



STANFORD
HOSPITAL & CLINICS

*Quality, Patient Safety &
Effectiveness Department*

CLINICAL
EFFECTIVENESS

EVIDENCE



PATIENT
CENTEREDNESS



c-i-care

QUALITY



VALUE



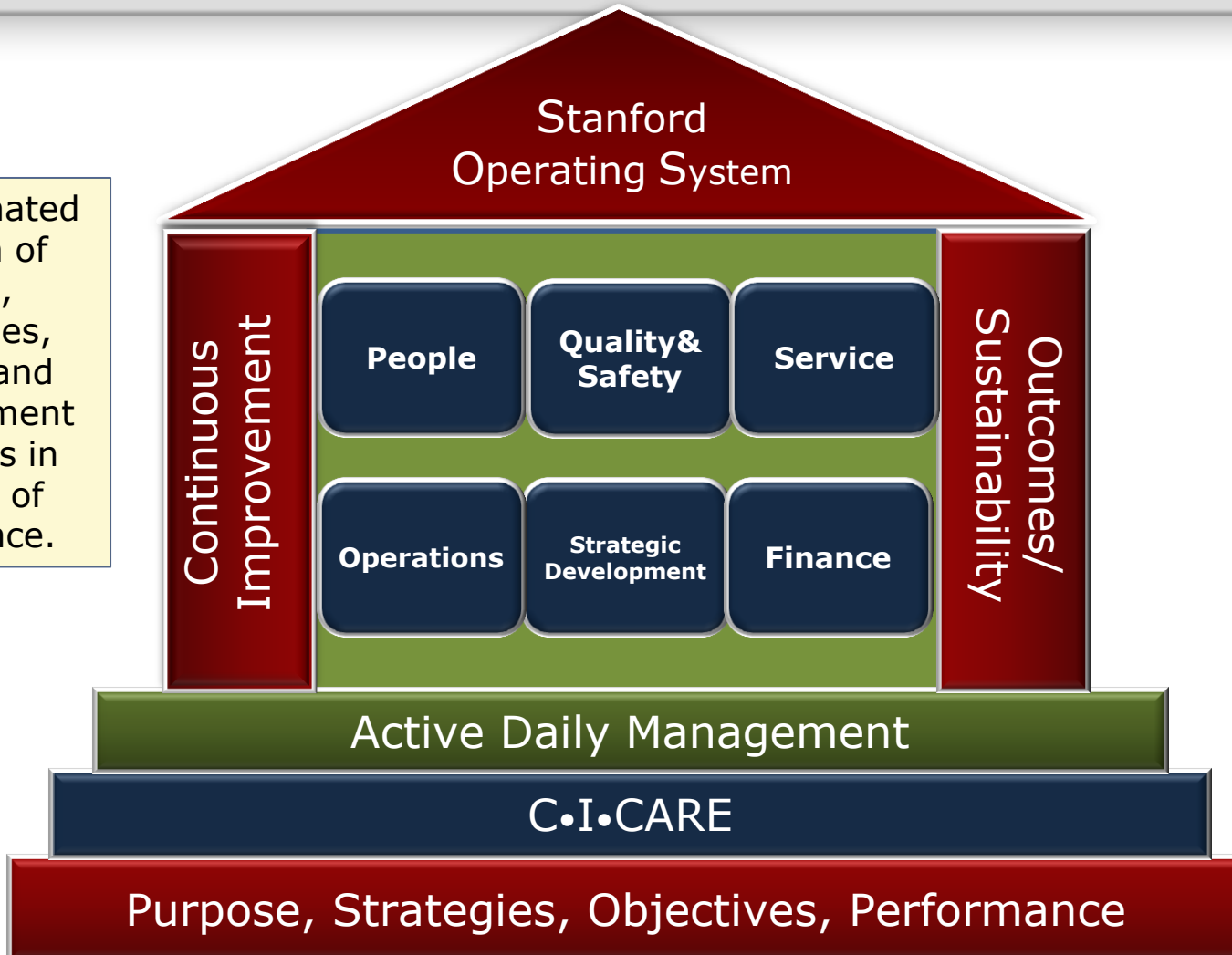
Quality, Patient Safety, & Clinical Effectiveness at Stanford Hospital & Clinics

Objectives

- ▶ Provide an overview of quality, patient safety & clinical effectiveness
- ▶ Explain the process to report adverse events
- ▶ Inform you of opportunities to engage in Quality, Patient Safety & Clinical Effectiveness work
- ▶ Explain the methodology used to improve patient outcomes and publicly reported data

Stanford Operating System (SOS)

A coordinated System of goals, strategies, tactics and management practices in pursuit of excellence.



MD-C-I-CARE

- ▶ A set of elements to remind physicians of the importance of patient centered interactions:
 - **Connect** with people by calling them by their proper name or name they prefer (Mr., Ms., Dr.)
 - **Introduce** yourself and your role
 - **Communicate** what you are going to do, how long it will take, and how it will impact the patient
 - **Ask** permission before entering a room, examining a patient or undertaking an activity.
 - **Respond** to patient's questions or requests promptly, anticipate patient needs
 - **Exit** courteously with an explanation of what will come next

This list is also on the back of your name badge

Philosophy for Clinical QI Work



- ▶ When designing quality improvement initiatives, SHC is guided by our model for Clinical Effectiveness
- ▶ Clinical Effectiveness is defined by 4 principles:
 - grounding solutions in **evidence-based practice**
 - designing care to be **patient-centered**
 - focusing on optimizing patient outcomes / **quality**
 - and providing high **value** for the care delivered (e.g. appropriate resource utilization)

Stanford Hospital and Clinics – Board Quality & Service Committee

Medical Executive Committee
Reviews and acts upon recommendations from
Med Staff Committees, GME, and SHC Dept

Quality, Patient Safety & Effectiveness Committee (QPSEC)

- Ensure regulatory compliance
- Prioritize improvement initiatives
- Define actions to achieve goals
 - Monitor Results

Quality Steering Committee (QSC)

- Culture of safety strategy
 - Root cause analysis
- Concurrent response to incidents or events
- Monitors follow up

Care Improvement Committee (CIC)

- Monitors Ongoing Practitioner Performance
- Identifies and resolves physician practices and related system issues
- Refers hospital system to process owners

Committee for Professionalism (CFP)

- Monitors and improves professional behavior
- Oversees Patient Advocacy Reporting System (PARS) program
- Evaluates complaints about MD behavior
- Implements improvement actions

Micro System
Task Forces & Teams

Multidisciplinary
Medical Staff
Committees &
Quality Councils

Safety incidents
Near misses
Sentinel events

Professional Practice
Evaluation Committees
(PPECs)

Patient &
Family Complaints

Staff & Physician
Complaints

2012 Quality Improvement (QI) Priorities

- Patient Progression - “Team Care”
- Readmissions Reduction
- Surgical Site Infection Reduction
- Sepsis Prevention, Identification, and Appropriate Treatment
- Appropriate Blood Utilization
- Optimal Management of Heart Failure Patients
- Patient-Centered Orthopedic Joint Program

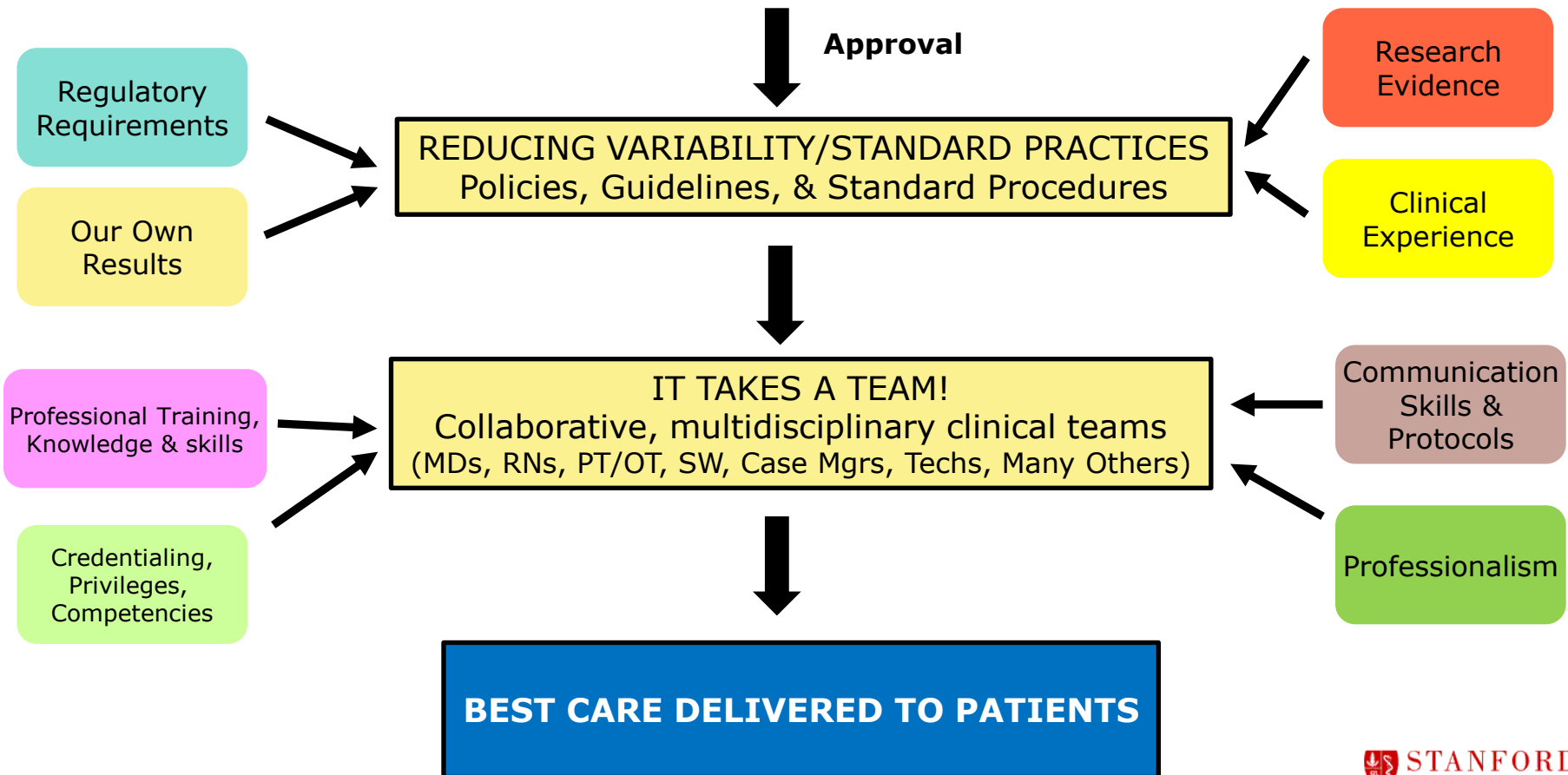
These are the goals for the organization that you directly impact.

Measuring Quality

- ▶ **Clinical Outcomes** – core measures (Joint Commission), mortality rates
- ▶ **Clinical Effectiveness** – Cost & quality balanced to achieve the desired outcome for the patient
- ▶ **Patient Satisfaction** (Press Ganey) & SHC Safety Culture Survey
- ▶ **Employee Engagement** (The Advisory Board Company)
- ▶ **Adverse Outcomes and Incident Reports** - Stanford Alerts For Events (SAFE)

Getting To The Best Care

The **MEDICAL EXECUTIVE COMMITTEE** governs clinical practice at Stanford Hospital & Clinics



Code of Professional Behavior

- ▶ A high standard of professional behavior, ethics and integrity are expected of each individual member of the SHC Medical Staff.
- ▶ The medical staff aims for the highest levels of patient care, trust integrity & honesty.
- ▶ Medical staff members have a responsibility for the welfare, well-being and betterment of their patients, along with a responsibility to maintain their own professional behavior and personal well-being.
- ▶ Each medical staff member is expected to treat all fellow medical staff members, hospital staff, house staff, students and patients with courtesy and respect and with regard for their dignity.

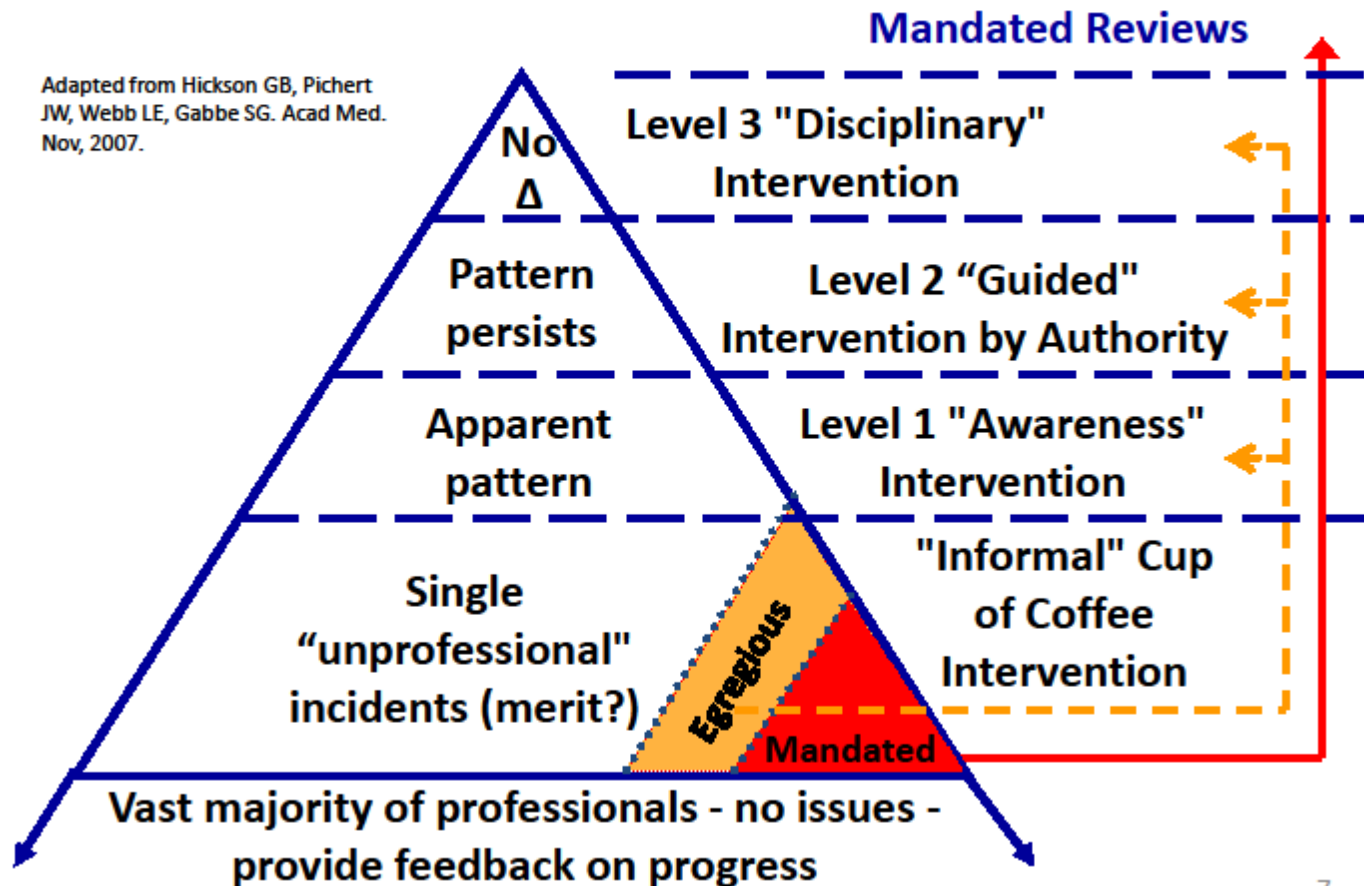
PARS & Committee for Professionalism (CFP)

- ▶ The Committee for Professionalism (CFP) is a sub-committee of the Medical Executive Committee (MEC) established to serve as resource for monitoring and improving the professional behavior of medical staff, individually and collectively. CFP oversees:
 - The Patient Advocacy Reporting System (PARS) program
 - Evaluation and follow up on complaints about MD behavior from staff or other physicians
- ▶ CFP strives to develop expertise and trust of peers to guide an informed, timely, effective SHC response to disruptive or unprofessional behavior.
- ▶ PARS is:
 - A tool for objectively identifying physicians who have an unusually large number or severity of patient & family complaints.
 - A process of presenting the data to physicians and supporting their improvement.

Example of SHC Response to Professionalism Issues

Promoting Professionalism Pyramid

Adapted from Hickson GB, Pichert JW, Webb LE, Gabbe SG. Acad Med. Nov, 2007.



Clinical Documentation – Key Points

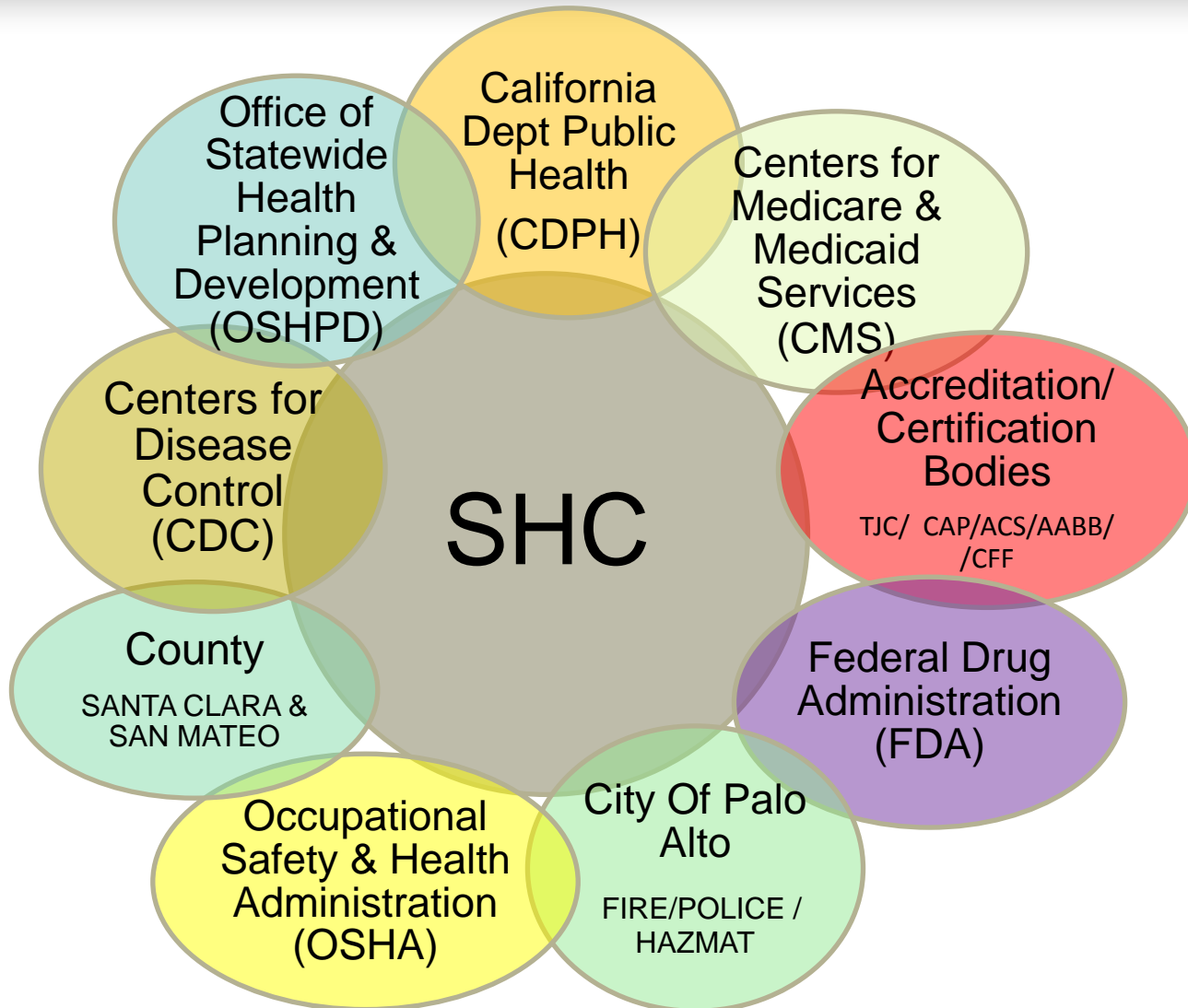
- The EMR must only contain factual and objective information pertaining to direct care of the patient and/or relevant conversations with patient/patient family.
- Current/complete records aid diagnosis and treatment; communicates pertinent information to other caregivers.
- Appropriate documentation:
 - ✓ Represents the physician(s) diagnostic rationale for diagnostic tests/procedures and treatments
 - ✓ Is used by hospital quality improvement teams, peer review committees, and licensing/ regulatory agencies to assess the quality of patient care
 - ✓ Is a key part of accreditation survey data collection
 - ✓ Provides information for financial reimbursement
 - ✓ Serves as a legal document for legal proceedings



Accreditation , Regulatory & Licensure

- ▶ Hospitals are subject to a multitude of regulations and must ensure compliance with all relevant regulations to:
 - Preserve quality and prevent harm
 - Maintain accreditation and certification
 - Maintain licensure for the provision of care
 - Avoid potential fines
- ▶ Institutions are compared based on compliance – another way that we demonstrate our quality
- ▶ Many quality and safety measures are now publicly reported (web sites). More will be in the future.

Surveyors are constantly on campus




Adverse Events and Sentinel Events

Adverse Events

- ▶ Unintended injuries or complications caused by healthcare providers.
- ▶ **Examples:**
 - Medication errors
 - Falls
 - Accidental puncture and laceration
 - Hospital acquired pressure ulcers infection

Sentinel Events

- ▶ Any unanticipated event resulting in death or major loss of function, not related to the natural course of the patient's illness or underlying condition.
- ▶ **Examples:**
 - Wrong site procedures; retained foreign body
 - Death, paralysis, coma, or other major permanent loss of function associated with a medication error.
 - Hemolytic transfusion reactions – errors blood transfusion
 - Pt fall that results in death or major permanent loss of function



IMMEDIATELY Contact SUMC Risk Management by dialing the page operator (dial 0) – **request the “Risk Manager on call”**. You may also contact the Quality Department at (650)725-9804.

Why Report?

- ▶ To prevent adverse outcomes (near miss, unsafe condition)
- ▶ To improve quality of patient care
- ▶ To improve patient safety
- ▶ To improve staff safety
- ▶ To promote a positive and safe environment for all
- ▶ For certain events, failure to report within 24 hours of discovery results in fines to the hospital - \$100 per event per day.

"The currency of patient safety can only be measured in terms of harm prevented and lives saved."

- Sir Liam Donaldson, World Health Organization

How to Report?

Click on the SAFE application

The screenshot displays the SHC CONNECT website interface. At the top left is the Stanford Hospital & Clinics logo. The main header features the text "SHC CONNECT" in large red letters. A navigation bar includes "Sign In", "Forms", "Policies", "Departments", and "Team Sites". On the right, a "FIND IT FAST" section contains search boxes for "Search Site:", "Find People:", and "LAST NAME".

The left sidebar contains several menu items: "DOCUMENTS", "DOCUMENT CENTER", "SITE MAP", "DISASTER RESPONSE AND RECOVERY GUIDE", "IT DOWNTIME CALENDAR", "SAFE", "Stanford Alerts for Events System", "KEY ISSUES", "BARGAINING ... update ...", and "NOTABLE QUOTES". The "SAFE" item is circled in green.

The main content area features a large image of a modern hospital building. Below it is a news article titled "Project Renewal Moves Forward with the City of Palo Alto". The article text reads: "SHC President and Chief Executive Officer Amir Dan Rubin and LPCH President and Chief Executive Officer Christopher G. Dawes announce an update in the Stanford University Medical Center Renewal Project. The Renewal Project—which will rebuild Stanford Hospital, expand Packard Children's and replace some School of Medicine facilities—took another..."

On the right side of the main content area, there are social media icons for Facebook, Twitter, and YouTube, followed by a "SELECT A STORY" section with three image thumbnails. Below that is a "GOT IDEAS?" button.

At the bottom right, there are three promotional sections: "TODAY'S HEADLINES" with a list of news items and a "MORE NEWS" link; "EpiCenter" with the text "YOUR SOURCE FOR EPIC SUPPORT AND INFORMATION"; and "Citrix Login" with the text "USE THIS TO ACCESS EPIC" and a "CITRIX FOR REMOTE USERS" link.

SAFE Welcome Page

Pages - SafeModified - Microsoft Internet Explorer provided by Stanford Hospital & Clinics

http://sppreprod.stanfordmed.org:20200/Pages/SafeModified.aspx

File Edit View Favorites Tools Help

Pages - SafeModified Launch MIDAS+

SHC CONNECT

Sign In Forms Policies Departments Team Sites

SAFE Welcome to Stanford Hospital and Clinics Event Reporting

STANFORD ALERTS FOR EVENTS SYSTEM

Please review the available forms below and select the one that best describes the event that occurred.

AN CILLARY EVENT	BLOOD/BLOOD PRODUCTS EVENT	GENERAL RISK EVENT	TREATMENT/NON-SURGICAL PROCEDURE RELATED EVENT
<ul style="list-style-type: none"> Diagnostic Test or Procedure Delay Extravasation Drug/Radiologic Contrast Inappropriate Collection Incorrect Report Labeling Error Lost Specimen Missed/Incorrect/Incomplete Diagnosis No Order Inadequate Surgical Equipment Order Entry Problem Repeat Stick Transport Unanticipated Radiation Exposure Unplanned Repeat Diagnostic Wrong Patient/Procedure/Site/Side Missed Test 	<ul style="list-style-type: none"> Apparent Transfusion Reaction Blood Consent Missing/Incomplete Blood Wastage Delay in Receiving Blood Products Blood Product Administration Blood Product Dispensing or Distribution Blood Product Order Labeling Error Wrong Patient Transfused 	<p>Use this if NONE of the other forms match your event</p> <p>MEDICATION EVENT</p> <ul style="list-style-type: none"> Adverse Drug Reactions Medication Errors Medication Safety Narcotics Discrepancy 	<ul style="list-style-type: none"> Cardiopulmonary Arrest Outside ICU Catheter or Tube problem Code and RRT Consent Missing or Incomplete Death in Restraints EMTALA Violation Inadequate Pain Management Incorrect Treatment/Procedure Injury Related to Medical Immobilization Injury Related to Restraints Insufficient Resources Isolation Procedure not Followed Monitored Inadequately Nosocomial Infection Omitted Treatment Performed Without Order Transfer to Higher Level of Care Treatment Delay Unexpected Complication Unexpected Death Unplanned Extubation Unplanned Transfer to ICU Ventilator Related Problem Wrong Meal
<p>BEHAVIOR EVENT</p> <ul style="list-style-type: none"> AMA, AWBS, or AWOL Abusive Patient Assault by Patient, Staff, or Visitor Sexual Abuse 	<p>CARE COORDINATION/RECORDS EVENT</p> <ul style="list-style-type: none"> Armband Incorrect or Missing Communication Inadequate with Providers, Agencies, Patient or Family Delay or Lack of Translation Assistance Documentation Issues Failure to Write Verbal Orders or Read Back Inappropriately Modified Orders Information Delayed Message Handling/Response Problem Missed/Incorrect Orders 	<p>SECURITY NON-MEDICAL EVENTS</p> <ul style="list-style-type: none"> Abduction Bodily Injury (non-patient/non-employee) Confidentiality Disclosure Criminal/Potentially Criminal or Illegal Activity Elevator Incident Exposure to Chemicals/Smoke/Fumes Fire/Explosion Personal Property Damage Personal Property Loss Privacy Inadequate Rape 	



Event Reporting Form for Physicians

Physician Only Reporting Form

Or call Hotline at 72X-XXXX

Describe Event or Observation:

Suggestion or Solutions:

Your Name:

Phone/Pager:

Email Address (if response requested)

Send

What Happens After You Report?

- ▶ SHC Patient Safety program will follow up to ensure that the issues are being addressed
- ▶ For serious adverse events, the Quality, Patient Safety & Effectiveness Department (QPSED) coordinates event resolution with Risk Management, peer review and other parties involved or impacted.
- ▶ Aggregated data is reviewed by Managers, Senior Management and Medical Staff leadership
- ▶ PI projects are often generated as a result of data analysis

The Joint Commission - National Patient Safety Goals

Improve accuracy of patient identification

- Use at least 2 patient identifiers when providing care, treatment, & services
- Eliminate transfusion errors due to misidentification

Improve effectiveness of communication among care providers

- Report critical results on a timely basis

Improve medication safety

- Labels ALL meds, medication containers, and solutions on/off sterile field in periop areas and other procedural settings
- Reduce harm related to anticoagulation therapy
- Maintain/communicate accurate patient med info (med reconciliation)

Universal Protocol for Preventing wrong patient, wrong site, wrong procedure

- Pre-procedure verification -- Site marking --Time Out before injection/incision

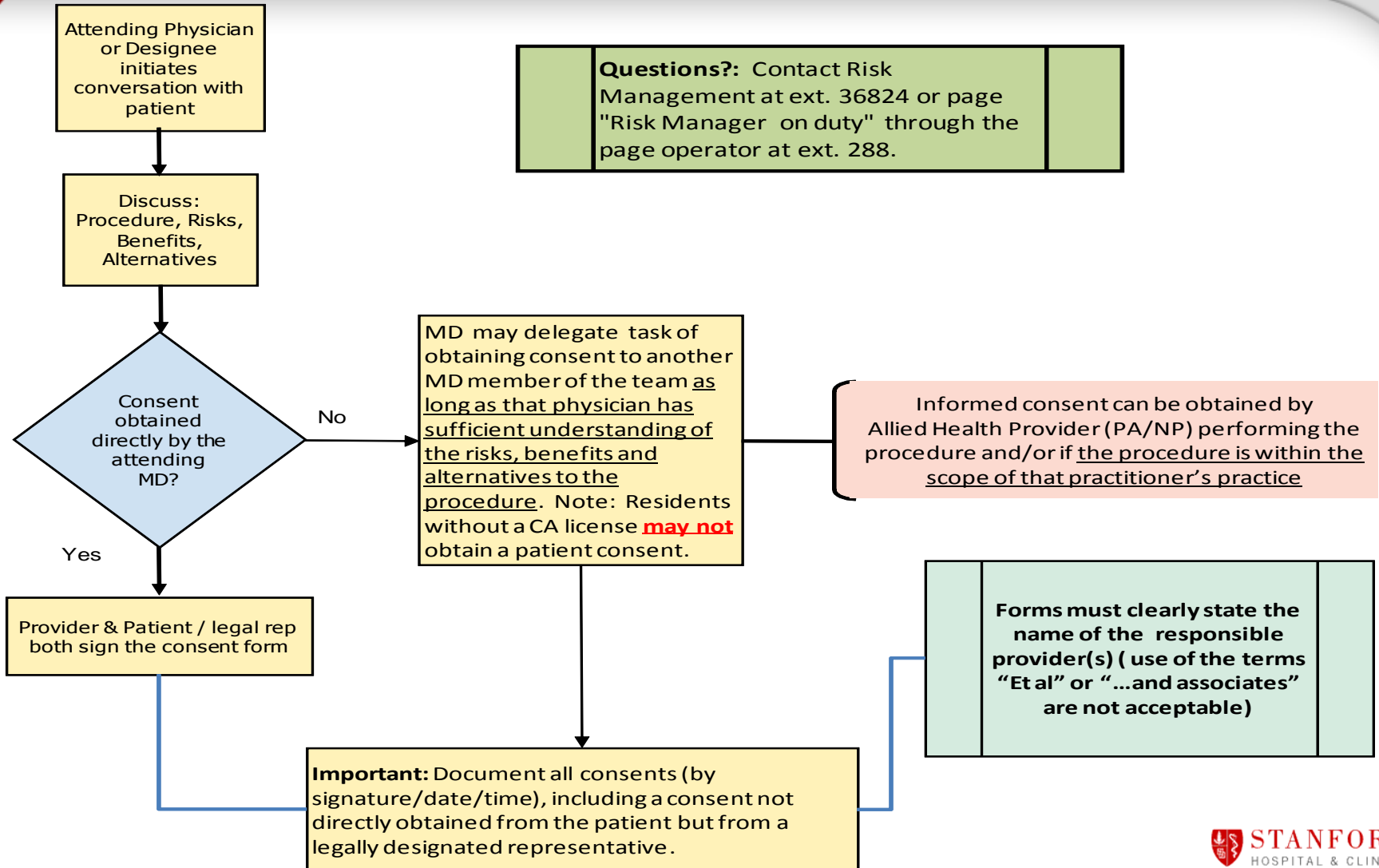
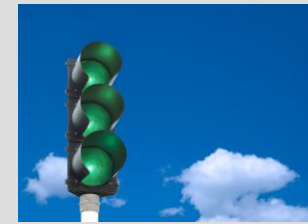
Reduce risk of health-care associated infections

- Improve hand hygiene compliance
- Prevent infections due to Multidrug-Resistant Organisms
- Prevent central-line blood stream infections (CLABSI)
- Prevent surgical infections (SSI)
- Prevent urinary tract infections (CAUTI)

Identify individuals at risk for suicide

****National Patient
Safety Goals are
listed on the back of
your badge**

Informed Consent



A Grievance/Complaint May Be Filed by Staff, Patients, and Families with the Following Regulatory Organizations:

California Medical Board

Central Complaint Unit

1-800-633-2322 (TDD: 916-263-0935)

2005 Evergreen St, Suite 1200

Sacramento, CA 95825-3236

www.medbd.ca.gov

California Department of Public Health (CDPH)

San Jose District Office

100 Paseo de San Antonio, Suite 235

San Jose, CA 95113

(408) 277-1784

The Joint Commission (TJC)

Office of Quality Monitoring 1-800-994-6610

Fax Number: 1-630-792-5636

Email: complaint@jointcommission.org

www.jointcommission.org



Questions?

**Contact: Quality, Patient Safety & Effectiveness
Department at (650) 725-9804**