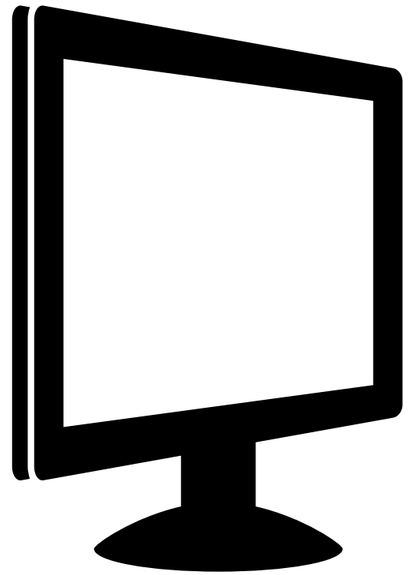
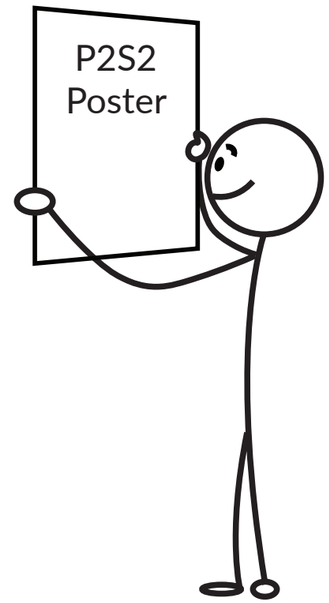
THE SHOW MUST GO ON

Our annual conference, the Pennsylvania Patient Safety Summit (P2S2), may have been canceled due to the pandemic, but that doesn't mean you have to miss out completely. Here are summaries of four quality improvement projects that would have been displayed as academic posters.





"Walking Out" VTE on an Orthopaedic Unit

Allegheny Health Network—Forbes Hospital
Dennise Gitzen, MSN, RN

Description: Venous thromboembolism (VTE) events affect nearly 600,000 Americans annually and are directly or indirectly responsible for at least 100,000 deaths per year. VTE events impact hospital quality, safety, and value-based programs. Also, missed doses can impact our VTE rate and are a cause for alarm. During 2018, 39% of our VTE events were attributed to our Orthopaedic unit.

Baseline data: Two indicators were selected for baseline metrics: VTE events and missed doses. In 2018, there were 2 to 4 VTE events quarterly for this unit. Any VTE event that was coded as Orthopaedic or Neuroscience was reflected in the data. The percentage of missed doses (VTE SQ prophylaxis) was also tracked and trended. The baseline for missed doses was approximately 20%.

Interventions: An audit tool was developed for interdisciplinary walking rounds. Baseline data and the go-live date were shared with the Orthopaedic staff. Rounds were standardized at every other Tuesday from 11 a.m. to 12 p.m. and began November 2018. Staff and patients were engaged during rounds for education and feedback. Real-time problem solving occurred during rounds, e.g., replacing missing equipment. VTE medication was reviewed for documentation errors, e.g., missed doses, and reconciled with antithrombotic guidelines. Educational tools were placed in admission packets for reference.

Results: The number of VTE events in 2019 Q1 was zero. The percent of missed doses declined from approximately 20% to 11% (a 9% improvement).

Relevance: Nursing leadership is imperative to improving the quality and safety of our patients. Strategies such as walking rounds empower the staff to make improvements in real time, address concerns, and involve the patients in their care. With the success of our pilot unit, this proactive approach has been adopted and spread to our other medical-surgical unit.

Reducing Complications Through the Implementation of ProvenRecovery™

Geisinger; Rachel Van Loan, BS; Thomas Hoffman, MS; Grant Walter, MS; Mary Connell, CRNP; Steven Endress, MSN; and Joseph Mlinarich, MBA

Introduction: ProvenRecovery™ is a modification of a similar program known as Enhanced Recovery After Surgery (ERAS®). Literature identifies that through implantation, organizations have improved complications and decreased length of stay (LOS) and cost for colorectal and other surgeries.

Aim: In implementing ProvenRecovery™ for elective surgeries, the goal was to reduce complications by 10%, LOS by 5%, readmissions by 10%, and cost by 5% overall for colorectal, hysterectomy, craniotomy, spine, plastic, cystectomy, vascular, transplant, and bariatric surgeries by July 2019.

Methods:

- Provided patients with an overview of their surgery and discharge expectations
- Established standard orders
- Provided immunonutritional supplication five days pre- and postsurgery
- Utilized opioid-sparing techniques intraoperatively and postoperatively
- Developed standard guidelines for early ambulation

Discussion: Despite early implementation struggles across nine service lines, we have exceeded our goals and can show an overall cost savings of over $3 million dollars from our two-year baseline after one year of implementing programs. Primary assessment shows that complications have a direct correlation to LOS, cost, readmissions, and mortality, and the program has the ability to transition across multiple elective surgeries with improved outcomes. Current implementation of similar programs like ERAS® have shown similar results, but lack the aggressive spread of this methodology to other service lines.

Conclusion: ProvenRecovery™ spread over multiple procedures and service lines has shown the ability to reduce complications and improve patient outcomes, implying that based on our results there is benefit to continue spreading the program quickly and expand to emergent surgery. Further investigation is needed into the amount of opioids that are prescribed during and at discharge to ensure that pain is controlled.

MOVES Program for Hospitalized Patients

Conemaugh Memorial Medical Center; Michelle Wozniak, MSN, and Jane Drzewiecki, BSN

Description: For most patients, hospitalization results in prolonged periods of bedrest even when they have the ability to walk. Although immobility is known to cause functional decline or complications, inpatient ambulation emerged as the most often missed element of nursing care. Hospitalized older adults are often discharged from acute care hospitals with activities of daily living functioning that are worse than their baseline functioning. As the model of physical therapy changed from daily visits to the concentrated model that is used today, physicians rely more on the nursing staff to ensure that patients are out of bed. To encourage staff to make ambulating patients a priority, the Move Often, Very Early, and Safely (MOVES) program was created.

Intervention: A nursing-driven, evidence-based assessment to evaluate if a patient is medically stable for ambulation is performed. Then a second assessment is completed to determine the level of assistance needed for ambulation. The ambulation protocol requires nursing staff to ambulate all patients scoring a 3 or a 4 a minimum of three times a day. At the end of 2019, patients scoring a 2 on the ambulation assessment were required to be up to a chair twice a day as well. Electronic documentation was added to our EMR [electronic medical record] to include the assessment as well as to monitor for ambulation compliance. Compliance graphs were added to the nursing quality dashboard.

Results: Timeline graphs showing improvement in length of stay, hospital-acquired pneumonia, venous thromboembolism (VTE), and the readmission rate are included on the poster. PDSA (Plan-Do-Study-Act) is the applied methodology. Data obtained through LifePoint data analytics from implementation through Q2 of 2019 show a decrease in length of stay from 6.25 in Q1 2017 to 5.69 in Q2 2019, decrease in hospital-acquired pneumonia and deep vein thrombosis (DVT), and a decrease in the readmission rate from 14.3% to 11% in Q2 2019.

Discussion: In conclusion, implementing an early mobility program improves care quality in a hospital setting.

Safety Reporting Across the Care Continuum

WellSpan Health;
Stacey Goldfarb, BSN, RN

Background: WellSpan Health is an integrated delivery network with all components of the care continuum except for skilled nursing facilities (SNFs). To improve care coordination and patient outcomes with SNFs and other post-acute care providers, WellSpan developed a preferred provider network (PPN).

Care transitions are critical phases in a patient's care journey which are prone to errors and hence safety concerns. Traditional safety reporting systems do not transcend silos for multiple entities and care settings to report and evaluate transition-related patient safety events. Additionally, traditional safety reporting systems lack interoperability to capture safety events that may occur for SNF patients receiving care in the outpatient setting.

Objective: WellSpan Health identified an opportunity to create and implement tools which allow stakeholders across the continuum to utilize a standard method to report patient safety events. For quality improvement, workflows are necessary to review and investigate these concerns. A key value was established to share learning from safety investigations with involved colleagues and promote shared learning among other facilities in the network, thus potentially preventing similar incidents in future. A mechanism for tracking and trending events was necessary to study the impact of interventions initiated after investigating an event or a pattern of error types.

Method: WellSpan Health utilizes a third-party vendor (TPV) safety portal to capture and analyze safety events originating in WellSpan facilities or on WellSpan grounds. On July 1, 2018, the TPV safety portal was modified to allow WellSpan employees to begin reporting non-WellSpan, post-acute safety events. PPN SNFs do not have access to the TPV safety portal. In February 2019, a safety reporting tool was added to the Post-Acute Portal. This tool provided the PPN facilities a venue for submitting WellSpan transition of care–related safety concerns. This functionality has created bidirectional, cross-continuum safety reporting capability.

Analysis: The enhanced patient safety reporting system has resulted in increased reporting focusing on patient-centered care while maintaining a just culture philosophy. Increased reporting has allowed opportunities for clinicians in acute care and post-acute care to collaborate regarding safety issues impacting mutual patients. Event investigation has led to education, standardized communication processes, and focused discussions.