RSA 151-G: 1, established the New Hampshire Health Care Quality Assurance Commission. Its intent is to enable health care providers to share information about adverse outcomes and prevention strategies in learning environments which foster candor and self-critical analysis while maintaining the confidentiality of the information submitted to the Commission, the proceedings of the Commission, and the results of the Commission’s deliberations.

Members of the Commission include one representative from each acute care hospital and free standing ambulatory surgical center (ASC), an “at large” public member and the designee of the Commissioner of the Department of Health and Human Services.

Members of the Executive Committee include:

Chair  
Scott Goodwin, D.A., RN, CPHQ, LSSBB  
Vice President/Chief Quality Officer  
Catholic Medical Center, Manchester

Vice-Chair  
Marge Kerns, RPh, VP Clinical Support Services, LRG Healthcare, Laconia

Immediate Past Chairs  
Stephanie Wolf-Rosenblum, MD, FCCP, MMM, Chief Medical Officer, Southern New Hampshire Medical Center, Nashua  
Jean Corvinus, RN, BSN, MS, CPHQ, Director, Quality & Performance Improvement, Frisbie Memorial Hospital, Rochester

At Large  
Sue Majewski, Chief Operating Officer, Bedford Ambulatory Surgery Center, Bedford  
Lori Key, RN, MBA, Director QA & Safety, Dartmouth Hitchcock Medical Center, Lebanon

The officers serve one year terms.
During its ninth year, the Commission met five times on the following dates:  

During the past year Thomas Bunnell served as the public representative, appointed by Governor Lynch in 2012. Mr. Bunnell helps add value by bringing the public perspective and ideals to our discussions.
Executive Summary

The following principles are used as a guide by the Commission in our efforts to promote high quality and safe care to all patients seeking services in our organizations:

✔ Promote High Reliability Organizations
  o Improving systems and standardizing processes to yield best outcomes and avoid harmful choices.

✔ Adopt Evidence-Based Best Practices to Improve Outcomes
  o Using scientific studies to select interventions that are proven to improve outcomes and avoid harm.

✔ Establish ‘Just Cultures’ within our Organizations
  o Creating cultures of safety where staff and providers involved in an error are treated fairly in the investigation process and we clearly understand contributing factors that involves differentiating system failures from human failures.

Prevention of Harm topics the Commission worked on this year included:

✔ Focusing on expanding the utilization of a Surgical Checklist to mean more than a tool, and incorporating elements of culture and team work into the surgical environment

✔ Examination and adoption of best practices to prevent healthcare acquired infections, with particular focus on environmental aspects of infection risk and surgical instruments / central sterile supply practices

✔ Understanding definitions of serious harm and the new types of serious reportable events required to be reported due to revisions of state statute

✔ Utilization of key learning from adverse event investigations at our hospitals and ASCs to prevent harm in other facilities

✔ Shared learning and best practices from the National Partnership for Patients initiative

✔ Adoption of healthcare wide prevention strategies for Venous Thromboembolism (VTE) – potentially fatal blood clots

✔ Continued encouragement of Just Culture adoption in Healthcare Organizations and ongoing education using practical examples of its application through Storytelling

✔ Exploring new approaches to hand hygiene initiatives, education and audits at our facilities

✔ Sharing ways that organizations engage staff and physicians in process improvement efforts aimed at improving patient safety and quality

The ninth year of Commission work demonstrated an ongoing commitment to Patient Safety and Quality Care by Hospitals and Ambulatory Surgical Centers in NH.
ACTIVITIES OF THE COMMISSION

The Commission is working under the protection of RSA 151:13a. Therefore, all new members received an orientation and signed confidentiality agreements, to allow for free exchange of sensitive information from members. All meetings were coordinated and meeting minutes were recorded by an administrative representative of the Foundation for Healthy Communities.

The Executive Committee met or held conference calls prior to meetings to set agendas and to suggest topics that reflected current priorities focused on eliminating harm and improving quality. Subcommittees of the Commission, i.e., Adverse Event Reporting met as needed to propose options for collaboration or recommendations for the statewide adoption of best practices. The group is highly committed to learning from one another through data gathering and the sharing of best practices about how to provide better and safer care to patients.
**High Reliability Organizations**

**Time Out & Patient Safety Checklists**

*The goal of the time out and checklist is to promote safety by verifying key risk factors associated with surgical procedures.* This includes verification of the right patient, for the correct procedure, on the correct side of the body, and also ensures that staff is prepared for any unusual circumstances that may arise.

Since its adoption in 2009, quarterly monitoring of the timeout and checklist process has been conducted. The greatest opportunity we have as a state is getting the team to focus on the time out at the time it is initiated. Despite adoption of the Surgical Safety Checklist, surgical errors persist. The results of ongoing quarterly checklist audits were regularly reviewed by the membership to gain better understanding of the issues. Members shared current practices and policies. Audit practices were also discussed, as a means to “coach” surgical teams to adopt best practices associated with use of the surgical checklist. Who initiates the checklist varies across organizations, and many have incorporated the surgeon to be responsible for this role in their policies.

Learning from ongoing events at organizations, members concluded that the checklist is one tool that offers a check for safety but that team behaviors are the key to prevention of surgical error. The following behaviors were identified as key to improving safety in the surgical area:

- **Engage the team:** set the tone, set expectations, open two-way communication – with a focus on all members engaging “in the moment”.
- **Introduce the patient:** enables the team to think about the patient, not just the surgical case – by personalizing the case to the patient and their goals, it brings a different level of patient engagement into the operating room.
- **Set safety focus:** role-model safety measures (e.g. respect to time-out, sterility, & count policies) – this is done with an awareness of the fast pace of the operating room and the pressure to adhere to surgery start times, but safety has to be the main focus.
- **Empower the team to speak up:** solicit feedback and input – the focus is that everyone’s role is to support the surgeon so that patient has a successful outcome, but there needs to be reinforcement from the surgeon that no issue is too small.

Additional resources:
[https://www.ecri.org/Documents/Patient_Safety_Center/Wrong_Site_Surgery_Prevention.pdf](https://www.ecri.org/Documents/Patient_Safety_Center/Wrong_Site_Surgery_Prevention.pdf)

**Conclusion:** There is a palpable shift in safety culture in our surgical areas and we are seeing more providers step up to lead the timeout process. We will continue to share and learn from each other as innovative models are introduced in this setting.
Management and Prevention of Healthcare Acquired Infections

The goal in all healthcare organizations is to reduce and eliminate opportunities for exposure to infection. ALL New Hampshire Hospitals are “Chasing Zero”, meaning we want to achieve zero healthcare associated infections.

Hospitals and ASCs are submitting their institution’s infection data, as required by law, to the National Health Safety Network (NHSN) or the NH Healthcare Associated Infection program. The 2012 Healthcare Associated Infection (HAI) Reports for Hospitals and ASCs were distributed to all members and results reviewed. The report represents the first summary of HAI-related data reported by ASCs in New Hampshire.

Overall results for NH include:

- Statewide hospital infection rates were lower than expected based on national data. A total of 198 HAIs were reported, representing 116 surgical site infections, 21 central line-associated bloodstream infections, and 61 catheter-associated urinary tract infections. The overall observed number of HAIs in NH hospitals was 25% fewer than expected based on national data. There were 54% fewer central line-associated bloodstream infections and 29% fewer surgical site infections. There were 11% more catheter-associated urinary tract infections but this was not statistically significant and was considered similar to national data.

- Statewide hospital HAIs in 2012 increased compared with 2011 because catheter-associated urinary tract infections and SSI following abdominal hysterectomy were added to hospital reporting requirements and account for the increased number of infections. This difference was not statistically significant (110 HAIs reported in 2011, representing 85 surgical site infections and 25 central line-associated bloodstream infections).

- Statewide ASC infection rates were lower than expected based on national data. A total of four surgical site infections (SSIs) were reported by the 12 ASCs that were licensed for the entire 2012 calendar year and were required to report these data. The overall observed number of SSIs in New Hampshire ASCs was 43% fewer than expected based on national data.

Results of staff influenza vaccination rates were discussed. It is noted that those organizations with healthcare personnel vaccination policies in place had significantly higher rates of influenza vaccination as a whole (92.8%) than hospitals without mandatory policies (76.8%). These policies often required unvaccinated employees to wear a mask during influenza season and accepted various medical, philosophical, or religious exemptions. Members shared how they approached policy development and implementation with practical examples that others were able to consider.

Source: 2012 Healthcare Associated Infection Report

Conclusion: Overall these results show that New Hampshire is on the right track to reducing HAIs in the state. Members were also provided many references, resources, webinars and workshops on HAI related topics via the Partnership for Patients initiative.
Measures of Surgical Quality of Care and Safety

The Surgical Care Improvement Project was designed to assist in measuring clinical interventions that are proven to reduce complications. The most current data is available for the public on the website www.nhqualitycare.org

Prevention of complications from surgery can include:

- Prevention of post op infection
  - Appropriate selection of antibiotics given before surgery and discontinued soon after surgery
  - Maintaining Blood Glucose levels within normal parameters can assist in faster post-operative healing and infection resistance.
  - Removal of the urinary catheter soon after surgery to prevent urinary tract infection (UTI)

- Prevention of Blood Clot Development (Venous Thromboembolism - VTE)
  - Blood thinning medications until patient is able to resume normal mobility
  - Mechanical compression devices to increase circulation in lower legs while on bed rest

- Prevention of Heart Attack or other cardiac complications
  - Timely medications during the perioperative period for high risk patients

Our hospitals have been participating in submission of this data for several years and continue to keep pace with new care practices that prove that we can better protect people from harmful preventative complications. Another source for information on this project is on the CMS Hospital Compare website: http://www.medicare.gov/hospitalcompare/search.html

**Conclusion:** New Hampshire hospitals continue to score in the top percentile for care we provide to prevent surgical infections and complications. CMS has established the achievable benchmark for these measures at 100%. NH hospitals will continue to pursue excellence in this area.
Adopt Evidence-Based Practices to Improve Outcomes

Adherence to Hand Hygiene Practices


Since April 2008, hospitals and ambulatory surgical centers have voluntarily monitored hand hygiene compliance within their institutions using trained observers. It is well known that one of the primary ways to decrease infections is by using evidence based practices for cleaning hands before and after contact with patients and with their environment; hence this is a basic yet critical aspect to improving outcomes and reducing harm from healthcare associated infections. In 2013, the reported rate of hand hygiene adherence was 91% based on almost 91,000 observations. This is compared to initial report of 83% in 2008 with nearly three thousand observations.

During the course of the year, the Partnering to Heal Video was viewed, shared and distributed to all members. This educational video helps remind us of the importance of individual accountability and reinforces the need to have a culture of safety which promotes speaking up to coworkers and providers who may “forget” to wash hands. Each organization has a fact sheet about the program and link to the video. All were asked to view it at their respective organizations and many have incorporated it into or are considering using the video for orientation and training.

Hand Hygiene is the most important intervention for preventing Healthcare Associated Infections
Commission members continue to acknowledge that a successful infection prevention campaign requires a continued, vigorous approach at the unit level with strong leadership support and requires regular feedback to staff to optimize results. At the most recent meeting the commission members expressed concerns with how valid this data is, since each organization may vary in their surveillance and collection methods. The Commission concluded that ongoing reminders and updates to staff on performance make a difference. This summer a subcommittee will meet to discuss other ways to approach standardizing audit methods and data collection. Another factor to be considered is the engagement of the public in their own hand hygiene practices and their awareness and expectation that providers and staff clean their hands prior to contact.

**Conclusion:** New Hampshire continues to have every hospital and ambulatory surgery center committed publicly and at the leadership level to this important process improvement initiative. The Commission will continue to pursue improved methods to validate data and the standardization of data collection.

**Serious Reportable Events / Adverse Events**

In January of 2010, hospitals and ASCs began reporting adverse events to the Bureau of Health Facilities Licensing as required by RSA 151: 38. The law was revised in 2013 and members of the commission focused on understanding the revised law and how to accurately apply definitions of events. The events are based on the National Quality Forum’s (NQF) revised list of twenty-ninety discrete adverse medical events, known as serious reportable events (SREs). To ensure that all patients are protected from injury while receiving care, NQF has developed and endorsed this set of SREs. This set is a compilation of serious, largely preventable, and
harmful clinical events, designed to help the healthcare field assess, measure, and report performance in providing safe care.

Events fall into the following Categories:
- Surgical or Invasive Procedure Events
- Radiologic Events (New)
- Product or device
- Patient protection
- Care management
- Environmental
- Criminal

Staff from the Bureau of Health Facilities Licensing attended Commission meetings to discuss changes in the law and how the annual report could be made more meaningful and informative for the general public. It is anticipated that the number of events reported will increase due to adoption of the new, broader list of events.

Members continue to report events to the Commission which helps foster candid and honest discussions, while probing systems failures and/or weaknesses. The activity and corrective actions taken are helpful to everyone, but most importantly to the patients we serve. Hospitals and ASCs not only shared specific events, but they also described their processes for closely monitoring any serious events which cause harm or the potential for harm.

The commission has been discussing and examining the root causes of these adverse events for several years and it is profoundly aware of the complexity within our hospital systems that creates and can set up an event to happen. James Reason wrote in 1997 that complex systems are like a set of layers of Swiss cheese. When the systems fail at each level, the holes align and allow errors to reach the patient. The objective is to keep each step from failing and building better steps. Organizations build multi step processes. However, from time to time a step fails and allows harm to reach a patient. The Commission focuses on systems that incorporate hard stops and corrections to prevent failure.

Discussion also encompassed the hard work staff and physicians undertake to understand why these events happen and how they can be prevented. Typically this process involves gathering a team in a timely manner to closely examine the factors that led to the event, also known as conducting a Root Cause Analysis (RCA). Factors commonly found via a RCA can include:
- Communication systems and breakdowns
- Orientation & training gaps

- Equipment malfunctions
- Failure to follow policies or protocols
- Failure to update and / or add new policies
- Confusion about roles and responsibilities and scope of duties

**Conclusion:** The goal of RSA 151:39 is to “facilitate quality improvement in the health care system” by increasing awareness of why events happen and how to prevent them from happening again. Individual facilities use the findings from their root cause analyses to prevent a repeat of similar events. Commission members continue to share, discuss and learn about root causes of adverse events that occur in our facilities.

**Eliminate Harm: Live Clot Free NH → Partnership for Patients**

In 2010 the CEOs and Board of Trustees at every acute care hospital in NH agreed to support the goal of eliminating harm by 2015. The Commission became a project implementation partner in this effort, with an initial focus on prevention of venous thromboembolism. In 2012, the Eliminate Harm Initiative work was transitioned into the efforts of the Partnership for Patients. Commission members are involved in many ongoing initiatives designed to reduce the occurrence of adverse events. The workshops offered via this Partnership served as a forum for bringing all elements of a successful healthcare acquired condition (HAC) prevention program to participating hospitals and their prevention teams. Participation in the Partnership for Patients initiative is a good fit for the Commission as goals and projects align with the Commissions principles of high reliability, adoption of evidence based practices and encouragement of a Just Culture in our organizations. Participation in this project allowed 3700 hospitals across the country to learn from each other on what works and is effective in prevention of harm. The approach in NH was to include all ASCs and other partners involved in providing care to our patients along the continuum. NH champions from local hospitals and community settings also served as faculty to provide supportive information relevant to all facets of successful programs through peer to peer/coaching panel sessions.
The Partnership for Patients is focused on making hospital care safer, more reliable, and less costly through the achievement of two goals:

- **Making Care Safer:** Preventable hospital-acquired conditions would decrease by 40%
- **Improving Care Transitions:** All hospital readmissions to be reduced by 20%

The Partnership for Patients includes the following areas of focus:

1) Adverse Drug Events  
2) Catheter Associated Urinary Tract Infections  
3) Central Line Blood Stream Infections  
4) Injuries from Falls and Immobility  
5) Obstetrical Adverse Events  
6) Surgical Site Infection  
7) Venous Thromboembolism  
8) Ventilator Associated Events  
9) Pressure Ulcers  
10) Readmissions

Patient and family engagement is also a critical component of this initiative. There are data collection requirements for our hospitals in all of the above areas which allow us to compare performance nationally as well as statewide. Another source for information on this project is on the website: [http://partnershipforpatients.cms.gov/](http://partnershipforpatients.cms.gov/)

**Conclusion:** The two goals of the Partnership for Patients are in alignment with eliminate harm and the mission and principles of the Commission.

**Healthcare Acquired Infection Exposures**

Over the past couple of years, there were two significant healthcare acquired infection exposures to patients reported. In 2012, a NH hospital experienced a significant hepatitis C outbreak which caused immeasurable harm to the patients, staff and the organization. Building upon the initial response in 2012, we continued to explore best practices for medication safety, in particular securing controlled substances, and shared resources for staff education about detection and awareness of drug diversion in the health care setting. Members were kept apprised of legislative activity occurring as a result of this outbreak.

Last year, there was a report of a patient with Creutzfeldt-Jakob disease (CJD) and potential risk of exposure to other patients through the use of equipment borrowed for a specialized procedure which may have been contaminated. Dr. Elizabeth Talbot, the Deputy State Epidemiologist who was the lead person on the CJD investigation, provided a detailed description of the investigation and time line of events at a Commission meeting. She also shared her expertise on the infectious diseases and quality control issues related to it. She offered an in depth review and analysis of the event involving the death of a patient with Creutzfeldt-Jakob Disease (CJD) and the potential exposure to another group of patients who had surgery that utilized some common instruments. Throughout her presentation, Dr. Talbot posed questions for discussion and reinforced the role of public health in the setting of potential outbreaks. The perspective of the hospital’s approach to responding to an event of this magnitude and nature was also shared.

**Conclusion:** Members reinforced the importance of prioritizing staff education in the areas of potential HAI exposures through possible drug diversion and contaminated equipment as well as preventing the risk of this occurring.
Establish a ‘Just Culture’
Transparency is an essential component of creating a Just Culture, especially when mistakes happen or harm occurs. How and when to communicate the occurrence of such an event to a patient or family members is not always readily understood or comfortably done by clinicians in these situations. The concepts of a Just Culture offer our organizations a means to fairly evaluate systems issues while ensuring personal accountability.
One organization shared their experience of a surgical adverse event and how the organization investigated the systems issues as well as behavioral factors that contributed to the event. As a result, the organization mandated education for all surgical staff and providers. They work on preparing them to develop teams while improving the processes that also contributed to the event. This is an excellent example of the role the Commission serves as a forum for sharing events and learning from each other.
We also employed the use of panel presentations by members who shared their approaches on how they engage staff and physicians in this important work, thus promoting a culture of safety throughout their organizations.

Conclusion: Members shared various ways they are engaging their organizations and staff in promoting a just Culture. An organization policy on Just Culture was shared by a member and is being adapted by others. The power of storytelling continues to be one of the strongest ways to model components of a Just Culture.

Summary
Year 9 has continued to bring NH hospitals and ASC’s together to focus on the prevention of harm and continuous learning. Hospitals and ASC’s are clearly supporting the efforts of the Commission as a primary lead in promoting the best patient safety practices.
The Commission will begin Year 10 in July 2014 with a continued focus on decreasing preventable harm by promoting high reliability organizations, adopting evidence-based best practices and continuing work to establish ‘Just Cultures’ within each institution. See framework for future activity on following page.
The Commission voted to adopt this ninth year report of the New Hampshire Health Care Quality Assurance Commission. All public documents as well as educational materials related to the Commission and its improvement activities can be found at www.healthynh.com.

For questions, please call: Scott Goodwin, 2013-2014 Commission Chair: 663-6509 or Anne Diefendorf, Administrator, 415-4271.

Respectfully submitted,

Anne Diefendorf
Administrator,
NH Health Care Quality Assurance Commission
# Framework for Commission Activity for 2014-2015

<table>
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<tr>
<th>Patient Safety Opportunities</th>
<th>Data Sources determining opportunity</th>
<th>Actions Commission is taking to improve</th>
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| Surgical & Procedural Safety | 1. Adverse Events Reported  
2. Surgical Checklist data  
3. Surgical Core Measures  
4. Partnership for Patients Educational Sessions | • Surgical Safety Subcommittee  
• Share Checklist Data  
• Discuss Root Causes of Adverse Events  
• Share protocols, and system re-designs to prevent future events |
| Adverse Event Reporting and Prevention | 1. State Adverse Event report  
2. Self-Reported Data to Commission  
3. Review of events in our hospitals at commission  
4. Shared information from Public Health  
5. Information from Dept. of Health & Human Services | • Adverse Event Subcommittee to focus on events and collaborate with Licensing & Regulation Services  
• Block time on Commission agendas for Hospitals / ASCs to share stories of AE and the subsequent findings from the investigations |
| Reduce Healthcare Associated Conditions  
- VTE prophylaxis  
- Hand Hygiene practice  
- Medication diversion prevention and detection  
- Use of infection prevention bundles | 1. Infection Data reported to NHSN & HAI program  
2. Occurrences of healthcare acquired VTE  
3. Hand Hygiene data  
4. Shared policies and practices on security of medications.  
5. Data submitted to Partnership for patients on all HACs  
6. Data shared on Readmissions and Care Transitions | • Monitoring data for trends  
• Asking top performers to share policies and practices  
• Looking for ways to keep Hand Hygiene a priority for all |