HIGHLIGHTING 2015 ACCOMPLISHMENTS AND OUTCOMES
Building a Culture of Excellence at St. Francis

2015 was a year of significant accomplishments for St. Francis Regional Medical Center. Quality, safety, and patient experience of care reflect a culture dedicated to achieving and sustaining excellence for the patients we serve. Notable 2015 accomplishments include achieving Truven Top 100 Hospital status and nomination as an America’s Most Valuable Care hospital by Stanford University School of Medicine.

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

Quality & Safety Department Overview

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, emergency preparedness, risk prevention, infection prevention, medical staff quality 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 oversight 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 medical staff, 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 attain state and national award recognition.

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

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St. Francis was awarded the Joint Commission Top Performer on Key Quality Measures designation for superior performance in pneumonia, surgical care, stroke and perinatal care for the third consecutive year. Top Performer hospitals represent the top 33 percent of all Joint Commission-accredited hospitals that reported measure data for 2014.

**Core Measures Optimal Care**

**Measure:** Venous Thromboembolism (VTE), Stroke (STK), and Global Immunization Optimal Care (IMM)

**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:**

- **VTE:** All Inpatients > 18 years of age and have a length of stay ≤ 120 days as defined by the Centers for Medicare and Medicaid Services (CMS).
- **STK:** Inpatients with a principal discharge diagnosis of STK or specific surgical procedures as defined by CMS.
- **IMM:** All inpatients age 6 months and older who have a length of stay ≤ 120 days as defined by CMS.

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

**Goal:**

- **VTE:** > 97.2%
- **STK:** ≥ 95.0%
- **IMM:** ≥ 97.0%

**Data Source:** Truven Health Analytics; Enterprise Data Warehouse

**Summary:**

**Venous Thromboembolism**

- Achieved 96.0% optimal care rate which matched Allina’s overall rate of 96.0%.
- Concurrent case monitoring with real time feedback/education to nurses and physicians was continued as a key tactic to sustain compliance.
- Opportunity exists in mechanical VTE prophylaxis (VTE-1) being ordered and not applied.
- Nursing Best Practice Alert (BPA) to support application of sequential compression devices was simplified with improved logic in October 2015.
- Focus is currently on ensuring the BPA is firing appropriately and keeping awareness of the BPA in the midst of alert fatigue.
- VTE-3 overlap therapy specifications tightened in 2015. A BPA fires when a patient is taken off overlap therapy sooner than recommended.

**Stroke**

- Achieved 95.0% optimal care rate which met the goal but was slightly below Allina’s rate of 98.0%.
- Inpatient code stroke resource binder developed and utilized in the high risk, low volume scenarios.
- Concurrent daily monitoring by Quality Improvement Specialist with real time resolutions around best practice and potential core measure misses.
- Improved communication process between imaging and neurology.
- Completed two community education sessions focused on signs/symptoms and prevention of stroke at the Prior Lake YMCA.
- Assured all inpatient rooms were wired for tele-stroke usage.

**Global Immunization**

- Achieved 94.0% optimal care rate which matched Allina’s overall rate of 94.0%.
- Concurrent daily monitoring by Quality Improvement Specialist with real time resolutions to potential misses.
- Participated in a pilot program in which a BPA alert appears for influenza screening if it is not documented as complete.
- Updated protocols for the 2015-2016 influenza season.

**Lead:** Angelina Buerck, Quality Improvement Specialist
Sepsis Optimal Care

MEASURE: Sepsis Optimal Care

DEFINITIONS:

Optimal Care – Percent of patients receiving all interventions appropriate to their care. The five-part sepsis optimal care bundle is comprised of the following measures:

- smart form selection ‘severe sepsis’ or ‘septic shock’
- met coding requirements and SIRS criteria.

EXCLUSIONS: Patients less than 18 years of age, outpatient, and other measure-specific exclusions as defined by Allina Health sepsis program.

GOAL: Establish goals for 7-part Optimal Care bundle for 2016. Compile 2015 baseline data.

DATA SOURCE: Sepsis Dashboard - Allina Shared Analytics Portal (ASAP)

SUMMARY:

- Baseline data for the 2015 optimal care (5 part bundle) was at 43%; meeting goal for the Emergency Department (ED). The end of year optimal care rate improved to 45%.
- Baseline data for the 2015 optimal care for all patients (Inpatient and ED) was at 42%. The end of year optimal care rate declined to 40%. Areas of opportunity are around fluid given and reassessment.
- Developed multidisciplinary sepsis team.
- Created education and presented to providers and nursing departments (ED and Inpatient).
- Updated order sets and standardized throughout the system.
- Provided one-on-one feedback to providers in areas noted to have opportunities for improvement.

LEAD: Jamie Stolee, Emergency Department Patient Care Manager and the Sepsis Care Team

Obstetrical Potentially Preventable Complications

MEASURE: Obstetrical Potentially Preventable Complications

DEFINITION:

Actual/Expected Ratio – Obstetric Potentially Preventable Complication (PPC) rates are calculated by dividing the actual number of PPCs by an expected number of PPCs to provide a performance ratio.

INCLUSIONS: Obstetric Potentially Preventable Complication (PPC) cases coded as obstetrical hemorrhage with/without transfusion.

Knowing that all complications in all cases cannot be prevented, the actual (A) percentage is adjusted for the expected (E). Target is 1.00 A/E.

EXCLUSIONS: Some case exclusions apply.

GOAL: < 11.6% actual/expected ratio.

Decrease the number of Allina Mother Baby Clinical Service Line mothers experiencing a potentially preventable obstetrical complication related to obstetrical hemorrhage (with and without transfusion) from an actual/expected ratio of 1.04 (with transfusion) and 1.08 (without transfusion) to an actual/expected ratio of 1.00 by July 1, 2016.

DATA SOURCE: PPC Dashboard - Allina Shared Analytics Portal (ASAP)

SUMMARY:

- Achieved a preventable overall OB complication rate of 5.8%; far exceeding the system goal.
- Achieved a 3.83% OB hemorrhage rate.
- System perinatal safety work group, a sub-group of Allina Pregnancy Care Committee, developed an obstetrical PPC tool kit. Staff education completed on the use of the tool kit at mandatory staff education days.
- Developed an obstetrical hemorrhage cart and checklist for the Family Birth Place unit and trained/educated staff and providers on the use of the hemorrhage cart.
- Provided postpartum hemorrhage simulation training to nurses and providers using the Allina Lucina (a life size, high fidelity birthing simulator).
- Participated in roll out of a quantitative blood loss initiative to accurately identify and minimize underestimation of maternal blood loss.

LEAD: Ann Friedges, Family Birth Place Patient Care Manager

![OB Potentially Preventable Complications Chart](chart.png)
Readmission Reduction

**MEASURE:** Potentially Preventable Readmissions (PPRs)

**DEFINITIONS:**

- **Actual/Expected Ratio** – PPR rates are adjusted for case mix severity by dividing the actual number of PPRs by an expected number of PPRs to provide a performance ratio.

- **Potentially Preventable Readmission (PPR)** – A readmission that is clinically related to the first admission as defined by a 3M software algorithm.

**INCLUSIONS:** Readmission rate to the same hospital for all eligible discharges. Readmissions must be clinically related as defined by a clinical review panel.

PPR reflects a chain of readmissions occurring within 30 days of any prior discharge and 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, burns and major multiple trauma.

**GOAL:** ≤ 1.08 actual/expected ratio.

**DATA SOURCE:** PPR Dashboard - Allina Shared Analytics Portal (ASAP)

**SUMMARY:**

- Achieved an actual/expected ratio of 0.93, far surpassing the annual goal of 1.08.

- Achieved an annual average of 17.8% for completion of moderate-high and high-risk patient transition conferences. This surpassed the Allina overall average of 10.1%.

- Implemented a Compassionate Care Prescription Assistance Program that will fund supplying 30 days of medications for patients who cannot afford the cost (for any reason). This program is unique in that it covers patients who may not normally qualify for assistance.

- Implemented discharge appointments being made prior to discharge for moderate-high and high-risk patients.

- Led the system with decreased readmissions in heart failure, COPD and pneumonia.

- Developed and utilized standardized discharge readiness checklists.

- Initiated a Rapid Performance Improvement Workshop to facilitate improved hand-offs and communication with home health care utilizing a home health care liaison.

**LEAD:** Angelina Buerck, Quality Improvement Specialist and the Readmission Reduction Team

**BACKGROUND**

- **Situation:** As a part of the MN from 2010-2015.

- **Goal:** 1.08 Actual/Expected Ratio

- **Data Source:** Allina Readmission Reduction Team

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- **Goal:** 1.08 Actual/Expected Ratio

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**ACTION STEPS**

- **Discharge Criteria**: St. Francis provided HF staff education for St. Gertrude’s staff.

- **Discharge Criteria**: Both facilities to utilize same HF readmission case reviews.

- **Discharge Criteria**: Collaboration between St. Francis and St. Gertrude’s increased.

- **Discharge Criteria**: HF readmission case reviews identified that about 50% of patients had high risk factors within the same HF patient stay.

- **Discharge Criteria**: SFRMC provided HF staff education for St. Gertrude’s staff.

- **Discharge Criteria**: Both facilities to utilize same HF readmission case reviews.

- **Discharge Criteria**: Collaboration between St. Francis and St. Gertrude’s increased.

- **Discharge Criteria**: HF readmission case reviews identified that about 50% of patients had high risk factors within the same HF patient stay.

**FINDINGS**

- **Improvements**

- **Improvements**

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- **Improvements**

**RESULTS**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

**CONCLUSION**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

**Next Steps**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

- **Increased collaboration**

**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

2015 HF Disease Specific Certification Team

**MEASURE:** Heart Failure (HF) Disease Specific Certification

**INCLUSIONS:**
- **Palliative Care Consult** – All inpatient admissions with a primary diagnosis of HF.
- **30-day Readmission** – Patients with a primary diagnosis of HF readmitted within 30 days of discharge with a HF diagnosis.
- **Depression Screen** – All inpatient admissions with a primary diagnosis of HF.
- **BMI** – All inpatient admissions with a primary diagnosis of HF and a BMI ≥ 35%.

**EXCLUSIONS:**
- **Palliative Care Consult** – Patients transferred to another inpatient facility and patients discharged to hospice.
- **30-day Readmission** – Number of patients with a primary diagnosis of HF readmitted within 30 days of discharge with a HF diagnosis.

**Depression Screen** – Number of depression screens completed, using the PHQ-9 tool.

**Body Mass Index** – Number of patients with a primary diagnosis of HF and Body Mass Index (BMI) greater than 35% for which HF education is documented.

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

**DATA SOURCE:** Manual data extraction

**Summary:**

**HF Program Overall**
- Successful on-site survey by The Joint Commission, recertifying organizational HF program (no requirements for improvement).
- Submitted two HF specific abstracts for poster presentations at the AAHFN National Conference (Palliative Initiatives in the HF Population and St. Gertrude’s Staff Education).
- Hardwired discharge readiness checklist with the hospitalist group.
- Achieved the lowest CMS HF readmission rate in the Allina system (metro hospitals) at 14.4%.

**Palliative Care Consult**
- Achieved a palliative care consult score of 77.0% which exceeded the goal of ≥ 65%.
- Defaulted palliative care consult order was added to the HF admission order set.
- Largest opportunity for improvement is related to patients who are admitted with an order set that is not HF (general admission, Special Care Unit admission).

**St. Francis successfully completed Heart Failure Disease Specific Certification biennial survey by The Joint Commission with no recommendations for improvement.**

St. Francis has been continuously certified since 2010 and is one of only two hospitals in the state of Minnesota with Heart Failure Disease Specific Certification.
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.

**GOAL:** ≥ 75th percentile

**DATA SOURCE:** HCAHPS survey; Enterprise Data Warehouse

The Sharon Loth patient satisfaction award is named for the first St. Francis Patient Representative and is selected based on improvement in the willingness to recommend survey question. The department winning the Sharon Loth Award selects the recipient of the We Couldn’t Have Done it Without You Award. The manager of the Sharon Loth Award winning department selects a support services department for the Support Stars Award. Quarterly Patient Experience Award Winners: Cancer Center – Sharon Loth Award, Pharmacy – We Couldn’t Have Done it Without You Award, Foundation – Support Stars Award.
SUMMARY:
- Completed 2015 at the 67th percentile; October – December rank of 74th percentile.
- Active pain management and communication with physician teams worked to improve survey composites.
- Launched responsiveness of staff initiative at year end with responsiveness summits for all Med/Surg and Special Care Unit staff.
- Targeted patient care rounding questions utilized to focus on specific survey questions and composites.
- Hardwired bedside handover report (nursing shift to shift report).
- Initiated care boards in the Same Day Surgery department and upgraded in the Med/Surg unit remodel.
- Established percentile goals for outpatient departments for 2015.
- Enhanced external campus signage to assist with patient way-finding.
- Monitored and enhanced internal and external way-finding signage and enhanced as part of front entrance construction project. Concierge service initiated for temporary front entrance.
- Presented quarterly Sharon Loth Patient Satisfaction Award, We Couldn’t Have Done it Without you Award and Support Stars award.

LEAD: Nancy Wolf, Patient Experience Site Lead

St. Francis was the recipient of the Healthgrades Patient Safety Excellence and the Healthgrades Patient Experience Award; one of only two hospitals in the state of Minnesota to receive both awards. St. Francis has received the Patient Experience Award for the last three years.

Communication with Doctors
Patient Experience

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.

GOAL: ≥ 75th percentile

DATA SOURCE: HCAHPS survey; Enterprise Data Warehouse

SUMMARY:
- Achieved annual goal of 75th percentile.
- Physician level data sharing was key to increasing the physician communication ranking.
- Developed concurrent process to share physician level patient experience data with hospitalists and other specialties rounding on inpatients (Surgeons, GI, Ortho, etc.).

Providing Outstanding Patient-Physician Experience

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 Nurses**

**Patient Experience**

**MEASURE:** Communication with Nurses

**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.

**DATA SOURCE:** HCAHPS survey; Enterprise Data Warehouse

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**The 8 C’s of Communication with Doctors:**

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

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**Providing Outstanding Patient-Nursing Experience**

1. **Know your patient**
   - Introduce yourself and relevant care information.
   - Review the patient’s medical history, allergies, and medications.
   - Confirm the patient’s comfort level and readiness for discharge.
2. **Communicate with all disciplines**
   - Share pertinent information with other healthcare providers.
   - Collaborate on the patient’s care plan.
3. **Placing the patient at the center of care every shift**
   - Ensure the patient is well-informed about their care.
   - Monitor the patient’s response to care.
4. **Be responsive and proactive**
   - Address patient needs promptly.
   - Anticipate patient needs and take appropriate action.
5. **Prepare for discharge**
   - Review the patient’s discharge plan.
   - Ensure the patient’s medications are up-to-date.
   - Provide clear discharge instructions.

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**SERVICE | PATIENT EXPERIENCE**

**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

- Continued emphasis on the “four C’s (Cards, Chairs, Care Boards, and Connect) at each hospitalist meeting.
- Added four more “C’s: Chart Review (prep for patient visit), Closing the Deal (patient discharge visit), Connect Physician to Physician (consults) and Check-in (post discharge call to high risk patients).
- Oriented three new hospitalists to St. Francis, with emphasis on patient experience.
- Developed physician feedback letter to share HCAHPS survey comments which identified a physician opportunity for improvement.
- Created data reports (modeling inpatient reports) for Emergency Department physicians.
- Continued emphasis on the “four C’s (Cards, Chairs, Care Boards, and Connect) at each hospitalist meeting.
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**LEAD:** Nancy Wolf, Patient Experience Site Lead

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5. **Connect** – Routinely complete patient rounding together (nurse and physician).
6. **Consults** – Connect physician to physician when requesting and responding to consults.
7. **Closing the Deal** – Provide clear and concise discharge information.
8. **Check-in** – Complete a post-discharge phone call for high-risk patients.
SUMMARY:

• Achieved 70th percentile annual ranking.
• Hardwired bedside handover report process in inpatient units.
• Sustained patient rounding program with a goal of rounding on each patient once during their hospital stay.
• Launched responsiveness of staff initiative utilizing responsiveness summits to meet with all Med/Surg and Special Care Unit staff and share expectations.

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.

• Decreased Nursing Assistant ratio (1:10 on days/evenings and 1:14 on nights).
• 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

The responsiveness of staff score represents the results of two HCAHPS survey questions that ask patients about whether they got help as soon as they wanted:
• after pressing the call button
• after asking for help getting to the bathroom or bedpan.

LEAD: Erin Kiernan-Johnson, Infection Preventionist

SUMMARY:

• Goal not met at 4.70 cases per 10,000 patient days.
• Small cluster of cases in September-October. Interventions included immediate staff and provider notification with feedback, department wide bleach cleaning and evaluation of supplies with increased pars.
• Antibiotic stewardship team active (Infectious Disease physician, Clinical Pharmacy Coordinator and Infection Preventionist) and meets bi-monthly to review antibiotic prescribing trends that may impact increased CDI rates.
• No issues with inappropriate testing as in previous year.
• A system-wide protocol for C. diff testing cancellation was approved for use when patient does not meet testing criteria.

LEAD: Erin Kiernan-Johnson, Infection Preventionist

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 exposure to recent antibiotic therapy.

Health care-associated Infection (HAI) – Positive laboratory-confirmed C. diff specimen collected >3 days after hospital admission (on or after day 4), with day of admission being day one, as defined by the Center for Disease Control (CDC).

INCLUSIONS: Patients hospitalized with positive laboratory test on hospital day four or later, day of admission being day one, as defined by CDC.

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

GOAL: ≤ 4.5 cases per 10,000 patient days

DATA SOURCE: Laboratory culture data

LEAD: Erin Kiernan-Johnson, Infection Preventionist
Employee Influenza Vaccination

**MEASURE:** Influenza Vaccination of Employees

**DEFINITIONS:** Participation defined as employees who either received the influenza vaccine at Allina/elsewhere or completed a declination form.

**INCLUSIONS:** St. Francis-employed staff

**EXCLUSIONS:** Non-employed St. Francis staff, providers, volunteers, and other Allina business unit employees are excluded from the employee compliance measure.

**GOAL:** 100% participation

**DATA SOURCE:** Allina PeopleSoft reports

**SUMMARY:**
- Achieved 96.5% (98.8%-2014) participation and 82.5% vaccination (80.8%-2014) compliance.
- Provided multiple free influenza clinics and 13 “flu deputies” promoted employee influenza vaccinations for patient and staff safety.
- Offered an influenza immunization clinic during the annual organizational safety fair.
- Participated in Allina-wide influenza campaign with communication plan, education and planning.
- Enhanced influenza form with pop-up educational points related to specific declination reasons.
- Initiated enhanced data collection and analysis of declination reasons.
- Focused follow-up with employees who did not participate in the program; utilized roving influenza cart to reach these employees.
- Introduced online process for volunteers and vaccine eligible non-employees to facilitate data collection.

**LEAD:** Lonna Selkirk, Employee Occupational Health Nurse

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 by a trained third-party hand hygiene observer.

**EXCLUSIONS:** Instances when third-party hand hygiene observer is unable to verify whether hand hygiene was performed.

**GOAL:** ≥ 85%

**DATA SOURCE:** Third party observer monthly audits

**SUMMARY:**
- St. Francis exceeded the Allina goal at 90%.
- A new “Why do you clean your hands?” hand hygiene campaign theme was implemented across the organization to provide refreshed hand hygiene messaging.
- Updated hand and respiratory hygiene stations were deployed across the hospital.
- Additional hand hygiene third-party observers were trained as unit-collected audits were separated from third-party observer data, to reduce potential for observer bias and Hawthorne effect.
- The Hand Hygiene Team will continue to meet bi-monthly in 2016 with a system goal of > 90%.

**LEAD:** Erin Kiernan-Johnson, Infection Preventionist and the Hand Hygiene Team

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A quarterly “Clean Hands Heroes” award was introduced in 2015, complete with a “Clean Hands Cookie” awarded to the department with the greatest positive improvement for the quarter compared to goal. PACU department accepting the award and cookie.
Surgical Site Infections

MEASURE: Surgical Site Infection (SSI)

DEFINITIONS: A SSI must meet CDC NHSN (Centers for Disease Control-National Healthcare Safety Network) specific criteria to be classified as a superficial incisional, deep incisional, or organ/space SSI.

INCLUSIONS: Colorectal and abdominal hysterectomy procedures meeting the NHSN definition for deep incisional or organ/space SSI within 30 days of the procedure.

EXCLUSIONS: Colorectal and abdominal hysterectomy procedure superficial SSIs.

GOAL: Colorectal – Rate of 3.09 SSI per 100 procedures
Abdominal Hysterectomy – Rate of 0.63 SSI per 100 procedures

DATA SOURCE: Cases meeting NHSN SSI criteria as determined by Infection Preventionist and Infectious Disease (ID) Medical Director review

SUMMARY:
- Colorectal goal not met with a rate of 7.69 SSIs.
- Abdominal hysterectomy goal met with zero SSIs (zero for the past three years).
- All SSIs meeting NHSN criteria are reviewed and trended by Infection Preventionist and ID Medical Director with feedback given to surgery leaders and surgeons.
- Surgery leadership and staff also notified of increased SSIs. SSI gap analysis completed with results and recommendations presented to Department of Surgery.
- Established reporting structure and Infection Prevention Program oversight for premature release of implants and Immediate Use Steam Sterilization (IUSS). IUSS rates and reasons trended with increases investigated.
- Other interventions included: OR cleaning audits with staff feedback, introduction of clean closure process for colorectal procedures and OR case observations for general infection prevention opportunities.

LEAD: Erin Kiernan-Johnson, Infection Preventionist

Patient Safety

MEASURE: Patient Visitor Safety and Near Miss Reporting

INCLUSIONS: All inpatients, outpatients and visitors.

EXCLUSIONS: Employee events or campus partner clinic patient events.

GOAL: 38 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 43.59%.
- Included as a goal in each patient care department safety culture action plan.
- Included as a measure in each nursing unit scorecard.
- Highlighted PVSR and good catch reporting in the annual St. Francis Safety Fair.
- Included significant PVSR and good catch follow up in department specific safety newsletters.
- Developed PVSR reporting education for nursing and other patient care staff which highlights a non-punitive reporting culture.
- Developed Just Culture education for St. Francis leaders; hardwired into new leader orientation process.
- 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.

Zero Adverse Health Events (AHEs) were reported in 2015! This is the first year since 2007 with no reportable AHEs.

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 for order verification and the potential for chemotherapy medication 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 tool.  
**EXCLUSIONS:** Outpatient falls, falls coded other than E-I (harm).  
**GOAL:** ≤ 0.74 falls with harm per 1000 patient days.  
**DATA SOURCE:** Patient days from financial data; fall data from Ace report and PVSR database

**SUMMARY:**  
- Far exceeded strategic goal with a rate of 0.52 inpatient falls with harm.  
- Planned toileting hardwired, greatly reducing falls related to toileting and falls with harm.  
- Held responsiveness summits to share data with staff, spread best practices and identify opportunities to improve.  
- Implemented a quarterly Med/Surg/Peds unit safety newsletter highlighting fall prevention strategies and data.  
- Implemented use of Posey chair pad alarms.  
- Increased use of safe patient moving equipment specifically the Sara Stedy manual standing aid.  

**LEAD:** Brianna Thompson, Med/Surg/Peds Patient Care Supervisor, and the Fall Prevention Team

St. Francis received a Leapfrog Hospital Safety grade of “A” in spring and fall of 2015 and has consistently been graded an “A” since 2012.

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.

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 workflows and procedures for possible failures and to prevent them by correcting the processes proactively rather than reacting after failures have occurred.
Days Away or Restricted Time

**MEASURE:** Days Away or Restricted Time (DART)

**INCLUSIONS:** Employee injuries resulting in days away or restricted time.

**GOAL:** ≤ 2.96

**DATA SOURCE:** Occupational Health Manager (OHM), Hours Worked Report

**SUMMARY:**
- Goal not met with a rate of 3.21.
- Completed root cause analysis/safety investigation for all employee injuries.
- Continued use of safe patient moving medallions on high risk unit to communicate patient mobility status, safe patient moving equipment needs and safe toileting requirements to prevent falls.
- Implemented inpatient surgical transport guidelines, a safe patient moving initiative focused on safe employee transport of patients from the Surgical Services Department to inpatient units.
- Purchased additional safe patient moving equipment for various units (Sara Stedy, AirPals, motorized carts, etc.).
- Completed replacement of overhead ceiling lifts and updated tracking on Med/Surg as part of unit remodel.
- Focus on weather related and indoor slip, trip and fall hazards with roll out of various communication materials to inform staff of pending inclement weather and reminders about slip, trip and fall hazards. Added salt buckets to hospital entrance locations.
- Held fourth annual St. Francis Safety Fair highlighting the Environment of Care.

**LEAD:** Amanda Saathoff, Safety Program Manager

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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:** 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. 2015 NPSG highlights include:

- **Nursing:** Critical test results communicated from nurse to provider within 20 minutes of obtaining verified results improved to 85% by year end.
- **All medications, medication containers and other solutions on and off the sterile field are labeled (all procedural settings) improved to 94%.
- **Zero central line associated blood stream infections.**
- **Medication reconciliation at patient discharge hardwired near 100%.
- **Hand hygiene compliance improved to 90%.
- **Zero wrong site, wrong surgery, wrong patient procedures.**
- **Clinical Alarm Safety system-wide policy developed; default alarm parameters established.**

**LEAD:** Nancy Wolf, Director Quality, Safety & Risk Management

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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 regards 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.
SAFETY | PATIENT SAFETY CULTURE

Table: How do we measure compliance?

<table>
<thead>
<tr>
<th>Goal</th>
<th>Observed Indicator</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1 – Improve the accuracy of patient identification.</td>
<td>Observational audit of patient caregivers using two patient identifiers (name and DOB).</td>
<td>1-goal</td>
<td>100%</td>
<td>99%</td>
<td>93%</td>
</tr>
<tr>
<td>Goal 2 – Improve the effectiveness of communication among caregivers.</td>
<td>Laboratory: Critical test results are communicated to the licensed healthcare provider or designee within 15 minutes of obtaining verified results.</td>
<td>1-goal</td>
<td>100%</td>
<td>98%</td>
<td>100%</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>1-goal</td>
<td>100%</td>
<td>80%</td>
<td>82%</td>
</tr>
<tr>
<td></td>
<td>Radiology: Imaging critical results are communicated to the physician within 25 minutes of verification as critical.</td>
<td>1-goal</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Goal 3 – Improve the safety of using medications.</td>
<td>Proceduralist: All medications, medication containers and other solutions on and off the sterile field are labeled (all procedural settings).</td>
<td>1-goal</td>
<td>100%</td>
<td>64%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Anesthesia: All medications, medication containers and other solutions on and off the sterile field are labeled (all procedural settings).</td>
<td>1-goal</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Overall compliance of dosing and lab monitoring of anticoagulation therapy.</td>
<td>1-goal</td>
<td>100%</td>
<td>98%</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td>Patients receive warfarin education prior to discharge.</td>
<td>1-goal</td>
<td>100%</td>
<td>75%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Medication Reconciliation – Admission within 24 hours.</td>
<td>1-goal</td>
<td>100%</td>
<td>77%</td>
<td>82%</td>
</tr>
<tr>
<td></td>
<td>Medication Reconciliation – Discharge.</td>
<td>1-goal</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Goal 7 – Reduce the risk of health care-associated infections.</td>
<td>Observational audits of hand hygiene before &amp; after room entry.</td>
<td>1-goal</td>
<td>100%</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td></td>
<td>Number of central line blood stream infections</td>
<td>1-goal</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Number of catheter associated urinary tract infections.</td>
<td>1-goal</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Number of surgical site infections.</td>
<td>1-goal</td>
<td>0</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Goal 15 – The organization identifies patients at risk for suicide.</td>
<td>Suicide risk screening completed within 24 hours of inpatient admission.</td>
<td>1-goal</td>
<td>100%</td>
<td>95%</td>
<td>93%</td>
</tr>
<tr>
<td>Universal Protocol – The organization fulfills the expectations set forth in the Universal Protocol.</td>
<td>Number of wrong site, wrong surgery, wrong patient procedures.</td>
<td>1-goal</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

= At goal or better  = Within 5% of goal  = >5% from goal

Regulatory Accreditation and Certification

SUMMARY:

With the St Francis triennial Joint Commission survey occurring in December of 2014, the regulatory activities for the first half of 2015 were focused on the preparation and submission of our corrective action plans and Measures of Success (MOS) associated with the findings from the survey. 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.

The corrective action plans were submitted to and accepted by The Joint Commission (TJC) in February 2015. One of the indirect requirements for improvement required a MOS, which involved submitting audited compliance data to TJC for a four month period. The required 90% or greater compliance rate was achieved and the final data was submitted in June 2015. St Francis was once again granted full accreditation status for all services surveyed. Additional and ongoing regulatory activities for the remainder of 2015 included:

- Completion of the intra-cycle monitoring/Focused Standards Assessment (FSA) by Joint Commission chapter and National Patient Safety Goal (NPSG) leads. Required by TJC, the FSA is an annual “self-assessment” of compliance to TJC standards. This was completed in December 2015. Four areas of partial compliance/opportunities for improvement were identified and corrective action plans were created.

- Completion of the annual Allina Internal Accreditation Survey which was held on November 11, 2015. Because this was the year following triennial survey, the internal survey was a focused one-day validation survey to assess ongoing compliance with the seven requirements for improvement received the previous year.

- Additional 2015 regulatory activities included development of a standardized organizational response/notification plan for all regulatory visits, participation in department safety rounds with a focus on TJC and NPSG requirements and the creation of numerous educational materials including the 2015 NPSG poster.

HEART FAILURE DISEASE SPECIFIC CERTIFICATION (DSC) PROGRAM

- Successful on-site HF DSC JC survey on May 12 resulting in recertification of the organizational HF program. There were no findings or requirements for improvement identified.
- Through these ongoing program improvements, St Francis had the lowest CMS heart failure readmission rate in the Allina system (metros) at 14.4%.
- St. Francis remains one of two hospitals in the state of Minnesota certified as a HF program by TJC.
2015 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, MRL Ultrasound General and Breast, Mammography, Nuclear Medicine, EchoSleep 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

**ORGANIZATION HONORS**

- **2013-2015**
  - Star Tribune Top 150 Workplace – Large Company (3rd year)
- **2011-2015**
  - Valley Rehab Services Top 100 Workplace – Small Company (5th year)
- **2013-2015**
  - Joint Commission Top Performer on Key Quality Measures (3rd year)
- **2015**
  - Commission on Cancer/American College of Surgeons Outstanding Achievement Award
- **2014 & 2015**
  - March of Dimes Top Performing Hospital: Early Elective Delivery
- **2014 & 2015**
  - The SafeCare Group 100 SafeCare Hospital Award
- **2015**
  - Truven Top 100 Hospitals Award
- **2015**
  - Healthgrades Patient Safety Excellence Award & Patient Experience Award
- **2015**
  - Leapfrog Group Hospital “A” Safety Grade (4th year)
  - MN Crime Prevention Association Business of the Year Award

**INDIVIDUAL HONORS**

Minnesota Hospital Association – Good Catch for Patient Safety Award Winners:

- Kristin Palmer, Special Imaging Technologist, Diagnostic Services
- Valerie Nichols, CST, Surgical Services
- John Zweber, CRNA, Surgical Services
- Jackie Kulyas, RN, Med/Surg
- Alina Vogel, RN, Med/Surg
- Karen Norton, RN, Surgical Services
- Rebecca Barnack, RN, Family Birth Place
- Stephanie Forbes, Nuclear Medicine Technician, Diagnostic Services

- Bobbi Starkey, Scheduler, Diagnostic Services
- Connie Miller, Multi-Specialty Imaging Technologist, Diagnostic Services
- Kim Schmitz, RN, Med/Surg

**2015 QUALITY & SAFETY COUNCIL**

- Candace Lano, RN, BSN, Regulatory Program Manager/Quality Improvement Specialist
- Brianna Thompson, RN, CMSRN, Med/Surg 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 Vloos, 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

**2015 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
- Brenda Vandersick, Administrative Assistant
- Nancy Wolf, MSN, RN, CPHQ, Director Quality, Safety, Risk Management & Medical Staff Services
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