program in 2013. The scribe program allows Hospitalists to spend more dedicated time with patients and families. Scribes accompany Hospitalists into the patient’s room and transcribe the patient plan of care in the electronic medical record. The Hospitalist is able to spend additional time with patients, contributing to enhanced patient satisfaction.*
St. Francis Integrative Health Program:

• 90 RNs have gone through Transformative Nurse Training (39% of nursing staff at St. Francis).

• All inpatient and outpatient departments have sent RNs through TNT. Integrative Health Practitioners started in April 2013 and provide care to all inpatient units and the Cancer Center. In 2014 Integrative Health will expand to additional outpatient units.

• RNs and Integrative Health Practitioners provide: Guided imagery, acupuncture, acupressure, therapeutic massage, relaxation techniques, aromatherapy and energy work therapies to patients.

• Since January 2013, 1042 patients have received aromatherapy. Integrative therapy by both RNs and Integrative Health Practitioners has shown decreases in pain, anxiety and nausea.

Inclusions: Returned adult (Med Surg, Intensive Care Unit, Family Birth Place) HCAHPS surveys.

Exclusions: Outpatient services other than those identified as inclusions, inpatient pediatric unit.

Goal: ≥ 75.6%

Data Source: HCAHPS survey; Allina Enterprise Data Warehouse.

Summary:

• 2013 goal missed by 0.9% (76.7%), however achieved the 85th percentile in the Pain Management Composite in HCAHPS.

• Expanded Integrative Therapies with a 1.0 FTE integrative practitioner hired. Provider and nursing staff education continued with lunch and learns utilizing experiential learning.

• Pain policy aligned with system. St. Francis team presented at Allina wide pain symposium.

• Enhanced reassessment work with leaders from each unit. Developed and shared value statements with nursing staff. Provided education regarding the onset of pain medications.

• Pain video business cards made available to patients prior to surgery; extending same education to surgeon’s offices.

• Successful aromatherapy trial in Same Day Surgery. Continued inpatient aromatherapy use. Patients reported significant decreases in pain, anxiety and nausea with use of aromatherapy.

• Collaborated with pharmacy to support chronic pain patients, education to providers and nursing staff about MAPs Pain Clinic.

• Addition of physical therapy and palliative care to Pain Experience Team. Increased engagement of pain team members.

• Nurse leader rounding continued with specific questions regarding pain.

• Coaching and support to staff for consistent completion of Care Board pain goal/plan.

Lead: Kathy Mason, Med/Surg Supervisor, and the Pain Experience Team
Patients Diverted from Hospital Admissions

Measure: Patient Diverts.

Inclusions: Patients diverted from an inpatient unit due to bed capacity or staffing.

Exclusions: Patients transferred for a reason other than bed capacity or staff availability.

Goal: No 2013 goal identified.

Data Source: Nursing Administrative Supervisor tracking database.

Summary:
- January and February resulted in several diverts due in part to a high influenza rate creating high census and ill nursing staff.
- Diverted 27 patients total from January-June and seven from July – December (34 for the year). Of this number, three diverts were related to no beds and 31 were due to lack of nursing staff. Nine patients were SCU admits and seven were Med/Surg admits. There were 15 diverts for FBP related to laboring patient surges during on several occasions throughout the year.
- Conducted quarterly reviews of census versus core staffing in Med/Surg, SCU and FBP. Positions were hired, or in process, to meet implemented core changes for days of the week and shifts in the day for high census and divert trends.
- Developed a Divert Task Force in July with staff and leadership from all inpatient nursing units, float pool and ED. The goal for this group was to create a “no divert culture” at St. Francis. This group created and implemented tactics to reduce diverts: Organizational “Divert/Prevention” policy, divert prevention status report, 24/7 divert huddle process, monthly and quarterly scorecard reporting for each nursing unit and recognition of positive deviance in divert prevention.

Lead: Chris Wolf, Resource Manager, and the Patient Flow Team


**Clostridium difficile Reduction**

**Measure:** Clostridium difficile Infection Reduction

**Definitions:**

*Clostridium difficile Infection (CDI)* — A contagious spore forming bacillus that is capable of causing significant illness and in some cases death. CDE is often related to extended antibiotic therapy.

*Hospital-acquired Infection (HAI)* — Identified through laboratory testing more than 48 hours after admission.

**Inclusions:** Patients hospitalized for more than 48 hours with positive laboratory test as defined by Centers for Disease Control (CDC).

**Exclusions:** Patients hospitalized that do not meet the laboratory-confirmed CDI definition as defined by the CDC.

**Goal:** ≤7.2 cases per 10,000 patient days

**Data Source:** Laboratory culture data

**Summary:**

- Achieved goal at 3.84 cases per 10,000 patient days (well below Allina goal).
- Provided staff communications and education on key CDI testing messages, enteric precautions, and cleaning requirements. Utilized multiple venues to share information and education: newsletter submissions, emails, nursing and medical staff meetings, and mandatory Nursing Assistant education focused on CDI prevention.
- CDI Workgroup meets bi-monthly to review data, including cases classified as hospital acquired infections, and to develop and implement new strategies to prevent the spread of CDI.

**Lead:** Erin Kiernan-Johnson, Infection Preventionist, and the CDI Reduction Team.
Hand Hygiene

Measure: Hand Hygiene

Definitions: Health care worker compliance with hand hygiene (hand washing or alcohol-based foam rub) upon room entry or exit.

Inclusions: Observable compliance or non-compliance with hand hygiene upon room entry or exit.

Exclusions: Instances when auditor is unable to verify whether hand hygiene was performed.

Goal: ≥ 70%

Data Source: Third party observer monthly audit data.

Summary:

- Achieved goal with 79% hand washing rate.
- Trained additional Secret Shopper (third party) auditors in third quarter and an audit tracking process was implemented.
- Hand hygiene education was featured at the fall Safety Fair – including data comparisons across departments and provider types.
- Hand Hygiene Workgroup continues to meet monthly. The team evaluates data and develops and implements new strategies to support the hand hygiene goal. Members from Surgical Services, Family Birthplace, and SCU were added.
- Positive Deviance Team for Hand Hygiene convened in fourth quarter, with a local goal of 90% Hand Hygiene compliance set for 2014.

Lead: Erin Kiernan-Johnson, Infection Preventionist, and the Hand Hygiene Team
Patient Visitor Safety Reporting

**Measure:** Patient Visitor Safety and Near Miss Reporting

**Inclusions:** All inpatients, outpatients and visitors.

**Exclusions:** Employee events or campus partner clinic patient events.

**Goal:** 25.6 near misses reported/1000 adjusted admissions

**Data Source:** Patient Visitor Safety Report (PVSR) Database.

**Summary:**
- Good catch reporting goal exceeded with a rate of 42.6%.
- Included good catch reporting a goal in each patient care department safety culture action plan.
- Good catch reporting measure added to nursing scorecards.
- PVSR and good catch reporting highlighted in the annual St. Francis Safety Fair.
- PVSR tool upgraded to include staff request for email follow up on events reported.
- Managers submitted near misses to the Minnesota Hospital Association for the Good Catch Award.

**CRITICAL EVENT REVIEWS/ ADVERSE HEALTH EVENTS**

- 15 Critical Event Reviews (CER) were conducted in 2013.
- Two of the CER were reportable Adverse Health Events (AHE) to the Minnesota Department of Health (both falls with fracture).
- Adequacy of staffing was assessed for all CERs. No staffing concerns were identified.
- All CER were reviewed by the St. Francis Quality & Safety Council and the Board of Directors.
- Each CER resulted in an action plan which addressed process and system opportunities.
Failure Mode Effect Analysis

- A Failure Mode Effect Analysis (FMEA), proactive risk assessment, was conducted on surgical services management of products of conception post D&C.
- The FMEA was initiated based on organizational opportunities identified during a gap analysis of body hold procedures and management of fetal demise.
- A team consisting of Family Birth Place, Same Day Surgery, Operating Room and Laboratory staff developed an education curriculum for surgery staff and updated the products of conception consent form to assure a standard hand off procedure for the specimen from one department to another.

**Lead:** Nancy Wolf, Director Quality, Safety & Risk Management.

**WHAT IS FAILURE MODE EFFECTS ANALYSIS?**

Failure Modes and Effects Analysis (FMEA) is a systematic, proactive method for evaluating a process to identify where and how it might fail, and to assess the relative impact of different failures in order to identify the parts of the process that are most in need of change.

Hospitals use the FMEA process to evaluate work flows and procedures for possible failures and to prevent them by correcting the processes proactively rather than reacting after failures have occurred.

**WHAT IS THE ADVERSE HEALTH EVENTS REPORTING LAW?**

Passed during the 2003 legislative session, the law provides health care consumers with information on how well hospitals, community behavioral health hospitals, and outpatient surgical centers are doing at preventing adverse events. The law requires that these facilities disclose when any of 29 serious reportable events occur and requires MDH to publish annual reports of the events by facility, along with an analysis of the events, the corrections implemented by facilities and any recommendations for improvement.

**THREE ST. FRANCIS STAFF RECEIVED THE MINNESOTA HOSPITAL ASSOCIATION GOOD CATCH AWARD:**

- Helen Orso, Med/Surg Nursing Assistant, was recognized for “stopping the line” during a Rapid Response Team event. As the team was preparing to use a lift device to move a patient from commode to bed, Helen noted that one of the sling loops was not attached properly. She stopped the transfer immediately.
- Georgia Baer RN, Same Day Surgery Nurse, was recognized for identifying a laterality discrepancy preoperatively and preventing a wrong site surgery.
- Cortney Ginther, Laboratory Technician, was recognized for identifying a discrepancy in a laboratory test and sharing the result with the patient’s physician.
Influenza Vaccination

Measure: Influenza Vaccination of Employees

Definitions:

Participation — Defined as employees who either received the influenza vaccine at Allina or completed a declination form.

Inclusions: St. Francis employed staff.

Exclusions: Non-employed staff, providers, volunteers, and other Allina business unit employees.

Goal: 100% participation

Data Source: Allina OnBase reports.

Summary:

- Achieved participation rate of 95.7%. This exceeded the 2012 participation rate of 84.4% by 11.3%. Achieved vaccination rate of 79.2% (from 73.5% in 2012).

- Managers were given names of staff who had not participated (either by receiving vaccine or completing declination form) and were able to follow-up with individuals, contributing to a large increase in participation.

- Utilized the “Flu Deputy” model with an emphasis on peer-to-peer vaccinations. Vaccine was also available for staff via Employee Health, designated units, and 24/7 in the Emergency Department.

- Influenza vaccination and program participation was encouraged via multiple venues, including TIE forums, Friday Messages, staff meetings, and other newsletters.

Lead: Erin Kiernan-Johnson, Infection Preventionist, and CDI Reduction Team
Fall Prevention

**Measure:** Inpatient Falls/Falls with Harm

**Inclusions:** Inpatient falls, coded as harm (E-I).

**Exclusions:** Outpatient falls, falls coded other than E-I (harm).

**Goal:** <0.76 falls per 1000 patient days

**Data Source:** Allina Enterprise Data Warehouse

**Summary:**
- Achieved 2013 goal at 0.76 falls with harm per 1000 patient days.
- Initiated new work tool for assigning and work flow for planned toileting.
- Integrated safe patient moving with falls work by merging teams.
- Increased use of mobility assessment and Safe Patient Moving (SPM) equipment, including the roll out of our safe patient moving medallions to Med/Surg and Special Care Unit.
- Increased awareness of types of falls throughout the departments by discussing at the staff meetings, and displaying the work in the new safety newsletter developed in 2013 to address SPM, falls prevention, and PVSRs.
- Continued fall risk audits and communication back to staff around bare minimums.
- Presented fall risk tools, recent learnings about fall risk with post-op orthopedic patients, and SPM medallions at the annual safety fair.

**Lead:** Brianna Thompson, Med/Surg Supervisor, and the Fall Prevention Team

![Inpatient Falls with Harm Rate](image-url)
### 2013 National Patient Safety Goals

<table>
<thead>
<tr>
<th>Goal 1—Improve the accuracy of patient identification</th>
<th>How do we measure compliance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observational audit of patient caregivers using two patient identifiers (name and DOB).</td>
<td>↑=good 100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 2—Improve the effectiveness of communication among caregivers.</th>
<th>How do we measure compliance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory: Critical test results are communicated to the licensed healthcare provider or designee within 15 minutes of obtaining verified results.</td>
<td>↑=good 100% 98% 95% 96%</td>
</tr>
<tr>
<td>Nursing: Critical test results are communicated from nurse to provider within 20 minutes of obtaining verified results.</td>
<td>↑=good 100% 71% 86% 57%*</td>
</tr>
<tr>
<td>Radiology: Imaging critical results are communicated to the physician within 35 minutes of verification as critical.</td>
<td>↑=good 100% 98% 100% 78%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 3—Improve the safety of using medications.</th>
<th>How do we measure compliance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>All medications, medication containers and other solutions on and off the sterile field are labeled (all procedural settings).</td>
<td>↑=good 100%</td>
</tr>
<tr>
<td>Overall compliance of dosing and lab monitoring of anticoagulation therapy.</td>
<td>↑=good 100% 95% 94% 93% 92%</td>
</tr>
<tr>
<td>Patients receive warfarin education prior to discharge.</td>
<td>↑=good 100% 87% 80% 90% 93%</td>
</tr>
<tr>
<td>Medication Reconciliation - Admission w/in 24hrs</td>
<td>↑=good 100%</td>
</tr>
<tr>
<td>Medication Reconciliation - Discharge</td>
<td>↑=good 100% 96% 97% 97% 99%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 7—Reduce the risk of healthcare-associated infections.</th>
<th>How do we measure compliance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observational audits of hand hygiene before &amp; after room entry.</td>
<td>↑=good 100% 78% 81% 81% 81%</td>
</tr>
<tr>
<td>Central line blood stream infection bundle is completed for all central lines inserted.</td>
<td>↑=good 100% 100% 100% 98% 93%</td>
</tr>
<tr>
<td>Number of central line blood stream infections.</td>
<td>↓=good 0 0 0 1 0</td>
</tr>
<tr>
<td>Number of catheter associated urinary tract infections in SCU</td>
<td>↓=good 0 0 0 0 0</td>
</tr>
<tr>
<td>Number of surgical site infections.</td>
<td>↓=good 0 2 8 5 6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 15—The organization identifies patients at risk for suicide.</th>
<th>How do we measure compliance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide risk screening completed within 24 hours of inpatient admission.</td>
<td>↑=good 100% 92% 94% 93% 90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Universal Protocol—The organization fulfills the expectations set forth in the Universal Protocol</th>
<th>How do we measure compliance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of wrong site, wrong surgery, wrong patient procedures.</td>
<td>↓=good 0 0 0 0 0</td>
</tr>
</tbody>
</table>

* Data incomplete for quarter

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### National Patient Safety Goals

**Measure:** National Patient Safety Goals

**Inclusions & Exclusions:** Vary based on the goal.

**Goal:** 100% compliance for rate based goals; zero for count based goals.

**Data Source:** Allina Enterprise Data Warehouse; medical record and observational audits.

**Summary:**

National Patient Safety Goals (NPSG) are established annually by The Joint Commission. The NPSG scorecard provides a visual display of safety outcomes and improvement efforts for each goal. 2013 NPSG highlights include:

- Zero catheter associated urinary tract infections.
- Medication reconciliation at patient discharge hardwired near 100%.
- Zero wrong site, wrong surgery, wrong patient procedures.
- Two patient identifier observational audits >95% compliance.

**Lead:** Nancy Wolf, Director Quality, Safety & Risk Management
In 2002, The Joint Commission established the National Patient Safety Goals (NPSGs) program; the first set of NPSGs was effective January 1, 2003. The NPSGs were established to help accredited organizations address specific areas of concern in regard to patient safety.

Following a solicitation of input from practitioners, provider organizations, purchasers, consumer groups, and other stakeholders, The Joint Commission determines the highest priority patient safety issues and how best to address them.

A panel of widely recognized patient safety experts advise The Joint Commission on the development and updating of NPSGs. This panel, called the Patient Safety Advisory Group, is composed of nurses, physicians, pharmacists, risk managers, clinical engineers and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of health care settings.

What are the National Patient Safety Goals?
Regulatory Accreditation and Certification

**Measure:** Regulatory and Accreditation Standards Compliance

**Inclusions:** Standards for which non-compliance or partial compliance is determined and plans of action developed.

**Exclusions:** Standards considered compliant or easily brought into compliance.

**Goal:** 100% participation

**Data Source:**
- Allina Internal Regulatory Survey.
- Annual completion of The Joint Commission (TJC) Focused Standards Assessment.
- Triennial Joint Commission Survey.

St. Francis Health Services in Jordan, a full service family clinic, opened in April 2013. Jordan Clinic is a hospital-based clinic with two family practice providers.
Summary:

- 2013 activity was focused on opportunities for improvement identified during the Focused Standards Assessment (FSA) submitted to TJC in February 2013.
- Successful TJC Disease Specific Heart Failure recertification on-site survey occurred in February 2013 with no recommendations for improvement.
- Allina Internal Accreditation Survey occurred on May 2013.
- In depth evaluation of the Centers for Medicare & Medicaid Services (CMS) revisions to the Interpretive Guidelines for Anesthesia Services which culminated in the creation of an Anesthesia Committee. This committee is led by the Anesthesia Medical Director and provides oversight for the delivery of anesthesia services in all departments of the hospital and by all care providers.
- Provided regulatory oversight to the planning and opening of our first hospital-based clinic (St. Francis Health Services in Jordan) in to ensure compliance with all applicable TJC and CMS regulations.
- Participated in all safety walk-arounds with a focus on TJC and NPSG requirements, created numerous educational materials including the 2013 NPSG poster and the submission of articles to St. Francis publications such as the Enquirer, Progress Notes and This Week at St Francis.

Lead: Candace Lano, Regulatory Program Manager and Erin Kiernan-Johnson, Quality Improvement Specialist
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