2015 ANNUAL REPORT
Quality, Patient Safety & Performance Improvement

HIGHLIGHTING 2014 ACCOMPLISHMENTS AND OUTCOMES

St. Francis
Regional Medical Center
2014 was a year of significant accomplishments for St. Francis. Quality, safety and patient experience of care reflect a culture dedicated to achieving and sustaining excellence for the patients we serve. St. Francis is committed to data transparency and sharing performance outcomes to empower stakeholders to make informed health care decisions.

The quality, safety and service work completed in 2014 is a strong foundation for the strategic initiatives and health care reform challenges which lie ahead in 2015. 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.
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CORE MEASURES OPTIMAL CARE

Measure: Stroke (STK), Surgical Care Improvement Project (SCIP) and 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:

STK and SCIP: Inpatients with a principal discharge diagnosis of STK or specific Surgical procedures as defined by the Centers for Medicare and Medicaid Services (CMS).

VTE: All Inpatients > 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: ≥ 95.4%

Data Source: Truven Health Analytics; Enterprise Data Warehouse.

Summary:

- Achieved a 2014 optimal care score of 97.0% which exceeded the strategic goal and surpassed Allina’s overall rate of 95.3%.
- Concurrent case monitoring with real time feedback/education to nurses and physicians continued as a key tactic to sustain compliance. Order sets were updated to reflect best practice and CMS core measure requirements.
- Core measures lead and Care Managers partner to assure compliance and identify appeal opportunities for measure failures.

Stroke

- Achieved annual optimal care score of 95.16% which exceeded the goal but was slightly below Allina’s overall score of 96.0%.
- A Stroke Coordinator was hired in 2014 and additional Stroke Program Team members were added to represent ED, EMS, Pharmacy, Speech, Med/Surg RN, Hospitalist, and Critical Resource Nurse.
- Second tele-stroke monitor ordered and ED staff trained on updated software.
- Received “Stroke Ready” designation from the Minnesota Department of Health.
- Opportunities for 2015 include: Decreased time from door to CT, including Telehealth Neurologist sooner in the Code Stroke process.
• St. Francis was awarded the **Joint Commission Top Performer** on Key Quality Measures designation for superior performance in pneumonia and surgical care for the second consecutive year. Top Performer hospitals represent the top 33 percent of all Joint Commission-accredited hospitals that reported measure data for 2013.

• St. Francis was acknowledged by Consumer Reports as having one of the highest safety ratings in the Twin Cities-Metro area.

**SCIP**
- Attained an optimal care score of 97.1% which was slightly below the goal of 97.7% but exceeded the overall Allina score of 96.7%.
- Continued daily concurrent monitoring by Quality Improvement Specialist with real time resolutions to potential misses.
- Updated order sets to reflect best practice and core measure requirements.

**VTE**
- Achieved annual optimal care score of 97.24% which far exceeded the goal of 93.0% and surpassed the Allina score of 93.8%.
- Continued daily concurrent monitoring by Quality Improvement Specialist with real time resolutions to potential misses.
- Updated order sets to reflect best practice and core measure requirements.
- Developed Best Practice Alert (BPA) to fire if anti-embolism devices are not applied within six hours of the physician order.

**Lead:** Angelina Buerck, Quality Improvement Specialist
READMISSION REDUCTION

ST. GERTRUDE’S HEART FAILURE PROGRAM

St. Francis partnered with St. Gertrude’s to integrate its HF program into the long term care setting. Program integration included a recurring HF orientation program for new St. Gert’s nurses, standardization of patient/resident education materials and development of a HF exacerbation protocol. This resulted in a 35% reduction in heart failure readmissions to St. Francis from St. Gertrude’s in 2013 and a 14% reduction in 2014.

IN REACH PROGRAM

An Emergency Department (ED) In-Reach Program was implemented in 2013 to connect high utilization ED patients with community resources. The program included allocation of a dedicated ED Social Worker.

The ED Social Worker case managed 43 patients in 2014, reducing ED visits for these patients from 344 pre-case management to 58 visits one year post-case management. The ED Social Worker also assisted with 20 nursing home and assisted living placements in 2014.

Both the reduction in ED visits and the availability of ED placement services contributed to a reduction in potentially preventable readmissions in 2014.

Measure: Potentially Preventable Readmissions (PPRs)

Inclusions: Measures readmission rate to 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. Includes all ages past newborn, all payers, and counts few planned readmissions. 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.

Goal: \( \leq 1.04 \) Actual/Expected (A/E) Ratio

Data Source: PPR Dashboard-Allina Shared Analytics Portal (ASAP)
Summary:
- Achieved an A/E ratio of 0.81, far surpassing the annual goal of 1.04. The A/E ratio equates to 22 patient readmissions prevented in 2014.
- Completed a Rapid Performance Improvement Workshop in January to assist in developing the 2014 action plan.
- Worked with St. Gertrude’s to decrease heart failure readmissions among shared patients. Rate decreased from 35.1% in 2013 to 14% in 2014.
- Developed standardized work flow to increase the number of transition conferences for moderate and high risk patients.
- Developed a COPD Team to begin in 2015. This group will develop focused initiatives to decrease this consistently high readmission diagnosis at St. Francis.
- After Visit Summary language simplified, making it clearer for patients to understand discharge instructions.
- Hardwired use of the Recommendation to Outpatient Provider order by the Hospitalists (YTD 95.0%).
- Assisted in development of a new, enhanced PPR dashboard.

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

The care transitions score represents the results of three HCAHPS survey questions that ask patients about key components of the care coordination process:
- Understanding the purpose of taking meds
- Understanding health management
- Whether hospital staff took patient preferences into account during discharge planning
HEART FAILURE PROGRAM

Measure: Heart Failure (HF) Disease Specific Certification

Inclusions: Patients with a HF primary diagnosis admitted to the hospital.

- **Palliative Care Consult:** Number of palliative care consults for primary diagnosis HF patients.
- **30-day Readmission:** Number of patients readmitted within 30 days of discharge with a HF diagnosis.
- **Depression Screen:** Number of depression screens completed, using the PHQ-9 tool.
- **Recommendation for Outpatient Provider (ROP):** Number of ROP orders completed.

Exclusions:

- **Palliative Care Consult:** Patients transferred to another inpatient facility. Patients discharged to hospice.
- **30-day Readmission:** Patients transferred to another hospital for inpatient care during primary admission for HF and elective readmissions.
- **Depression Screen:** Patients transferred to another inpatient facility, discharged to hospice, or with documented patient refusal, cognitive barriers or other documented reason for no screen.
- **ROP:** Patients transferred to another inpatient facility or discharged to hospice.

Goals:

- Palliative Care Consult: ≥ 65%
- 30-day Readmission: < 15%
- Depression Screen: ≥ 90%
- ROP: ≥ 95%

Data Source: Medical record abstraction

Summary:

**Palliative Care Consult:** Achieved a Palliative Care Consult score of 83.3% which exceeded the goal of > 65%. Defaulted Palliative Care Consult order was added to the HF admission order set. Largest opportunity is around patients who are admitted with an order set that is not HF (general admission, admit SCU).

**30-day HF Readmission:** Achieved a 30-day readmission score of 12.0 % which exceeded the goal of <15.0%. Implemented and utilized discharge readiness checklist to assure patients were off IV diuretics and stable on oral diuretics for 24 hours prior to discharge. Developed a standard process to assure moderate high-risk and high-risk for readmission patients receive Transitional Care Conference. Hardwired a process for follow up appointments to be made prior to discharge by RN Care Coordinators and added to their After Visit Summary (AVS). Provided education to all care providers in the use of the “Teach back” method; to be used in educating and reinforcing Heart Failure education.

**Depression Screen:** Achieved a depression screen score of 79.0% which is below goal of > 90.0%. PHQ9 depression screen added to HF admission order set. Provided reinforcement to staff when data showed a decrease in use of the PHQ9. Improved access to the PHQ9 tool for staff; PHQ9 tool added to admission HF packet.

**Recommendation for Outpatient Provider:** Achieved a ROP score of 97.3% which exceeded the goal of > 95.0%. Provided case monitoring and feedback/education to nurses and physicians to achieve and sustain compliance with ROP use.

Lead: Angelina Buerck, Heart Failure Coordinator, and the Heart Failure Program Team
The HF Team initiated the first annual organizational **low sodium food drive**. The team successfully collected 120 lbs. of low sodium food and donated them to the Shakopee Community Action Program.
PATIENT EXPERIENCE AWARD
St. Francis received national recognition in 2014, receiving the Women’s Choice Award-Best Hospital for Patient Experience in Emergency Care.

MEASURING PATIENT EXPERIENCE
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.

OUR COMMITMENT TO CARE
In early 2014, leaders throughout the system began introducing employees to Our Commitment to Care, a set of service standards and behaviors centered around Our Promise. The St. Francis Standards of Behaviors became the basis for the system-wide Our Commitment to Care.

OUR PROMISE:
• Our dedication to provide care in a way that fulfills what patients say they want and need from us.

OUR MISSION, VISION & VALUES:
• The foundation that guides everything we do.

PATIENT EXPERIENCE OF CARE
Measure: Overall Patient Satisfaction
Inclusions: Returned adult (Med/Surg, Special 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: ≥ 75th percentile
Data Source: HCAHPS survey; Enterprise Data Warehouse
Summary:

- Surpassed annual goal at 80th percentile ranking. Consistently ranked ≥ 75th percentile throughout 2014.
- Active pain management and communication with doctors teams worked to improve these survey composites. Physician level data sharing was key to increasing the physician communication ranking.
- Responsiveness of staff initiative launched by point of care nursing staff with a focus on planned toileting and hourly rounding.
- Targeted patient care rounding questions utilized to focus on specific survey questions and composites.
- Bedside handover report (nursing shift to shift report) initiated at patient bedside.
- Transitioned to new survey vendor mid-year (Press Ganey). Leader training on use of the Press Ganey website completed.
- Percentile goals established for outpatient departments for 2014.
- External campus signage enhanced to assist with patient way-finding.
- Commitment to care signage placed in elevators and throughout the organization.

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

**Inpatient Overall Patient Experience**

Percentage of patients selecting 9 or 10:
Using any number form 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?
The communication with doctors score represents the results of three HCAHPS survey questions that ask patients how often their doctors:
- Treated them with courtesy and respect
- Listened carefully to them
- Explained things in a way they could understand

**THE 7 C’S OF COMMUNICATION WITH DOCTORS:**

1. Cards - Share provider business cards with each patient/family
2. Chairs - Sit down and talk with the patient/family
3. Care Boards - Update the provider’s name daily
4. Connect - Routinely complete patient rounding together (nurse and physician)
5. Closing the Deal - Provide clear and concise discharge information
6. Consults - Connect physician to physician when requesting and responding to consults
7. Check-in - Complete a post-discharge phone call for high risk patients

**Measure:** Communication with Doctors

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

**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:** ≥ 75th percentile

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

**Summary:**
- Achieved rank of 65th percentile. Significant increase in percentile ranking occurred in Q4.
- Tight Hospitalist staffing contributed to a decline in percentile ranking.
- Utilized hospitalist scribe survey to identify opportunities for individual hospitalist feedback related to patient interaction.
- Continued emphasis on the “four C’s (Cards, Chairs, Care Boards, and Connect) at each hospitalist meeting. Added three more C’s: Closing the deal (emphasis on the patient discharge visit), Connect physician to physician (consults) and Check-in (post discharge call to high risk patients).
- Oriented four new hospitalists to St. Francis, with emphasis on patient experience.
- Issued Hospital Outstanding Patient Experience (HOPE) award recognizing exceptional physicians monthly.
- Developed concurrent process to share physician level experience data with hospitalists and other specialties (Surgeons, GI, Ortho, etc.).
- Developed feedback letter to share HCAHPS survey physician comments with opportunity for improvement.

**Lead:** Nancy Wolf, Patient Experience Site Lead
COMMUNICATION WITH NURSES PATIENT EXPERIENCE

**Measure:** Communication with Nurse

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

**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:** ≥ 75th percentile

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

**Summary:**
- Surpassed annual goal at 85th percentile ranking.
- Empowered point of care nursing staff (in collaboration with unit councils) to develop the bedside handover report process. Successfully implemented in Q1 2014.
- Patient rounding program hardwired with a goal of rounding on each patient once during their hospital stay.
- Responsiveness of staff initiative launched by point of care nursing staff (Med/Surg unit council) with a focus on planned toileting and pain management.
- Developed closing Med/Surg North script for staff to share with patients and families moved to Med/Surg South.

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

BEDSIDE SHIFT HANDOVER

The bedside shift handover report occurs at nursing shift change; nurses who are going off duty share information about the patient’s care with nurses who are coming on duty. Nurses meet at the patient’s bedside to talk about the patient’s care. This provides the patient and family the opportunity to meet the nurse taking over the patient’s care, ask questions and share important information with the nurses.

The communication with nurses score represents the results of three HCAHPS survey questions that ask patients how often their nurses:
- Treated them with courtesy and respect
- Listened carefully to them
- Explained things in a way they could understand
PAIN MANAGEMENT PATIENT EXPERIENCE

ST. FRANCIS INTEGRATIVE HEALTH PROGRAM-2014 HIGHLIGHTS

93 Registered Nurses (RNs) have completed the Transformative Nurse Training (TNT) program; approximately 40% of the St. Francis nursing staff. All inpatient and outpatient departments have trained TNT RNs.

Two Integrative Health Practitioners were added to the integrative health team to expand services into the evening. The team now totals five practitioners. These practitioners provide integrative health consultations to inpatients and the St. Francis Cancer Center.

Practitioners delivered 1,469 inpatient integrative health visits in 2014, with an average length of 41 minutes per visit.

RNs and Integrative Health Practitioners provide guided imagery, acupuncture, acupressure, therapeutic massage, relaxation techniques, reflexology, aromatherapy and energy work therapies to patients. These therapies have demonstrated decreases in pain, anxiety and nausea.

In 2015 integrative therapy services will be added to the new St. Francis Outpatient Clinic and a Holistic Nursing Council will be launched.

Measure: Pain Management Patient Experience

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

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

Goal: ≥ 75th percentile

Data Source: HCAHPS survey; Allina Enterprise Data Warehouse

Summary:
- Achieved 2014 strategic goal.
- Hired an additional 1.0 FTE integrative health practitioner. Provided Lunch and Learns with experiential learning.
- Added a spiritual care representation to the Pain Experience Team.
- Reviewed pain reassessment work with each unit and on an individual staff basis to hardwire documentation improvements.
- Created pain video business cards; available to patients prior to surgery and shared education with surgeon offices.
- Implemented a new numbing mist product for IV insertions; PainEase.
- Created a comfort bundle in collaboration with Integrative Therapy Practitioners.
- “POKE” protocol adopted in the Family Birth Place unit to decrease pain.
- Pharmacy “Pain” presentation to Med/Surg/Peds and SCU nursing staff; July 2014.
- Clarified patient care board language for pain communication.
• Stocked pain DVDs in each Med/Surg/Peds room to increase availability for patients.
• Collaborated with Surgical Services to determine process to communicate patient chronic pain plans.
• Worked with Pharmacy and Surgeons to successfully increase patient satisfaction with pain management for spinal surgery patients.
• Provided guided imagery education to Chaplains.
• Continued integrative therapy consults, including aromatherapy. Patients reported significant decreases in pain, anxiety and nausea.
• Continued nurse leader rounding including specific patient questions regarding pain.

**Lead:** Kathy Mason and the Pain Experience Team

The pain management score represents the results of two HCAHPS survey questions that ask patients about pain management during their hospital stay:
• How often was your pain well controlled?
• How often did the hospital staff do everything they could to help you with your pain?
PATIENT DIVERTS

NO DIVERT CULTURE

The Divert Task Force focused their efforts on establishing a “no divert culture” at St. Francis. Involvement of frontline staff was integral in the success of this initiative, along with an array of communication venues to discuss urgent divert situations with St. Francis leaders. The “no divert culture” initiative also resulted in the development of a divert policy to guide decision making and identify work flow. This initiative was highly successful through a three pronged approach: Awareness building at all levels (staff, leaders and physicians), transparency of data and development of communication process to aid decision making 24/7.

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: ≤ 15 patient diverts

Data Source: Nursing Administrative Supervisor tracking database

Summary:
- Achieved strategic goal with only 5 patient diverts in 2014 (down from an 34 in 2013).
- Developed a Divert Task Force to address the organizational patient divert issue and create a “no divert culture”.
- Conducted quarterly review of census versus core staffing for key departments.
- Increased or transferred FTE positions to Med/Surg and the critical care float pool to match resources specific to days of the week and shifts with high census points and divert trends.
- Increased the number of cross-trained staff; specifically Medical/Surgical staff cross-trained to support the needs of the SCU.
- Developed an organizational divert prevention policy, a divert prevention status report form, a divert huddle conferencing process 24/7 (involving Administrative Supervisor shift charge nurses, administrative team member and nurse leader on call) and a divert scorecard for each nursing unit.
- Implemented recognition of positive deviance in divert prevention which included sending out thank you cards to care team members who stayed late or came in extra to care for patients.

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. CDI 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 Center for Disease Control.

**Exclusions:** Patients hospitalized that do not meet the laboratory-confirmed CDI definition as defined by the Centers for Disease Control.

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

**Data Source:** Laboratory culture data

**Summary:**
- Goal not met at 8.78 cases per 10,000 patient days.
- Greatest opportunity identified in two areas:
  - Late testing and inappropriate testing (testing with a non-infectious reason for symptoms present); 6.27 cases/10,000 patient days actually met the clinical definition.
- Staff and provider education provided on CDI Testing Key Messages and Testing Algorithm in multiple venues, including nursing and medical staff meetings, newsletters and emails.
- An Excellian CDI testing smart phrase was created and shared with nursing staff to communicate reasons for not testing.

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

![Graph showing hospital acquired Clostridium difficile infection rate from 2009 to 2014, with 2014 goal of ≤ 7.2 cases per 10,000 patient days.]
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:** ≥ 85%

**Data Source:** Third party observer audits

**Summary:**
- St. Francis exceeded the Allina goal at 86%.
- A successful implementation of the “Approach & Coach” accountability model, coupled with a roll-out of “Stop the Line” Policy with visible staff engagement were key to hand hygiene compliance.
- Hand Hygiene data was shared across the organization with colorful “You’ve Got a Lot on Your Hands” themed posters with unit-specific data posted within departments.
- The Hand Hygiene Team will meet bi-monthly in 2015 and has a local goal of ≥90%.

**Lead:** Erin Kiernan-Johnson, Infection Preventionist, and the Hand Hygiene Team
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 are excluded from the employee compliance measure.

Goal: 100% participation.

Data Source: Allina OnBase reports.

Summary:
- Achieved 98.78% participation (95.7%-2013) and 80.8% vaccination (79.2%-2013) compliance.
- Provided multiple free influenza clinics across the organization, including use of 14 “Flu Deputies” who promoted vaccinations for patient and staff safety.
- Paired the kick off immunization clinic with the annual safety fair in September.
- Participated in the Allina wide influenza campaign for development of an online documentation process, communication plan, education, and system coordination.
- Introduced a new online influenza consent/declination form and successfully implemented for the first time.
- Enhanced the influenza documentation form with declination reasons for data collection and analysis.
- Loaded influenza lot numbers into the vaccination system for ease of administrator completion.
- Expanded influenza vaccine offerings to include egg-free vaccine and quadrivalent vaccine (trivalent vaccine available in previous years).
- Improved reporting capabilities by the online system, allowing identification of employees who had not yet participated in the program.
- Focused follow-up with employees who had not participated in the program via the roving influenza vaccination cart.
- Coordinated with Volunteer Services to capture volunteer vaccination rates; volunteers assisted with influenza clinics.

Lead: Lonna Selkirk, Employee/Occ Health Nurse.
SAFETY

PATIENT SAFETY

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.

Measure: Patient Visitor Safety and Near Miss Reporting
Inclusions: All inpatients, outpatients and visitors.
Exclusions: Employee events or campus partner clinic patient events.
Goal: 35.10 good catches reported/1000 adjusted patient admissions
Data Source: Patient Visitor Safety Report (PVSR) database
Summary:
- Good catch (near miss) reporting goal exceeded with a rate of 44.83%.
- Good catch reporting included as 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 by manager on events reported.
- Department specific safety newsletters include significant PVSR and good catch follow up.
- Managers submitted near misses to the Minnesota Hospital Association for the Good Catch Award. Nine staff/medical staff received the Good Catch for Patient Safety Award:
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.

OPERATION RED HAT

Jennifer Levar, RT, Diagnostic Services, originated the idea of placing a red surgical hat on patients who have a breast needle localization procedure. The safety concern identified was that the staff are unaware of the needle beneath the patient’s gown and blanket. There was no “visual” to warn the staff that a needle has been placed. Staff could shuffle blankets, move the patient and inadvertently move the needle. There is the potential to jeopardize the placement of the needle or create a needle stick for staff. The red hat acts as a visual safety alert to Diagnostic and Surgical Services staff caring for the patient.

- Lisa Ginn, CST, Surgical Services (also received the statewide overall quarterly Good Catch for Patient Safety Award)
- Dane Nelson, MLS, Laboratory
- Pam Solberg, RN, Surgical Services
- Ashley Evans, RN, Med/Surg
- Jennifer Levar, RT, Diagnostic Services
- Katie Paulson, Mammography Tech, Diagnostic Services
- Peggy Miller, RN, Surgical Services
- Dr. Mathew Braasch, Surgeon
- Vicki Johnson, RN, Surgical Services
PATIENT SAFETY (CONT)

Critical Event Reviews/Adverse Health Events

- 14 Critical Event Reviews (CER) were conducted in 2014.
- Four of the CERs were reportable Adverse Health Events (AHE) to the Minnesota Department of Health (fall with fracture, surgical medication event, wrong procedure, and irreplaceable specimen).
- Adequacy of staffing was assessed for all CERs. No staffing concerns were identified.
- All CERs 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 for improvement.

Failure Mode Effect Analysis

- A Failure Mode Effect Analysis (FMEA), proactive risk assessment, was conducted on the pharmacy chemotherapy double check process for new chemotherapy orders.
- The FMEA was initiated based on a high risk human process and the potential for chemotherapy order errors resulting in harm to patients.
- A pharmacy team consisting of staff pharmacists, pharmacy clinical coordinator and pharmacy manager process mapped the chemotherapy order process and developed standard workflow, procedures and education for staff.
FALL PREVENTION

Measure: Inpatient Falls with Harm

Inclusions: Inpatient falls, coded as harm (E-I) in the PVSR database

Exclusions: Outpatient and visitor falls; falls coded other than E-I in the PVSR database

Goal: ≤ 0.76 falls with harm per 1000 patient days

Data Source: Financial data; BOE Reporting System; PVSR database

Summary:
- Exceeded strategic goal with a rate of 0.69 inpatient falls with harm.
- Focused on planned toileting with daily staff rounds.
- Continued integration of fall prevention work with Safe Patient Moving Team.
- Implemented a process for fall prevention super users to meet with each new staff member to talk about the falls prevention program and current initiatives.
- Fall prevention super users presented at the annual safety fair.
- Initiated a quarterly safety newsletter to share fall results and prevention tactics.
- Utilize root cause analysis of all falls at monthly Fall Prevention Team meeting.
- Met with each staff nurse and nursing assistant regarding within arm’s reach and re-contracted with staff for support.
- Implemented toileting recommendations (mobility tool); how to move to the BR safely with physical therapy.
- Created new falls prevention badge buddies and distributed to staff.

Lead: Brianna Thompson, Med/Surg/Peds Patient Care Supervisor, and the Fall Prevention Team
PATIENT SAFETY CULTURE SURVEY

**Measure:** Staff Perception of Patient Safety Culture

**Data Source:** Agency for Healthcare Research and Quality (AHRQ) Patient Safety Culture survey

**Summary:**
2014 is the fourth year in which Allina used the national AHRQ survey to evaluate patient safety culture. This is the second Allina survey in which all hospital employees participated in the survey.

- 2014 overall survey results for St. Francis Regional Medical Center were the second highest in the Allina System and above all national benchmarks for hospitals of similar size.
- In addition to a 3% increase in the overall perception of safety score, St. Francis increased each survey composite scores and was higher than the AHRQ benchmark for each composite.

The increase in patient safety survey scores was attributed to an organizational plan including:

- Leader sharing of survey results with staff and action plan development specific to each department.
- Department specific action plans focused on increasing near miss/good catch reporting and hand hygiene in conjunction with goals as determined by staff and patient care unit councils.
- Leader sharing of survey action plan progress at the Quality & Safety Council throughout the year.
- Incorporation of patient safety initiatives into annual St. Francis safety fair.
- Communication plan to share patient safety initiatives with staff throughout the year via multiple venues (forums, president Friday message, staff rounding, This Week, etc.).
- Leader training in crucial conversations, development of a physician related concern process and roll out of the system-wide Stop the Line policy. Additionally, TeamSTEPPS training was initiated in the Surgical Services department.

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

TeamSTEPPS

In 2014 the Surgical Services Department (operating room and endoscopy) implemented the TeamSTEPPS program in the operating room. Physicians and staff co-led this initiative and selected the debrief tool as the first safety communication intervention to implement.

The debrief is a structured information exchange session designed to improve team performance and effectiveness through lessons learned and reinforcement of positive behaviors. The debrief occurs at the conclusion of the procedural case and includes clarification of estimated blood verification, specimen verification urine output, wound class, and other pertinent information related to the case.

TeamSTEPPS is an evidence-based teamwork system designed jointly by the Department of Defense and the Agency for Healthcare Research and Quality (AHRQ) to improve communication and teamwork skills among health care professionals.

<table>
<thead>
<tr>
<th>Survey Results June 2014</th>
<th>St. Francis</th>
<th>Allina Health Allina System</th>
<th>AHRQ Benchmark (50-99 beds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants:</td>
<td>469 (64%)</td>
<td>8332</td>
<td>405,281</td>
</tr>
<tr>
<td>Overall perceptions of safety</td>
<td>78%</td>
<td>65%</td>
<td>68%</td>
</tr>
<tr>
<td>Frequency of events reported</td>
<td>69%</td>
<td>58%</td>
<td>67%</td>
</tr>
<tr>
<td>Supervisor/manager expectations &amp; actions promoting safety</td>
<td>83%</td>
<td>75%</td>
<td>78%</td>
</tr>
<tr>
<td>Organizational learning – Continuous improvement</td>
<td>82%</td>
<td>71%</td>
<td>74%</td>
</tr>
<tr>
<td>Teamwork within units</td>
<td>85%</td>
<td>81%</td>
<td>81%</td>
</tr>
<tr>
<td>Communication openness</td>
<td>74%</td>
<td>63%</td>
<td>74%</td>
</tr>
<tr>
<td>Feedback &amp; communication about error</td>
<td>73%</td>
<td>62%</td>
<td>67%</td>
</tr>
<tr>
<td>Non-punitive response to error</td>
<td>56%</td>
<td>49%</td>
<td>47%</td>
</tr>
<tr>
<td>Staffing</td>
<td>72%</td>
<td>57%</td>
<td>57%</td>
</tr>
<tr>
<td>Hospital management support for patient safety</td>
<td>87%</td>
<td>70%</td>
<td>63%</td>
</tr>
<tr>
<td>Teamwork across hospital units</td>
<td>75%</td>
<td>60%</td>
<td>63%</td>
</tr>
<tr>
<td>Hospital handoffs &amp; transitions</td>
<td>61%</td>
<td>44%</td>
<td>49%</td>
</tr>
<tr>
<td>≥ 5% above AHRQ Benchmark</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 5% above AHRQ Benchmark</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SAFETY

NATIONAL PATIENT SAFETY GOALS

NPSGS

In 2002, The Joint Commission established its 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.

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.

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.

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: BOE Reporting System; Enterprise Data Warehouse; medical record abstraction and observation audits

Summary:

- National Patient Safety Goals (NPSG) are established annually by The Joint Commission. The NPSG scorecard provides a visual display of safety processes and outcomes with associated improvement efforts for each goal. 2014 NPSG highlights include:
  - Zero catheter associated urinary tract infections.
  - Zero central line associated blood stream infections.
  - Medication reconciliation at patient discharge hardwired near 100%.
  - Hand hygiene compliance improved to 90% by Q4.
  - Two patient identifier observational audits >96% compliance.
  - A new NPSG was added in 2014, NPSG #6: Clinical Alarm Safety. Work was initiated to raise awareness regarding the goal, set alarm system safety as a priority focus and identify the most important alarm signals to manage within each unit. This goal will be phased in with full implementation of policies and procedures and staff/medical staff education by 2016.

Lead: Nancy Wolf, Director Quality, Safety & Risk Management
## 2014 National Patient Safety Goals

<table>
<thead>
<tr>
<th>How do we measure compliance?</th>
<th>Goal</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1— Improve the accuracy of patient identification</strong></td>
<td>Observational audit of patient caregivers using two patient identifiers (name and DOB).</td>
<td>↑ =good</td>
<td>100%</td>
<td>95%</td>
<td>97%</td>
</tr>
<tr>
<td><strong>Goal 2— Improve the effectiveness of communication among caregivers.</strong></td>
<td>Laboratory: Critical test results are communicated to the licensed healthcare provider or designee within 15 minutes of obtaining verified results.</td>
<td>↑ =good</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>Nursing: Critical test results are communicated from nurse to provider within 20 minutes of obtaining verified results.</td>
<td>↑ =good</td>
<td>100%</td>
<td>83%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Radiology: Imaging critical results are communicated to the physician within 35 minutes of verification as critical.</td>
<td>↑ =good</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Goal 3— Improve the safety of using medications.</strong></td>
<td>All medications, medication containers and other solutions on and off the sterile field are labeled (all procedural settings). (Proceduralist)</td>
<td>↑ =good</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>All medications, medication containers and other solutions on and off the sterile field are labeled (all procedural settings). (Anesthesia)</td>
<td>↑ =good</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overall compliance of dosing and lab monitoring of anticoagulation therapy.</td>
<td>↑ =good</td>
<td>100%</td>
<td>90%</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>Patients receive warfarin education prior to discharge.</td>
<td>↑ =good</td>
<td>100%</td>
<td>85%</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Medication Reconciliation – Admission (within 24 hrs)</td>
<td>↑ =good</td>
<td>100%</td>
<td>70%</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Medication Reconciliation – Discharge</td>
<td>↑ =good</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td><strong>Goal 7— Reduce the risk of healthcare-associated infections.</strong></td>
<td>Observational audits of hand hygiene before &amp; after room entry.</td>
<td>↑ =good</td>
<td>100%</td>
<td>83%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Central line blood stream infection bundle is completed for all central lines inserted.</td>
<td>↑ =good</td>
<td>100%</td>
<td>98%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>Number of central line blood stream infections (SCU)</td>
<td>↓ =good</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Number of catheter associated urinary tract infections (SCU)</td>
<td>↓ =good</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Number of surgical site infections</td>
<td>↓ =good</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>Goal 15— The organization identifies patients at risk for suicide.</strong></td>
<td>Suicide risk screening completed within 24 hours of inpatient admission.</td>
<td>↑ =good</td>
<td>100%</td>
<td>91%</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Universal Protocol— The organization fulfills the expectations set forth in the Universal Protocol</strong></td>
<td>Number of wrong site, wrong surgery, wrong patient procedures.</td>
<td>↓ =good</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- At goal or better
- Within 5% unfavorable variance
- 5% unfavorable variance
Regulatory Accreditation and Certification

- 2014 activity focused on final preparations for the St. Francis Triennial Joint Commission (JC) survey which occurred in December. Preparations incorporated all hospital department/units and all outpatient/off-site locations:
  - Updated and distributed the St. Francis Joint Commission Survey Handbook, a useful resource designed to guide staff through many of the key elements often reviewed during a JC survey.
  - Focused regulatory rounding by the Regulatory Program Manager in all departments/units, including all outpatient/off-site locations. Rounding occurred 1-3x/year throughout the year (unit type specific) with emphasis on identifying and correcting regulatory risks specific to the department.
  - With the 2014 increase from one JC ambulatory survey day to two survey days, additional preparation occurred in the ambulatory areas with special attention given to Jordan Clinic, the organization’s first hospital-based clinic, which was surveyed for the first time this year.
  - Created numerous educational materials including an updated/enhanced 2014 NPSG poster, just-in-time unit preparation checklists, staff and physician survey pamphlets, sting operations, table tents and submitted regular articles to St. Francis publications such as the Enquirer, Progress Notes and This Week at St. Francis.
  - The Allina Internal Accreditation Survey was held in September 2014 which is a two day internal survey coordinated and conducted by the Allina regulatory leads from across the system. The survey is designed to replicate an actual JC survey. The survey provided an excellent opportunity for staff to “practice” for our actual JC survey.
  - Our extensive preparation culminated in a successful Triennial Joint Commission Survey which occurred on December 9 – 12, 2014. The surveyors were very complimentary of our facility and the care and services we provide. We were given the ultimate compliment from the lead RN surveyor who said, “I would work here and I would receive my care here.” St. Francis received two direct impact and five indirect impact findings in the following areas:
    - Medication Management
    - Life Safety
    - Environment of Care
    - Infection Control
    - Patient Rights
Heart Failure Disease Specific Certification Program

- Hired and oriented a new Quality Improvement Specialist to coordinate the St. Francis Heart Failure Program.
- Successfully completed the JC intra-cycle call in February 2014.
- Enhanced the heart failure program through collaboration with St. Gertrude’s:
  - Development of a standard heart failure education curriculum for new nurses.
  - Implementation of staff education on a quarterly basis due to a high staff turnover rate in the skilled nursing facility.
- Implemented heart failure discharge criteria for diuretic use; patients off IV diuretics and stable on oral diuretics for 24 hours prior to discharge.
- Improved ordering of cardiology consult follow up appointments for heart failure patients.

Lead: Candace Lano, Regulatory Program Manager
Angelina Buerck, Quality Improvement Specialist/Heart Failure Program Coordinator

ST. FRANCIS NAMED TOP 100 HOSPITAL

St. Francis has been named one of the Top 100 Hospitals in the country by Truven Health Analytics, TM. We were one of 20 small community hospitals in the nation who exceeded expectations on overall organizational performance, including patient care, operational efficiency and financial stability.

St. Francis was chosen for the small community class honor. According to the study, we are part of a group that:

- Has a lower mortality index considering patient severity
- Has fewer patient complications
- Avoids adverse patient safety events
- Follows accepted care protocols
- Has lower mortality and 30-day readmission rates
- Keeps expenses low
- Sends patients home sooner
- Scores better on patient satisfaction surveys

Being named a Top Hospital means we represent the highest national standards in care and set the benchmark for others around the country to follow.
2014 HONORS AND AWARDS

ACCREDITATION AND CERTIFICATIONS

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
Laboratory Accreditation by the College of American Pathologists
Diabetes Self-Management Education Program Certification by the American Diabetes Association
American College of Radiology Accreditation: CT Scan, MRI, Ultrasound General and Breast, Mammography, Nuclear Medicine, Echo
Sleep Center Accreditation by the American Academy of Sleep Medicine
Level III Trauma Center designation by the State of Minnesota
Acute Stroke Ready Hospital designation by the State of Minnesota

INDIVIDUAL HONORS

Mary Bothof, RN, 2014 March of Dimes Community Health Nursing Nurse of the Year Award
Joel Aronson, RN, 2014 March of Dimes Staff Nurse-Critical Care Nurse of the Year Award
Jamie Stolee, RN, ED Patient Care Manager, 2014 Allina Uncommon Caring Award
Steve Wilson, RN, Critical Care Float, 2014 Allina Uncommon Caring Award

Minnesota Hospital Association – Good Catch for Patient Safety Award Winners:
- Lisa Ginn, CST, Surgical Services
- Dane Nelson, MLS, Laboratory
- Pam Solberg, RN, Surgical Services
- Ashley Evans, RN, Med/Surg
- Jennifer Levar, RT, Diagnostic Services
- Katie Paulson, Mammo Tech, Diagnostic Services
- Peggy Miller, RN, Surgical Services
- Dr. Mathew Braasch, Surgeon
- Vicki Johnson, RN, Surgical Services

2013 & 2014 Star Tribune Top 100 Workplace – Large Company
2013 & 2014 Valley Rehab Services Top 100 Workplace – Small Company
2013 & 2014 Allina Best Care (ABC) Award
2013 & 2014 Joint Commission Top Performer on Key Quality Measures
2013 & 2014 Shakopee Chamber of Commerce Member Business of the Year-Large Business
2014 Minnesota Hospital Association Save Our Skin Award
2014 Women’s Choice Award-Best Hospital for Patient Experience in Emergency Care
2014 Minneapolis/St. Paul Business Journal Second Shortest Emergency Department Wait Times in the Region
2014 Consumer Reports Top Rated Safety Score (Twin Cities-Metro)
2014 Minnesota Department of Health FLUSAFE Program Recognition
2014 Hennepin County Medical Center Trauma Team Excellence Award
2014 Minnesota Hospital Association Community Benefit Award-Witaya Care
2014 Minnesota Hospital Association Partnership for Patients Award
2014 QUALITY & SAFETY DEPARTMENT

Angelina Buerck, RN, BSN, CPHQ, Quality Improvement Specialist
Erin Kiernan-Johnson, MS, RN, CPHQ, Infection Preventionist
Margaret Knutson, Data Analyst
Candace Lano, RN, BSN, Regulatory Program Manager/Quality Improvement Specialist
Roger Marturano, RN, Patient Representative/Quality Improvement Specialist
Renee Nicolet, Medical Staff Coordinator
Amanda Saathoff, Safety Program Manager
Heather Satrom, Administrative Assistant
Nancy Wolf, MSN, RN, CPHQ, Director Quality, Safety, Risk Management & Medical Staff Services

2014 QUALITY & SAFETY COUNCIL

Candace Lano, RN, BSN, Regulatory Program Manager/Quality Improvement Specialist
Brianna Thompson, RN, CMSRN, Med/Surg/Peds Patient Care Supervisor
Katie Prindle, MT, HEW, Laboratory Manager
Brian Prokosch, MD, VP Medical Affairs
Monique Ross, RN, BSN, Director Surgical Services
Deb Ryan, MPH, RN, NEA-BC, Vice President Patient Care
Janell Schultz, PharmD, Pharmacy Manager
Dorinda Vloo, RN, BSN, SCU Patient Care Supervisor
Chris Wolf, MSN, RN, NE-BC, Patient Care Manager Resource Services
Nancy Wolf, MSN, RN, CPHQ, Director Quality, Safety, Risk Management & Medical Staff Services
For further information, contact:

**Nancy Wolf, Director**
Quality and Safety Department
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stfrancis-shakopee.com/patients-quality-safety.html