



Best practices from D.C. hospitals and the health care community

QUALITY SHOWCASE





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THE UNIFYING FORCE

ADVANCING HOSPITALS AND HEALTH SYSTEMS IN THE DISTRICT OF COLUMBIA



DC Hospitals are Leaders in Creating Quality Systems of Care

As the District of Columbia Hospital Association (DCHA) celebrates the milestone of 45 years acting as a unifying force advancing hospitals and health systems in the District, we are proud to share examples of our hospitals' commitment to patient safety that drives positive outcomes. In collaboration with members and the community, we seek to promote policies and initiatives that strengthen our system of care, preserve access, eliminate disparities, and promote better health.

We are proud to highlight the work of our hospital members to improve patient safety and quality in a time of competing priorities. The initiatives presented in this publication emphasize quality improvement methodology and highlight the innovative and effective projects taking place within District hospitals. These initiatives represent the dedication of our health leaders in the District to provide quality and equitable care for the communities we serve.



Jacqueline D. Bowens President & CEO



Gayle Olano-Hurt Vice President Patient Safety & Quality Operations



DOUBLE CHECK CHAMPIONS FOR HIGH-RISK MEDICATIONS

MedStar Washington Hospital Center

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In the U.S. almost 10,000 deaths per year are attributed to medication errors with 19% of these errors occurring in the intensive care unit (ICU). These errors are preventable with proper independent nurse double-checks. Guided by the PDSA framework, a cohort of new to practice nurses in the ICU at a large, urban, academic medical center created a checklist and designated double check champions (DCC) to increase compliance in performing independent double-checks for high-risk medications. Nurses were educated about this practice change using an educational PowerPoint presentation that was distributed and continuously played on the breakroom television monitor. Two DCCs were selected each shift to assist nurses throughout their shift

with completing double-checks as needed. Data collection was completed pre- and post-intervention and included chart audits assessing compliance with doublecheck sign offs. Results were successful, noting a 20% increase in compliance from pre to post. Additionally, commonly missed high-risk medications also showed a marked increase in witness compliance. Nurses reported high satisfaction with the practice change and found that education, checklists, and assigned DCCs streamlined their workflow, reducing the burden of completing the nurse double-check process. Overall, with results displaying an increase in high-risk medication doublechecks, this intervention has the potential to reduce medication-related errors and increase the safety of patients.



Figure 1. ICU Comparison PRE-Intervention

Figures 1-2. In addition to compliance audits of high-risk medication witnessing in the Neuro ICU, a compliance report was generated for all ICUs at MWHC. Percent of medications witnessed pre-intervention ranged from low 47% (Unit A) to high of 88% (Unit D). Post-intervention compliance was similar with Unit A having 40% and Unit 3G with 91%. Note, post-intervention compliance on unit where DCC was implemented surpassed all units including Unit D which had highest pre-intervention compliance.





Figure 2. ICU Comparison POST-Intervention

MedStar Washington Hospital Center

DIAGNOSTIC STEWARDSHIP PROGRAM FOR C. difficile TESTING: A FIVE-YEAR REPORT

MedStar Washington Hospital Center

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Clostridioides difficile is the causative organism for antibiotic-associated colitis and a problematic healthcare-associated infection (HAI). Healthcare Facility-Onset (HO) cases are defined as cases occurring > three days after admission to a facility. Diagnosing C. difficile requires testing stool for the presence of toxin or the toxinencoding gene. Prior data has reported that asymptomatic colonization with C. difficile occurs in ~10% of hospitalized patients, and thus judicious testing is needed to diagnosis true infection while avoiding the detection of asymptomatic carriage. In 2017, we instituted a diagnostic stewardship program (DSP) focused on improving C. difficile testing.

The DSP consists of an electronic medical record algorithm to guide provider

ordering and a daily review of all orders by the Infection Prevention/Infectious Diseases team. Orders are reviewed to ensure adherence with testing guidelines, to include the presence of diarrhea (> 3 stools/day) and the absence of alternative causes of diarrhea (e.g., laxative administration). Orders which do not meet criteria are discussed with the primary team with a recommendation for cancellation, although the ultimate decision on testing is deferred to the care providers.

Implementation of a DSP for the detection of C. difficile infection has resulted in a marked and sustained decrease in the number of HO cases for over five years. Ultimately, advances in laboratory assays are needed to discriminate between true infection and colonization.





Data presented are the number of cases, the rate/10,000 cases and the standardized infection ratio (SIR) during a fiveyear period after implementation.



MWHC Hospital – Onset Clostridium difficile Metrics Rate vs SIR by Fiscal Year MSH Target: SIR ≤ 0.520

MedStar Washington Hospital Center

ELECTRONIC MEDICAL RECORD SOLUTIONS TO REDUCE STAT RADIOLOGY ORDERS: A PATIENT SAFETY INITIATIVE

MedStar Washington Hospital Center

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Timely radiographic imaging can significantly impact patient management and outcome. When all radiographic imaging are ordered as STAT, all imaging gets done in the order they are received; this hinders the ability to properly prioritize testing that truly needs to be done STAT. This can have significant impacts on patient safety when much needed diagnostics are delayed. To facilitate prioritization, we implemented a strategy to restrict STAT ordering for indications not considered life threatening. After multidisciplinary consideration, the following tests were no longer allowed to be ordered as STAT: Computed Tomography (CT) head, chest, abdomen, or pelvis for known cancer or mass, CT chest, abdomen, or pelvis for infection (pneumonia or abscess), CT chest for interstitial lung disease or pulmonary nodule. Magnetic Resonance

Imaging (MRI) could be ordered STAT for only Code situations (stroke and/or cord compression).

When the provider tried to order nonlife-threatening indications as STAT a "pop up" alert would appear explaining the restriction and a requirement to order the test as routine. Through this intervention we were able to decrease the ordering of STAT CTs from 69% to 60% (p<0.001) within two months. This had a larger impact on MRI STAT orders from 42% to 28% (p<0.001). This intervention reduced STAT CT and MRI ordering rates, prioritizing imaging tests. This also reduced phone calls to our radiology department to get truly STAT imaging done in a timely fashion. From a safety standpoint, this allows us to expedite life-saving interventions after obtaining necessary timely information.



Figure 1. Left: % reduction in CTs ordered STAT upon implementation. Right: % reduction in MRIs ordered STAT upon implementation.





MedStar National **Rehabilitation Network**

IMPROVING PATIENT OUTCOMES THROUGH HIGH INTENSITY GAIT TRAINING

MedStar National Rehabilitation Hospital

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There is high quality evidence supporting implementation of High Intensity Gait Training (HIT) for recovery of gait in the neurologic population. Despite the evidence and professional organization's push to implement HIT for individuals following Stroke, Brain Injury and Incomplete Spinal Cord Injury, changes in practice have been limited and practice settings have identified barriers including equipment, human resources, and knowledge. This two-phase Quality Improvement Project sought first to assess the feasibility of introducing HIT at MedStar National Rehabilitation Hospital through a pilot project, then to assess effectiveness and ongoing refinement of large-scale implementation throughout the inpatient physical therapy (PT) service. In the pilot study (Phase 1), they compared two statistically similar patient cohorts with neurological disorders receiving HIT vs traditional physical therapy. Gait

speed, fall risk, length of stay, discharge disposition and functional mobility outcomes were compared to determine effectiveness. Barriers were assessed and addressed throughout this phase. In Phase 2 implementation of HIT across the inpatient PT service was completed following didactic and hands on training. Regular examination of outcomes, enrollment, and knowledge gaps are ongoing. In both phases, statistically significant improvements in falls risk, gait speed and change in function were observed in those receiving HIT interventions compared to traditional. HIT outcomes demonstrated enhanced functional gains, reduced fall risk, increased discharge home, decreased length of stay and improved gait speed compared to traditional intervention. Ongoing data collection highlights the effectiveness of HIT and identifies opportunities to further improve staff education, allocation of resources and enrollment.





Figure 1. Average Discharge Berg Balance Score

*Average Discharge Scores for Berg Balance test demonstrates differences at discharge between HIT and Traditional therapies. (p<0.001) All groups were similar at admission.



AVERAGE DISCHARGE QUALITY INDICATORS*

Figure 2. Average Discharge Quality Indicators Score

Average Discharge Quality Indicators demonstrated differences between HIT and Traditional therapies, particulary with the SCI group.

Case Study



trial, the SLPs learned and utilized the various functions of HealthTouch: inputting patients' preferences, placing menu selections, monitoring therapeutic diets, and including communication strategies for use by Food and Nutrition.

In the first quarter of the pilot study, 90% of SLPs utilized HealthTouch

(HealthTouch). After a small-scale

MedStar National

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Rehabilitation Network



A PILOT STUDY

MEAL SELECTIONS FOR PATIENTS

MedStar National Rehabilitation Hospital

WITH COMMUNICATION DISORDERS:

In inpatient rehabilitation settings, the meal ordering process can be difficult for those with complex communication disorders, due to a variety of challenges. This can lead to frustration, reduced patient satisfaction, decreased sense of autonomy, and decreased food intake, potentially leading to malnutrition. In an environment of competing priorities, there are unexplored opportunities for interdisciplinary collaboration to provide a more accessible and inclusive meal ordering process, thus supporting patient satisfaction and decreasing factors contributing to malnutrition.

Using the Plan-Do-Check-Act (PDCA) model to develop a solution at MedStar National Rehabilitation Hospital (MNRH), Speech-Language Pathologists (SLPs) worked with the Clinical Nutrition Manager to understand the food selection process and dietary management software



RESULTS

Sized solids with thin liquids

stayed on this diet by choice

Nutrition to order his meals often received the same foods

input meals during therapy

• SLP used her training and experience to provide tailored communication related to dietary needs -

> Daily time increased from **1.625** min (with Food and Nutrition) to 11.5 min (with SLP)

• Patient achieved greater comprehension of diet options, directly resulting in Easy to Chew solids

• Improved patient satisfaction with meals (as reported by patient to SLP)

improved patient/family satisfaction, improved food intake, increased interdisciplinary collaboration, and broadened familiarity with individualized nutritional guidelines created by Registered Dieticians (RDs). Interdisciplinary collaboration between SLPs, RDs, and Hospitality Associates creates opportunities to improve patient and family satisfaction and decrease factors contributing to malnutrition. The methods used could be successfully adapted to other hospital settings with access to electronic ordering systems and designated rehabilitation staff.

WORKPLACE VIOLENCE PREVENTION: A MULTIDISCIPLINARY APPROACH

MedStar Georgetown University Hospital

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Workplace violence in health care is a national crisis. It has a catastrophic emotional, mental, and physical impact on an already strained workforce. Health care organizations must implement various interventions to ensure associates are adequately prepared to identify, address, de-escalate, and potentially defend against violent patients and visitors.

Associate safety is a top priority at MedStar Georgetown University Hospital (MGUH). With support from executive leadership, MGUH has developed a comprehensive Workplace Violence Prevention (WPVP) program. A multidisciplinary committee was established to coordinate, implement, and track interventions to address three focus areas: communication, education/ training, and resource allocation.

The goal of the program is to employ a variety of strategies to proactively reduce the risk of associated harm. The WPVP committee has implemented targeted interventions to improve event reporting, enhance administrative controls, and optimize the response when an event occurs. Additional strategies include de-escalation training courses, utilizing a violence prevention algorithm, and empowering associates to report any actual or potential incidences of workplace violence. The

Event overview

Associate support

8 ୧୦୦୦ Who is tasked with next steps?

Plan-Do-Study-Act methodology is utilized to foster continuous process improvement. This methodology allows the WPVP committee to evaluate and refine processes based on measurable outcomes. As a result of this program, MGUH has seen a positive impact, as evidenced by increased event reporting, increased use of available resources, and engagement in education and training programs.



Health care organizations must use innovative strategies to address and prevent workplace violence and maximize workforce support. MGUH has taken great strides to prevent harm and build a safe culture that is responsive and effective.

WHAT CANDIDA WE DO: A MULTI-FACETED **APPROACH TO TACKLING AN UPTICK IN CASES AT A DC METRO HOSPITAL**

MedStar Georgetown University Hospital



Figure 1. Factors Contributing to Hosipital Acquired C. auris



Candida auris (C.auris), a multi-drug resistant fungus, is a major public health concern due to its high mortality rate (roughly 30-60% for an invasive infection), inherent resistance to available antifungals, and the challenge of existing laboratory methods to provide accurate identification. Consequently, it has caused outbreaks in health care facilities and is typically associated with a recent admission to a long-term care facility. Of concern, a major teaching hospital in the DC area experienced a considerable increase in hospital acquired (HA) cases over an eightmonth period. Thus, to inform mitigation efforts, this project sought to identify possible causes.

Cases were identified via TheraDoc, an electronic surveillance system. HA cases were defined as the identification of *C.auris* from any site on or after hospital day four.

Of the 20 cases identified during the study timeframe, August 2021 to March 2022, 14 were HA. Pre-intervention, the HA case rate was two/month, with a maximum of six. Post intervention, the facility was able to reduce its HA case rate to 0.5/month. Chart review revealed: 3/14 (21%) had documentation of an admission to a sub -acute/rehabilitation facility 90 days prior to admission, 3/14 (21%) had an unknown status, while 57% were admitted from home.

A potential limitation of this study is the possible inflation of HA cases due to the lack of a standardized definition in the DC region. Additionally, improved documentation by the clinical team would assist with determining additional risk factors.



Figure 2. Control Chart Trending HA Case Count, Pre and Post Intervention



HOSPITAL ACQUIRED INFECTION

- Lack of admission screening
- Variation in PPE compliance

- Late notification from DCDOH
- Lack of ability to test in house
- Unclear confirmatory results
- Lack of standardized definition for health care facility cases

IMPACT OF SUPPLY CHAIN DISRUPTION ON CLABSI IN A PEDIATRIC TRANSPLANT UNIT

MedStar Georgetown University Hospital

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A Central Line Associated Bloodstream Infection (CLABSI) is a serious infection caused by pathogens entering the blood stream via a central line. CLABSIs increase hospital stays, costs, morbidity, and mortality. In 2022, a pediatric transplant unit in an urban teaching hospital in DC had a significant increase in CLABSIs compared to previous years 2020 and 2021. This project is a review of the initiatives taken to reduce CLABSIs within this patient population.

Blood cultures meeting the National Healthcare Safety Network (NHSN) definition for a CLABSI between January-December 2022 were extracted via the electronic medical record (EMR). CLABSI mitigation strategies included a multidisciplinary approach with observations, chart audits, education, and environmental cleanliness from MayDecember 2022. Data was analyzed using stage I-MR statistical control chart.

Fifteen CLABSIs were identified in 2022, which is a 200% increase compared to the previous two years. 93.3% of the CLABSIs were clustered between May-September 2022. The shortage of necessary line maintenance supplies was identified in March 2022 as a main contributing factor in the rise of CLABSIs.

With return of supplies in November 2022 and continued mitigation efforts the Pediatric Transplant Unit was able to sustain zero CLABSIs for five consecutive months and return their SIR and SUR to below baseline. The unit continues education, chart audits, and environment cleanliness to strive for no patient harm and maintain a culture of safety.



Figure 1. Initiatives Taken to Reduce CLABSIs Within a Highly Pediatric Population





ENVIRONMENT

- Deep clean of the entire unit
- Ensure all curtains changed appropriately

HOWARD **UNIVERSITY** HOSPITAL

TAKING WOUND CARE OUTCOMES TO THE NEXT LEVEL

Howard University Hospital

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In an effort to improve wound care at Howard University Hospital (HUH), the HUH Wound Care team utilized a multidisciplinary systematic approach toward improvements. The Wound Team's goal was not only focused on the prevention of hospital acquired wounds and improved wound care outcomes but reaching HUH's goal of "Do No Harm" to our patients. Our journey began by assessing the current wound program, our rate of occurrences, and then devising an action plan based on evidence-based care. Initially on average, per month, HUH reported from one to four Hospital Acquired Stage III/IV pressure injuries and 10 to 15 pressure injuries (all stages). Over time, initiatives have been implemented and results measured and evaluated. If improvements were noted, the initiatives were permanently adopted. Negative outcomes led the team to reassess

and alter the initiatives per evidence-based practice. As of April, and May 2023, the HUH Rate of Acquired Pressure Injuries was 0.57 and 0.81 per 1,000 inpatient days, as compared to 7.23 in November 2022. Outstanding improvements have also been noted in the rate of acquisition of hospital pressure injuries Stage III or IV from 4 to 0 for the past nine months. Further advances at HUH wound care include our preparation for our new Outpatient Wound Center, allowing our in-patients to continue receiving exceptional wound care post discharge.



Rate of Hospital Acquired Pressure Injuries (Rate per 1,000 Inpatient Days)



Figure 1. of April and May 2023, the HUH Rate of Acquired Pressure Injuries was 0.57 and 0.81, respectively, per 1,000 inpatient days, as compared to 7.23 in November 2022.



MIDLINE OR MIDDLE AGES! CATHETER ASSOCIATED BLOODSTREAM INFECTION REDUCTION AND PATIENT SATISFACTION IMPROVEMENT STRATEGY. A QUALITY IMPROVEMENT INITIATIVE

Howard University Hospital



Mpey Tabot Tabot MD; Renee Skific MD; John Prempeh MD: Mailen Fernandez: Rohan Kuruvilla: Mesay Asfaw MD; Daniel Larbi MD; Angella P. Browne, BSMT (ASCP), MBA, CIC; Terrance Jacobs; Shelly McDonald-Pinkett MD; Angesom Kibreab MD; and Alem Mehari MD

Central line associated bloodstream infections (CLABSI) are associated with increased health care cost, morbidity and mortality. Reducing the number of central lines placed can decrease the rate of CLABSI. To fight CLABSI rate at our institution, Internal Medicine residents were trained to place midlines.

Twenty Internal Medicine residents trained in point-of-care ultrasound (POCUS) were selected for midline placement training. Two residents with POCUS expertise were trained by travel trainer nurses, who then taught the remaining eighteen residents through simulation practice and bedside training. The trained residents placed midlines on consenting patients. Random patients who received midlines completed a patient satisfaction survey. CLABSI standardized infection ratio (SIR) for Howard University Hospital (HUH) was queried on hospital compare from 2017 to 2023.

Our results showed that 85% of trained residents completed the training and reported feeling comfortable with midline placement. Between 2021 and 2023, the certified residents collectively inserted 200 midlines, averaging 18 per resident. The midlines had an average dwell time of 13.8 days; no midline-related infections were reported. The rate of central line placement decreased by 18%. 85% of patients expressed comfort with their midlines. Our SIR for CLABSI improved from worse than national benchmark in prior years to no difference from 2022 to 2023 as seen below.

To conclude, midline insertion led by trained internal medicine residents effectively reduced the CLABSI rates at HUH and led to improved patient satisfaction. It is an effective catheter associated bloodstream infection reduction strategy and more providers should be trained in this procedure.



24 | DCHA's Quality Showcase

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Press Ganey's study, "The Nursing Special Report: The Influence of Nurse Work Environment on Patient, Payment and Nurse Outcomes in Acute Care Settings," found a positive nursing environment and appropriate staffing to be associated with high quality patient care." Reducing reliance on agency RN staff due to high costs and the need for continuity of permanent staff to provide long-term sustenance of quality initiatives and measures were the primary drivers for this project. Our baseline agency RN labor mix over total RNs at Howard University Hospital (HUH) was at 39% (June 2022) with target and world-class benchmarks at 15% and 10%, respectively. The cost of agency staffing was \$1.7MM in September 2022 and reduced to \$0.96MM by May 2023. After conducting a root cause analysis, factors at interplay included, not a large enough labor pool to allow flexibility with staffing, and ineffective

coordination between recruiters and nurse managers. Interventions included mining efforts to establish staffing ratios based on average daily census, retention, and recruitment to drive qualified inbound staff, augmenting the staff with a hospital based per-diem pool and increased coordination between nurse managers and recruiters to facilitate timely hiring and onboarding. Post-implementation of countermeasures, the agency mix was reduced from 39% to 14%, achieving our target benchmark, led to a cost reduction of agency staff of over 60%. Ongoing interventions for staff engagement include implementation of Rounds Plus to assess compliance with quality initiatives. Adequate nurse staffing and organizational and managerial support for maintaining a healthy nursing work environment are key to improving care delivery, patient/safety outcomes and clinician satisfaction.



Figure 1. RN Staffing costs:

45

- Agency RN costs were calculated by taking the Kronos hours for Clinical Nurse Job Classes and multiplying by avg. rate of \$114/hr. until March 2023 where the rate used was \$111/hr.
- Permanent RN Staff costs are taken from the ٠ payroll files and reflect total paid dollars by Clinical Nurse I-IV job classes only.
- Per-Diem Staff costs were also taken from the payroll files and reflect total paid dollars by Per-Diem Clinical Nurse Pool job classes (all levels) only.

HOWARD **UNIVERSITY** HOSPITAL

REDUCTION IN AGENCY NURSING STAFFING

Howard University Hospital

Agency RN's as % of Total RN's





IMPROVING THE UTILIZATION OF PALLIATIVE CARE CONSULTATION IN THE NEONATAL INTENSIVE CARE UNIT

Children's National Hospital

Emily Rosenstein, DNP; Sofia Perazzo, MD; and Jan Wilson, DNP, CRNP, NNP-BC, C-ELBW, FAANP Perinatal palliative care (PC) provides comprehensive and interdisciplinary care for infants with life-limiting or chronic critical conditions. The utilization of palliative care services for neonates remains limited despite endorsement by professional organizations. This project aimed to increase the use of early PC consults in one neonatal intensive care unit from 33% to 100%.

The Plan-Do-Study-Act model guided this quality improvement project. Standardized diagnostic, prenatal referral, and chronicity trigger eligibility criteria were implemented in one level IV neonatal intensive care unit. Interventions to improve compliance included staff education, redesigned workflow, and bedside rounding to identify eligible patients. De-identified patient data was collected by manual chart auditing and consult compliance was analyzed with a run chart. Education data was collected by clinician surveys and attendance at training sessions.

Median palliative care consult ordering compliance for eligible patients improved from 33% to 100% and maintained at 100% for 10 weeks until project cycle conclusion. Seventeen patients met inclusion criteria, and 16 (94%) received consult orders. The median time from admission to consult order entry was reduced from 40 to 15.5 days. Educational training was received by 98% of the site health care providers. Clinician comfort in identifying palliative care-eligible infants significantly improved after the educational training (Z=3.02, p=0.003).

Quality improvement methodology successfully improved early PC consult ordering within one neonatal intensive care unit. Standardization of eligibility criteria, bedside rounding, and personnel education increased the use of these services. Further research is needed to evaluate the impact on family experiences.





Figure 1. Pre-Implementation during July and August 2022



Proportion of Perinatal Palliative Care-Eligible Patients That Have a Consult Placed



REVISION PROCESS OF MODIFYING AN EXISTING SEPSIS TRIGGER TOOL TO ENHANCE DATA CAPTURE FOR IPSO SUSPECTED CRITICAL, IPSO SUSPECTED **SEPSIS & IPSO SUSPECTED INFECTION**

Children's National Hospital

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The Triggers Program uses electronic health record detection to identify potential adverse events. The program identifies potential adverse events to reduce the frequency and severity of future events. In June 2018, the Triggers and the Improving Pediatric Sepsis Outcomes Committee collaborated for the development of a "Suspected Sepsis Trigger Tool." In 2022, IPSO and Triggers created a revised and improved tool "Sepsis Trigger 2.0."

Revision process of modifying a triggers tool to enhance data capture of patients with IPSO Suspected Critical, IPSO Suspected Sepsis and IPSO Suspected Infection.

The trigger tool used IPSO logic converted into a scalable algorithm within Cerner's HealtheIntent platform. The algorithm identified patients meeting the criteria of suspected severe and non-severe sepsis. This revision aims to revise the data to include IPSO's updated sepsis definitions

and inclusion criteria. The code was reconstructed for additional fields and logic to the current report.

List of patients are populated into a report daily filtered into three criteria: Suspected Critical Sepsis, IPSO Suspected Sepsis, and Suspected Infection. DEI measures were included in the new report and an additional 42 data variables to capture data for process improvement.

This revision provides data that is more accurate with additional measures for quality and process improvement. Data is extracted daily to identify bolus and antibiotic administration within the appropriate time lengths, order set qualifications, and arrival date time. Restructuring triggers to the hospital's evolution helps support data driven guality initiatives and policies to reduce patient harm and identify and prevent adverse events.





ASSESSING DIVERSITY, EQUITY, AND INCLUSION THROUGH THE LENS OF HEALTHCARE-ASSOCIATED INFECTION PREVENTION

Children's National Hospital

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Central-line associated bloodstream infections (CLABSIs) and surgical site infections (SSIs) are two major types of healthcare-associated infection (HAI) and patient harms that can be prevented by consistently applying evidence-based infection prevention practices. Evaluating CLABSIs and SSIs by race, ethnicity, and gender is essential to identify opportunities in improving infection prevention practices while ensuring equity in patient care. We analyzed two cohorts of pediatric patients under 18 years. The CLABSI cohort includes patients with a central line hospitalized between 1/1/2016 and 12/31/2022, and the SSI cohort includes patients undergoing colon, ventricular shunt, or spinal fusion surgery between 1/1/2016 and 10/31/2022. Patients' self-reported race, ethnicity, and gender were extracted from the electronic registration system. CLABSIs and SSIs are identified using the CDC's surveillance definitions. CLABSI

rate per 1000 central line days and SSI rates per 100 surgeries were calculated for each group within the racial, ethnicity, and gender categories. The analysis revealed the overall CLABSI rate of 0.64, significantly lower than the national rate of 0.8. The self-reported multi-racial and multi-ethnic groups had the highest CLABSI rate of 0.83 and 0.77, respectively. Neither was statistically significantly higher than the Caucasian and Black groups. The overall SSI rate was 3.2, with the Caucasian and Black groups being 2.5 and 2.3, respectively. Both were significantly lower than the multiracial (11.0) and Asian (9.4) groups. The low and similar CLABSI rates confirm the success of our decade-long standard central-line care. The disparity in SSI rates highlights the urgency to improve post-surgery wound care and the discharge processes.



	CLABSI/10 central line
Race	
Asian	0.8
Black or African American	0.6
Caucasian	0.5
Multi-racial	0.8
Native Hawaiian, Pacific Islander or Other	0.7
Patient declined/unknown	0.6
Ethnicity	
Hispanic, Latino or Spanish Origin	0.8
Not Hispanic, Latino or Spanish Origin	0.6
Patient declined/unknown	0.5
Multi-ethnicity	0.8
Gender	
Male	0.6
Female	0.7
TOTAL	0.6

Figure 1. CLABSI rates

0 iys	IRR	95% CI	SSI/100 Procedures	IRR	95% CI
	1.5	0.6-3.5	9.4	3.7	1.4-8.1
	1.2	0.7-1.9	2.3	0.9	0.5-1.7
	Reference	-	2.5	Reference	-
	1.5	0.7-3.3	11.0	4.4	1.6-6.7
	1.3	0.8-2.1	0.0	0.0	0.6-2.3
	1.2	0.4-2.7	6.5	2.6	-
	1.3	0.9-1.8	3.4	1.1	0.5-1.8
	Reference	-	3.1	Reference	-
	0.8	0.2-2.0	5.3	1.7	0.5-4.5
	1.3	0.0-7.2	0.0	0.0	-
	0.9	0.6-1.2	2.5	0.76	0.5-1.2
	Reference	-	3.8	Reference	-
	-	-	3.2		



DECREASING FALL RATE THRU FALL AGREEMENT FORM AND EDUCATION AN EVIDENCED-BASED PRACTICE

Sibley Memorial Hospital

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Celine Dellinger, RN, BSN, MS-BC; Dinah Tibayan, RN, BSN; Anne Durias, MSN RN, MS-BS RN-BC; and Anne McMurray, MSN, RN, RN-BC

Most hospitals have fall-prevention programs and still have high fall rates. In the United States, it is estimated that patient fall incidents in the acute care setting average to 3.3 to 11.5 per 1,000 patient days. The unit's comprehensive unit-based safety program (CUSP) has come up with an initiative to supplement the current fall prevention practices. The objective of this project is to decrease inpatient fall rate from 2.6 per 1,000 patient days to less than 1.7. The survey question is "How will the next patient will be harmed?" and most staff answered FALL. In addition to the current unit's fall intervention, we added the Fall Agreement and Education Form (FAEF) for patients who scored MODERATE or HIGH using Johns Hopkins Fall Risk Assessment Tool

(JHFRAT). It was discussed and encouraged through daily morning huddles and monthly CUSP meeting. The FAEF is comprised of four questions easily answered by the patient and an agreement side that requires the patient to sign under four conditions without coercing/forcing them but having them personally be involved in their care. The criteria for patients included in signing the fall agreement education form are as follows: above 18 y/o, alert and oriented, the papers should be signed within 24 hours of admission. From FY2021 to 2022, the unit had a significant fall rate decrease from 2.6 to 1.2 per 1000 patient days. From 15 in-patient falls to seven in just a year. The FAEF was proven to decrease fall rate in an inpatient Orthopedic floor.

IMPLEMENTATION • Initiated October 2021. Unit staff attended hands-on training about the form • Discussed in daily huddles and monthly CUSP meetings • Nurse Navigators are on-board introducing to orthopedic patients during pre-op teaching • Forms must be signed within 24 hrs of admission **CRITERIA** • All patients admitted to 6B who are alert and oriented • Score as Moderate and High Fall risk on JHFRAT • 18 years old and above



• Visual fall risks signs and fall intervention on patients who score Moderate or High Fall Risk on JHFRAT (Johns Hopkins Fall Risk Assessment Tool)

Fall Education and Agreement Form



THE SAFE SURGERY CHECKLIST

Sibley Memorial Hospital

Cynthia Metz, MSN, RN; and Giovanna Oliveira Silvera, BSN, RN

According to the joint commission sentinel event data, about 12% in 2021 and 6% in 2022 were related to wrong surgery including wrong site, wrong procedure, wrong patient and wrong implant. Efforts for reducing preventable harm has been a focus for health care organizations. Leading causes of preventable perioperative harm are time-out not performed, inadequate staff to staff communication during hand-off and inadequate communication of relevant patient information. The Safe Surgery Checklist was developed at the Sibley Memorial Hospital (SMH), Johns Hopkins Medicine, to provide a quality surgical timeout and ensure safety in the operating room through sharing necessary information in the three key intraoperative stages pre-

anesthesia time out, pre-incision time-out and post-procedure time-out. The Safe Surgery Checklist was implemented at SMH in April 2023. The Safe Surgery Checklist has allowed for a safer surgical time-out practice.

The objective is to describe implementation and utilization of the Safe Surgery Checklist, using descriptive statistics to describe utilization and use of the Safe Surgery Checklist at SMH from May and June 2023. The data is still being collected and in conclusion, a safer surgical process to prevent wrong surgery is needed. The approach should be done in stages to ensure maximum participation from the surgical team as well exchange of relevant information for the procedure.



Figure 1. Pre-anesthesia Timeout Compliance







IMPROVING ACCESS TO EMERGENCY CARE

Sibley Memorial Hospital

Margaret Korkes, MSN, RN, CEN; and Kimberly Anderson-Carroll, BSN, RN, CEN

The emergency department (ED) serves as a crucial access point in providing quality care due to an increase in comorbidities and a lack of primary care. ED volumes continue to increase so understanding why all patients present is of upmost importance. Ensuring they are triaged and evaluated by a provider quickly reduces the number of those that leave without being seen.

To demonstrate that ability to triage patients faster, gets them seen by a provider quicker, thus reducing the number of patients who leave the ED without having their health issues addressed.

Statistics are used to demonstrate a reduction in the time it takes for a patient to have triage completed upon arrival reduces the time it takes to be seen by a

provider, and thus the overall percentage of patients that present for care at Sibley ED who leave prior to being seen. It was determined that a change in process and staffing was needed to accomplish this. At the beginning of FY 2023, a rapid medical evaluation provider was added during peak hours of 12 pm to 9 pm Monday to Friday. In addition, nursing positions were added to support triage with a second nurse from 11 am to 11 pm, six days a week.

In the fourth guarter of FY 2022, the left without being seen rate (LWBS) soared to over 7%, however, the national benchmark goal rate is <2%. This trend continued into the first two quarters of FY 2023. During the same time, triage was completed on all patients within 10 minutes of arrival only 53% of the time and patients were seen by



Figure 1. FY23 - SMH ED Left Without Being Seen Percentages

a provider within 30 minutes of arrival only 47% of the time. As a result of the additional support in triage, during the last quarter of FY 2023 patients had triage completed within 10 minutes 70% of the time and were seen by a provider in 30 minutes 59% of the time. In addition, the left without being seen rate has dropped to 2.7%.

Health care is unaffordable to many people so they rely on the ED as the primary access point for care delivery. This leads to an overcrowded ED and, in turn, many patients may leave prior to being seen by a provider. Implementing strategies to improve timeliness of care will improve the physical, social, and mental health of our community.



FY23 – SMH ED Left Without Being Seen Percentages



EDUCATION & CALL BACKS FOR PATIENTS WITH HYPERTENSIVE DISORDERS OF **PREGNANCY INCREASES ADHERENCE TO POSTPARTUM CARE**

The George Washington University Hospital

Sheetal Sheth, MD; Emily Nuss, MD; Erika Sasaki, MD: Phyllis Harris-White, RN; Lauren Wohl, DPT, CPHQ; Kathryn Marko, MD; and Lisa Cook, RN

The Alliance for Innovation on Maternal Health Hypertension Safety Bundle recommends postpartum a blood pressure (BP) follow-up within 3-7 days of discharge for patients with Hypertensive Disorders of Pregnancy (HDP). Prior to this pilot, only 9% of patients at George Washington University Hospital (GWUH) with HDP met this goal. In January 2023, GWUH initiated a call-back program to increase postpartum follow-up and improve education for HDP patients.

GWUH's OB team identified inpatients with HDP and placed an "HDP Order" in the EMR, which initiated hypertension education and a call-back. A RN called patients 3-5 days after discharge to review home blood pressures (BP), screen for preeclampsia (PEC), ensure medication adherence, and discuss follow-up.

GWUH enrolled 125 patients in the pilot. The RN reached 88 (71%) of patients. 23

patients required medical follow-up, came to triage, or had medications titrated remotely. 40 patients had normal BPs. 25 patients had no BP cuff or were not taking their BPs. 37 patients were not reached, for those patients GWUH successfully facilitated an outpatient follow-up for 17 patients. Of patients enrolled, 63% were Black or African American, yet 92% who had no BP cuff were Black or African American, representing a racial disparity.

The program improved recommended 3-7-day follow-up eight-fold (to 71%) and standardized PEC education. Patients without a cuff were disproportionately Black or African American. GWUH will partner with pharmacies and insurance companies and seek funding to ensure that every at-risk patient leaves GWUH with a blood pressure cuff.

BEFORE

Figure 1. The call back and BP monitoring program improved immediate postpartum follow-up eight-fold (from 9% to 71%) and standardized PEC education for our patients.

38 | DCHA's Quality Showcase



AFTER



Ryan Lin, MD; Paul Lin, MD, FACS; and Juliet Lee, MD, MA, FACS

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL **A CULTURE OF SAFETY BY REPORTING MEDICAL ERRORS**

MEDICAL STUDENTS CONTRIBUTE TO

The George Washington University Hospital

Third-year medical students' role in

the culture of safety is evolving. The

Surgery Clerkship students.

purpose of this study was to determine

what medical errors or adverse events

are observed and reported by third-year

A retrospective cross-sectional study was

performed, examining medical error and

oriented to patient safety, quality measures,

lectures. Descriptive analysis of the reports

adverse event reports. Students were

and event reporting through didactic

and their outcomes was performed.

A total of 126 reports was submitted and 110 reports were deemed appropriate for event

reporting. Students identified concerns centered on patient care (61%), policies and procedures (12.7%), and systems issues (26.3%). The most common outcome of the reporting was education and training for the provider (70%).

This data suggests that medical students are observant of and will report errors if they are taught and made aware of their role in a culture of safety.



Patient Care and Safety



OBJECTIVE LAB BUNDLES FOR URINE TOXICOLOGY TESTING TO REDUCE BIAS

The George Washington University Hospital



Sheetal Sheth, MD, CPHQ; Faridat Folarin-Amode, MD; Jaslyn Piggott, MD; Elizabeth Miller, LGSW; Kris Kohn, RN; and Lauren Wohl, DPT, CPHQ

Perinatal substance use can increase the risk of stillbirth, preterm birth, and low birth weight. Approximately 5% of birthing individuals have substance use disorder (SUD). Fear of arrest, judgment, and loss of custody due to SUD may prevent enrollment in prenatal care or substance use disclosure. This disproportionately affects persons of color, exacerbates health disparities, and hinders access to care. While ACOG recommends universal screening and early identification of SUD to decrease maternal and neonatal morbidity, a universally accepted guideline does not exist.

Using the quality improvement model, a subcommittee developed objective laboratory bundles (OLB) for common clinical scenarios on Labor and Delivery that warrant a urine toxicology (UTox) screen (i.e., systolic BP >200, altered mental status, etc.). A standard consent was created, and providers received education regarding the need for informed consent and

implementation of the OLB. Monthly chart audits assessed patients with UTox testing to determine if objective findings triggered testing and if consent was documented.

96% of patients had an objective etiology for UTox testing after implementation as opposed to 68% before implementation. 70% of patients had documented consent for UTox as opposed to 10%.

Implementation of OLB standardized UTox testing, reduced provider bias and improved consent rates. The OLB act as a checkpoint to evoke provider consideration regarding the reasoning behind ordering a UTox. Future directions include streamlining access to treatment for patients with SUD and expanding to other departments the use of objective bundles for other testing at risk of provider bias.

Only 2 fallouts since implementing objective lab bundle



Figure 1. Results of Implementation of OLB standardized UTox testing





ENSURING CORRECT USAGE OF DYNAMIC APPRAISAL OF SITUATIONAL AGGRESSION SCORING TOOL ON AN INPATIENT

Sibley Memorial Hospital



Ivy Hunt, BSN BC-RN

It was observed that Dynamic Appraisal of Situational Aggression (DASA) screening was being used incorrectly on several occasions in routine chart audits on the Behavioral Health Unit. Workplace Violence has risen significantly over Covid. In a recent study by Press Ganey it was noted that every 6 days a hospital staff member is attacked by a patient. The DASA is a proven and valid tool to predict patient aggression but if the tool is used improperly, it will not be able predict aggression properly.

The Aim of this QI project was to improve accuracy of scoring the DASA tool thus creating a safer environment for patients and staff. Using the Model for improvement (PDSA), chart audits were performed to identify barriers to proper scoring. Based on the results of the chart audits; education via MyLearning Module previously designed was assigned and nurses had to attest to hospital policy by signing

the Aggressive Patient Management policy. Charts audited again to look for improvements in accuracy.

Forty-eight patients' charts were audited for their entire length of stay pre-intervention. They were chosen at random by using a hospital unit census for seven days per month. The charts were audited for DASA Score, nursing notes, social work notes and provider notes looking for keywords found in the DASA scoring tool as well as looking at Aggressive Events flowsheet. Each discrepancy was noted and put into categories. The post chart audits were collected and analyzed in the same manner. Seventy-four charts were audited post intervention and 49 charts audit pre-intervention revealed 77 errors in these categories: Irritability (38), Communication (25), Impulsivity (17) and Verbal threats (2), Not Complete/ No Reassessment (7) Seven aggressive events were documented not reflected, equaling

1.57 error per chart. Intervention was applied to 15/23 nurses that worked on the unit. Seventy-four charts audit post intervention, 78 errors revealed in the following categories: Irritability (21) Communication (9), Impulsivity (6), Not Complete/No Reassessment (42) Verbal Threats (3). Three aggressive events were documented not reflected in DASA scoring, equaling 1.05 error per chart.

The intervention improves the accuracy of DASA scoring. With the increased accuracy the unit will be safer for patients and staff. We will be able to provide interventions for aggression earlier and advocate for more resources including more staff based on acuity of patients. The study may have been more accurate if we included which nurses made the errors and which nurses took the intervention to better isolate if the education itself was the reason for the improvement. Also, would try to ensure more participation by the nursing staff.

DASA Review Quality Improvement Project



Errors Per Chart

Figure 1. Results of Implementation of OLB standardized UTox testing

ADAPTING SAFETY & QUALITY INITIATIVES TO REDUCE CLABSI IN AN ENVIRONMENT OF COMPETING PRIORITIES

MedStar Georgetown University Hospital

Tara Millson, DNP, RN, CIC, FAPIC Shirley Bomhoff, MSN, LSSBB; and Hannah McLaughlin,

MSN, RN, PCCN

A large teaching hospital in the District of Columbia (DC) experienced an increase in variability of central line associated blood stream infections (CLABSI) standard infection ratio (SIR) since the start of the Covid-19 pandemic. Similar challenges were documented nationally by the CDC in the published analysis. In an environment of competing priorities, our challenge was to engage the frontline in creating resilient solutions that make it easy to do the right thing.

The SMART performance improvement (PI) methodology was utilized, combining Lean Six Sigma concepts with high reliability, and change management. The performance improvement team tested and implemented the following interventions:

- Two RN central line dressing change separating soiled and clean tasks
- CLABSI Council and standardized interdisciplinary debrief

- Standardized Electronic CLABSI event review
- Multidisciplinary rounds and "continued medical necessity" dialogue
- CHG bathing reinforcement
- Central line accessing and blood culture ordering practices

Organization wide CLABSI SIR has decreased from a mean of 0.88 (Q3FY20 -Q3FY22) to 0.34 (Q4FY22 - Q2FY23)

Preliminary results at the organization indicate that the Interventions are effective at reducing CLABSI SIR. We plan to spread the interventions system wide. The standardized CLABSI electronic event review will be used to track and trend factors that support sustained improvement.



Figure 1. Pre-Implementation during July and August 2022



Control Chart: MGUH CMS CLABSI SIR: Q1FY19–Q3FY23

QUARTER/FY



WHEN HARM OCCURS: **THE COMMUNICATION & RESOLUTION PROGRAM**

Sibley Memorial Hospital



Sharon Powell, MS, RN, CPHQ

According to a recent Hopkins study, medical errors are the third leading cause of death. People from ethnic and minority backgrounds have higher rates of HAIs, complications, and ADEs. Factors include: bias, stereotyping, clinical uncertainty, language proficiency, patient beliefs, and engagement. Hospitals continue to work to improve care and safety, unfortunately, errors continue. It is important that hospital leadership is transparent with patients and families when these events occur.

Sibley Memorial Hospital launched a Communication and Resolution Program (CRP). CRP is a systematic approach to unexpected medical events that cause harm to patients during hospitalization. CRP requires team members to communicate empathetically with patients and families, review the event, explain what happened, implement processes to avoid

recurrence, and apologize and work towards a resolution, which may include compensation. The process treats disclosure as an ongoing systematic procedure that partners the clinical team with CRP leadership, Risk, Safety and Claims. It also activates support for the healthcare team involved.

CRP has become active in the organization. Providers are reaching out to leadership when issues arise to facilitate CRP discussions as necessary. Through CRP, hospitals and liability insurers proactively offer compensation. A recent study by hospitals in Massachusetts showed that only 5% of events led to malpractice claims or lawsuits. Their findings suggest that CRP will not lead to higher liability costs when hospitals adhere to their commitment to offer compensation proactively.



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DCHA is a unifying force advancing hospitals and health systems in the District of Columbia by promoting policies and initiatives that strengthen our system of care, preserve access, eliminate disparities, and promote better health outcomes for patients and communities.

DCHA's Quality Collaborative, comprised of hospital and health care leaders, provides an advisory role on identification of priorities that lead to the District's hospitals becoming recognized leaders in high quality, safe and innovative patient care. Learn more about the Quality Collaborative at dcha.org/quality-safety/ dcha-quality-collaborative/.