Quality and Patient Safety Primer

Module 3: National Programs with Nursing Sensitive Outcomes

Information Current as of 10/1/2013
Learning Objectives

Upon completion of this module, participants will be able to:

- Identify at least 2 current indicators for:
  - National Quality Forum (NQF)
  - Nursing Sensitive Outcomes
  - Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS)
  - CALNOC
  - NDNQI
  - Other Industry or Regulatory Requirements
National Programs with Nursing Sensitive Outcomes

Public Reporting pending

- National Quality Forum (NQF)
- The Joint Commission (TJC)
- Centers for Medicare and Medicaid (CMS)

Additional indicators can be found with
Collaborative Alliance for Nursing Outcome (CALNOC)
National Database of Nursing Quality Indicators (NDNQI)

http://www.jointcommission.org/national_quality_forum_nqf_endorsed_nursing-sensitive_care_performance_measures/
http://www.jointcommission.org/
http://partnershipforpatients.cms.gov/
NQF & TJC Consensus for Nursing Sensitive Care Measures

• Quantifying the effect of nurses & nursing interventions on:
  o Quality of care processes
  o Patient outcomes
  o Support evidence-based staffing plans
  o Data that underscores impact of nursing shortages

• Focus on
  o Patient centered outcomes
  o Nurse centered intervention measures
  o System centered measures
  o Not on a single disease or population
NQF Endorsed Nursing Sensitive Care Measures (12 Measures)

1. Death of Surgical Inpatients with Treatable Serious Complications
2. Pressure Ulcer Prevalence (Hospital-Acquired)
3. Patient Falls
4. Falls with Injury
5. Restraint Prevalence
6. Urinary Catheter-Associated Infections (ICU)

Nursing Sensitive Care Measures (cont.)

7. Central Line Catheter-Associated Bloodstream Infections (ICU & NICU)
8. Ventilator-Associated Pneumonia (ICU & NICU)
9. Skill Mix
10. Nursing Care Hours per Patient Day
11. Voluntary Turnover
12. Practice Environment Scale-Nurse Work Index

- Nurse participation in hospital affairs
- Nurse foundations for quality of care
- Manager ability, leadership, support of nurses
- Staffing & resource adequacy
- Collegiality of nurse-physician relations

Note: Initially there were 15 NQF Nursing-Sensitive Measures identified. The total number was later revised to 12. All smoking cessation related measures were removed.
NQF – Perinatal Care
National Consensus Standards 2012

1. Elective Delivery
2. Incidence of Episiotomy
3. C-Section rate for low-risk 1st birth
4. Appropriate Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision- C-Section
5. Appropriate DVT prophylaxis C-Section
6. Hepatitis B Vaccine to newborn infants prior to discharge
7. Antenatal Steroids
8. Intrapartum Antibiotic Prophylaxis for Group B Streptococcus
9. Infants < 1500g not delivered at appropriate level of care
10. Neonatal Blood Stream Infection Rate
11. Health Care-Associated blood stream infections in Newborns
NQF – Perinatal Care
National Consensus Standards 2012

12. Late Sepsis or Meningitis in Very Low Birth Neonates
13. Exclusive Breast Milk Feeding
14. Proportion of Infants 22 to 29 Weeks Gestation Screened for Retinopathy of Prematurity

National Programs with Nursing Sensitive Outcomes

NQF National Voluntary Consensus Standards for Emergency Care (22 Measures)

1. Aspin at arrival
2. Median time to fibrinolysis
3. Fibrinolytic therapy received within 30 minutes of ED arrival
4. Median time to ECG
5. Median time to transfer to another facility for acute coronary intervention
6. Administrative communication
7. Patient information
8. Vital signs
9. Mediation information
10. Physician information

National Programs with Nursing Sensitive Outcomes

NQF National Voluntary Consensus Standards for Emergency Care (cont.)

11. Nursing information
12. Procedures and tests
13. Median time from ED arrival to ED departure for admitted ED patients
14. Median time from ED arrival to ED departure for discharged ED patients
15. Admit decision time to ED departure time for admitted patients
16. Door to provider
17. Left without being seen
18. Server sepsis and septic shock: management bundle
19. Confirmation of endotracheal tube placement
20. Pregnancy test for female abdominal pain patients
21. Anticoagulation for acute pulmonary embolus patients
22. Pediatric weight in kilograms
Evolution of Leadership Safe Practices

2003 Safe Practices:
- Culture related activities provided as a list
- Lack of standardization
- Selected reading provided
- Evidence sample provided

2006 Update:
- Harmonized across NQF, AHRQ, Joint Commission, CMS, IHI, Leapfrog Group to line item specification
- Leadership Structures and Systems held firm.
- Care Settings Standardized
- Implementation Guides Added
- Thoroughly Evidence-based and literature cited.

2009 Update:
- Harmonization partners grew from 2006 to include CDC, APIC, and HRSA.
- Leadership Structures and Systems held firm.
- Added Patient Involvement chapter and included in all practices.
- Comprehensive update to Evidence.
- Made care settings standardized to CMS frame.
NQF Safe Practices – 2010 update

Safe Practice 1: Leadership Structures and Systems

Leadership structures and systems must be established to ensure that there is organization-wide awareness of patient safety performance gaps, direct accountability of leaders for those gaps, and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

NQF Safe Practices – 2010 update

Safe Practice 2: Culture Measurement, Feedback, and Intervention
Healthcare organizations must measure their culture, provide feedback to the leadership and staff, and undertake interventions that will reduce patient safety risk.

Safe Practice 3: Teamwork Training and Skill Building
Healthcare organizations must establish a proactive, systematic, organization-wide approach to developing team-based care through teamwork training, skill building, and team-led performance improvement interventions that reduce preventable harm to patients.
NQF Safe Practices – 2010 update

Safe Practice 4: Identification and Mitigation of Risks and Hazards
Healthcare organizations must systematically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously drive down preventable patient harm.

Safe Practice 5: Informed Consent
Ask each patient or legal surrogate to “teach back,” in his or her own words, key information about the proposed treatments or procedures for which he or she is being asked to provide informed consent.
NQF Safe Practices – 2010 update

Safe Practice 6: Life-Sustaining Treatment
Ensure that written documentation of the patient’s preferences for life-sustaining treatments is prominently displayed in his or her chart.

Safe Practice 7: Disclosure
Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient and, as appropriate, the family should receive timely, transparent, and clear communication concerning what is known about the event.
NQF Safe Practices – 2010 update

Safe Practice 8: Care of the Caregiver
Following serious unintentional harm due to systems failures and/or errors that resulted from human performance failures, the involved caregivers (clinical providers, staff, and administrators) should receive timely and systematic care to include: treatment that is just, respect, compassion, supportive medical care, and the opportunity to fully participate in event investigation and risk identification and mitigation activities that will prevent future events.

Safe Practice 9: Nursing Workforce
Implement critical components of a well-designed nursing workforce that mutually reinforce patient safeguards, including the following:
Safe Practice 9: Nursing Workforce Cont’d…
A nurse staffing plan with evidence that it is adequately resourced and actively managed and that its effectiveness is regularly evaluated with respect to patient safety.

Senior administrative nursing leaders, such as a Chief Nursing Officer, as part of the hospital senior management team.

Governance boards and senior administrative leaders that take accountability for reducing patient safety risks related to nurse staffing decisions and the provision of financial resources for nursing services.

Provision of budgetary resources to support nursing staff in the ongoing acquisition and maintenance of professional knowledge and skills.
NQF Safe Practices – 2010 update

Safe Practice 10: Direct Caregivers
Ensure that non-nursing direct care staffing levels are adequate, that the staff are competent, and that they have had adequate orientation, training, and education to perform their assigned direct care duties.

Safe Practice 11: Intensive Care Unit Care
All patients in general intensive care units (both adult and pediatric) should be managed by physicians who have specific training and certification in critical care medicine (“critical care certified”).

Safe Practice 12: Patient Care Information
Ensure that care information is transmitted and appropriately documented in a timely manner and in a clearly understandable form to patients and to all of the patient’s healthcare providers/professionals, within and between care settings, who need that information to provide continued care.
NQF Safe Practices – 2010 update

Safe Practice 13: Order Read-Back and Abbreviations
Incorporate within your organization a safe, effective communication strategy, structures, and systems to include the following:
For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person who is receiving the information record and “read-back” the complete order or test result.
Standardize a list of “Do Not Use” abbreviations, acronyms, symbols, and dose designations that cannot be used throughout the organization.

Safe Practice 14: Labeling of Diagnostic Studies
Implement standardized policies, processes, and systems to ensure accurate labeling of radiographs, laboratory specimens, or other diagnostic studies, so that the right study is labeled for the right patient at the right time.
NQF Safe Practices – 2010 update

**Safe Practice 15: Discharge Systems** A “discharge plan” must be prepared for each patient at the time of hospital discharge, and a concise discharge summary must be prepared for and relayed to the clinical caregiver accepting responsibility for post discharge care in a timely manner. Organizations must ensure that there is confirmation of receipt of the discharge information by the independent licensed practitioner who will assume the responsibility for care after discharge.

**Safe Practice 16: Safe Adoption of Computerized Prescriber Order Entry** Implement a computerized prescriber order entry (CPOE) system built upon the requisite foundation of re-engineered evidence-based care, an assurance of healthcare organization staff and independent practitioner readiness, and an integrated information technology infrastructure.

**Safe Practice 17: Medication Reconciliation** The healthcare organization must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care.
NQF Safe Practices – 2010 update

Safe Practice 18: Pharmacist Leadership Structures and Systems
Pharmacy leaders should have an active role on the administrative leadership team that reflects their authority and accountability for medication management systems performance across the organization.

Safe Practice 19: Hand Hygiene
Comply with current Centers for Disease Control and Prevention Hand Hygiene Guidelines.

Safe Practice 20: Influenza Prevention
Comply with current Centers for Disease Control and Prevention (CDC) recommendations for influenza vaccinations for healthcare personnel and the annual recommendations of the CDC Advisory Committee on Immunization Practices for individual influenza prevention and control.
NQF Safe Practices – 2010 update

**Safe Practice 21: Central Line-Associated Bloodstream Infection Prevention**
Take actions to prevent central line-associated bloodstream infection by implementing evidence-based intervention practices.

**Safe Practice 22: Surgical-Site Infection Prevention**
Take actions to prevent surgical-site infections by implementing evidence-based intervention practices.

**Safe Practice 23: Care of the Ventilated Patient**
Take actions to prevent complications associated with ventilated patients: specifically, ventilator-associated pneumonia, venous thromboembolism, peptic ulcer disease, dental complications, and pressure ulcers.
NQF Safe Practices – 2010 update

Safe Practice 24: Multi-Drug-Resistant Organism Prevention
Implement a systematic multi-drug-resistant organism (MDRO) eradication program built upon the fundamental elements of infection control, an evidence-based approach, assurance of the hospital staff and independent practitioner readiness, and a re-engineered identification and care process for those patients with or at risk for MDRO infections.

Note: This practice applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant *Staphylococcus aureus*, vancomycin-resistant *enterococci*, and *Clostridium difficile*. Multidrug-resistant gram-negative bacilli, such as *Enterobacter* species, *Klebsiella* species, *Pseudomonas* species, and *Escherichia coli*, and vancomycin-resistant *Staphylococcus aureus*, should be evaluated for inclusion on a local system level based on organizational risk assessments.
NQF Safe Practices – 2010 update

Safe Practice 25: Catheter-Associated Urinary Tract Infection Prevention
Take actions to prevent catheter-associated urinary tract infection by implementing evidence-based intervention practices.

Safe Practice 26: Wrong-Site, Wrong-Procedure, Wrong-Person Surgery Prevention
Implement the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery for all invasive procedures.

Safe Practice 27: Pressure Ulcer Prevention
Take actions to prevent pressure ulcers by implementing evidence-based intervention practices.
NQF Safe Practices – 2010 update

Safe Practice 28: Venous Thromboembolism Prevention
Evaluate each patient upon admission, and regularly thereafter, for the risk of developing venous thromboembolism. Utilize clinically appropriate, evidence-based methods of thromboprophylaxis.

Safe Practice 29: Anticoagulation Therapy
Organizations should implement practices to prevent patient harm due to anticoagulant therapy.
NQF Safe Practices – 2010 update

Safe Practice 30: Contrast Media-Induced Renal Failure Prevention
Utilize validated protocols to evaluate patients who are at risk for contrast media-induced renal failure and gadolinium-associated nephrogenic systemic fibrosis, and utilize a clinically appropriate method for reducing the risk of adverse events based on the patient’s risk evaluations.

Safe Practice 31: Organ Donation
Hospital policies that are consistent with applicable laws and regulations should be in place and should address patient and family preferences for organ donation, as well as specify the roles and desired outcomes for every stage of the donation process.
NQF Safe Practices – 2010 update

Safe Practice 32: Glycemic Control
Take actions to improve glycemic control by implementing evidence-based intervention practices that prevent hypoglycemia and optimize the care of patients with hyperglycemia and diabetes.

Safe Practice 33: Falls Prevention
Take actions to prevent patient falls and to reduce fall-related injuries by implementing evidence-based intervention practices.

Safe Practice 34: Pediatric Imaging
When CT imaging studies are undertaken on children, “child-size” techniques should be used to reduce unnecessary exposure to ionizing radiation.
Collaborative Alliance for Nursing Outcomes

Advancing global patient care, safety, outcomes and performance measurement efforts by:

- Leveraging a dynamic nursing outcomes database and reporting system.
- Providing actionable data to guide decision making
- Conducting research to optimize patient care excellence
- Building expertise in the use of evidence based practice.

www.calnoc.org
CALNOC Structural Nursing Measures

- Hours of nursing care per patient day
  - RN HPPD
  - LPN HPPD
  - UAP HPPD
- Skill Mix*
- % Contract Hours
- Ratios*

*calculated by CALNOC

- Voluntary Turnover Rate
- RN Characteristics
  - Education
  - Certification
  - Years of Experience
- Unit Rate of Admissions, Discharges and Transfers
CALNOC Process Measures

• **Falls & Hospital Acquired Pressure Ulcers**
  - Risk assessment
  - Time since last risk assessment
  - Risk Score (Pressure Ulcers)
  - Risk Status
  - Prevention protocols in place

• **Medication Administration Accuracy Safe Practice Adherence**

• **PICC Line Insertion Practices** (who inserted, where, presence of a dedicated team)
National Programs with Nursing Sensitive Outcomes

CALNOC Outcome Measures

- Hospital Acquired Pressure Ulcer Rate by Stage
- Fall Rate & Injury Fall Rate
- Restraint Prevalence Rate
- Central Line-Associated Blood Stream Infections in PICC Lines
- Medication Administration Accuracy Nurse Safe Practice Findings and Error Rates
National Programs with Nursing Sensitive Outcomes

National Database of Nursing Quality Indicators (NDNQI)

• National, nursing quality measurement program that provides hospitals with unit-level performance comparison data
• All indicator data are reported at nursing unit-level
• A national data resource to examine the relationship between nurse staffing and patient outcomes

http://www.nursingquality.org/
NDNQI (cont.)

Structure Indicators

• Nurse Turnover Indicator
• Nursing Care Hours Indicator
• Patient Days Indicator
• RN Education Indicator

NDNQI RN Survey- unit level survey to identify needs of the RN staff, improve their work environment and enhance retention and recruitment.

http://www.nursingworld.org
NDNQI (cont.)

Clinical Indicators

- Catheter Associated Urinary Tract Infection (CAUTI)
- Central Line-Associated Bloodstream Infection (CLABSI)
- Falls and Falls with Injury
- Pain Assessment/Intervention/Reassessment (AIR) Cycle
- Peripheral IV Infiltration
- Pressure Ulcer Prevalence
- Restraint Prevalence
- Ventilator-Associated Events (VAE)
- Ventilator-Associated Pneumonia (VAP)

http://www.nursingquality.org/
The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care.

Many of these measures are either directly or indirectly impacted by the role of a nurse.

Hospital Consumer Assessment of Healthcare Providers & Services (HCAHPS)

- HCAHPS has 27 questions
  - 18 patient perspectives on care and patient rating items that ask “how often” or whether patients experienced a critical aspect of care rather than whether they were “satisfied” with the care. Questions encompass eight key topics:
    - communication with doctors
    - communication with nurses,
    - responsiveness of hospital staff,
    - pain management,
    - communication about medicines
    - discharge information,
    - cleanliness of the hospital environment
    - quietness of the hospital environment
  - 4 screener questions to direct patients to relevant questions
  - 5 demographic questions
    - three items adjust for the mix of patients across hospitals
    - two items that support congressionally-mandated reports

HCAHPS Sample of Questions

- Overall rating of facility
- Willingness to recommend facility
- Sample of questions…
  - …Did nurses treat you with courtesy & respect? ☐
  - …Did nurses listen carefully to you? ☐
  - …Did nurses explain so you could understand? ☐
  - After you pressed the call button, how often did you get help as soon as you wanted it? ☐
  - How often did you get help to the bathroom as soon as you wanted?

http://www.hcahpsonline.org/home.aspx
HCAHPS and Hospital Value-Based Purchasing

- The Hospital Value-Based Purchasing (Hospital VBP) program links a portion of hospitals' payment from CMS to performance on a set of quality measures.
- The Hospital VBP Total Performance Score (TPS) for FY 2013 has two components: the Clinical Process of Care Domain, which accounts for 70% of the TPS; and the Patient Experience of Care Domain, 30% of the TPS.
- The HCAHPS Survey is the basis of the Patient Experience of Care Domain.

National Programs with Nursing Sensitive Outcomes

Institute for Healthcare Improvement

IHI 100,000 Lives Campaign

IHI 5,000,000 Lives Campaign
IHI 100K Lives Campaign

- Deploy Rapid Response Teams
- Evidence-based AMI care
- Prevent Adverse Drug Event (meds reconciliation)
- Prevent Central Line Infections
- Prevent Surgical Site Infections
- Prevent Ventilator Associated Pneumonia

http://www.ihi.org/IHI/Programs/Campaign/
http://www.remakingamericanmedicine.org/lives.html
IHI 5 Million Lives Campaign

• In addition to the 100-K Initiatives:
  o Prevent Harm from High-Alert Medications
  o Reduce Surgical Complications
  o Prevent Pressure Ulcers
  o Reduce Methicillin Resistant Staph. Aureus (MRSA) Infection
  o Deliver Evidence-Based Care for Heart Failure
  o Get Boards on Board

http://www.ihi.org/IHI/Programs/Campaign/
http://www.ihi.org/IHI/Programs/Campaign/Campaign.htm?TabId=1
Leapfrog’s 4 Leaps for Safety

1. Computer Physician Order Entry
2. Evidence-Based Hospital Referral
   - Coronary Artery Bypass Graft (CABG)
   - Percutaneous Coronary Intervention
   - Abdominal Aortic Aneurysm Repair
   - Esophagectomy
   - Pancreatic Resection
   - Bariatric Surgery
   - Aortic Valve Replacement
   - Elective High Risk Deliveries

3. ICU Physician Staffing

http://www.leapfroggroup.org/home
Additional Industry Demands
Related to Safety & Quality

*Today's nurse must know and practice within the guidelines dictated by industry regulatory bodies*
Center for Medicare/Medicaid Services (CMS)

Hospital Acquired Conditions
Mandated Reporting and no payment
42 More Measures for Hospitals in 2009
2013 Hospital Acquired Conditions
Mandated Reporting and reduced payment

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Pressure Ulcer Stages III&IV
5. Falls and Trauma
6. Cather-Associated Urinary Tract Infection (UTI)
7. Vascular Cather-Associated Infection
8. Manifestations of Poor Glycemic Control

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html
Hospital Acquired Conditions
Mandated Reporting and reduced payment cont’d...

7. Surgical Site Infection, Mediastinitis following Coronary Artery Bypass Graft
8. Surgical Site Infection following certain orthopedic procedures
9. Surgical Site Infection following Bariatric Surgery
10. Surgical Site Infection following Cardiac Implantable Electronic Device

8. Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures
9. Iatrogenic Pneumothorax with Venous Catheterization

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html
42 Measures for Hospitals for payment
Data from discharges beginning 2009 (combined listing)

- Surgery patients on a beta blocker prior to arrival, who received a beta blocker during the perioperative period
- Heart Failure, AMI, and Pneumonia 30-Day Re-admission and Mortality rates

**AHRQ Patient Safety and Quality Indicators**
- Death among surgical patients with treatable complications/Nursing sensitive measure: Failure to rescue
- Iatrogenic pneumothorax
- Postoperative wound dehiscence
- Accidental puncture or laceration
42 Measures for Hospitals for payment
Data from discharges beginning 2009 (combined listing) cont’d…

AHRQ Patient Safety and Quality Indicators (cont’d)
• Abdominal aortic aneurysm mortality rate
• Hip fracture mortality rate
• Mortality for selected surgical procedures (composite)
• Mortality for selected medical conditions (composite)
• Complications for selected indicators (composite)

Structural measure
• Participation in a systematic database for cardiac surgery

This program was developed by the Association of California Nurse Leaders’ 2008 & 2009 Quality and Patient Safety Committees

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Thank You for Participating in this Program!