Planning for Never Events
July 22, 2012
2:15-3:30pm

“Never” Events

Today’s Speakers

Kathleen Glendening, M.P.H., B.S.N., N.H.A.
Corporate Director, Clinical Services,
Catholic Health East

Aysha Kuhlor
Director, Clinical Services, Saint Mary Home,
Vice President (NADONA)

Objectives for Today’s Presentation

• Learn the history of how the “Never” Event programs were initiated and developed.
• Learn the characteristics of a Culture of Safety.
• Explain the data collection reporting process, and the dashboards of the “Never” Event programs.
• Learn the “5 why” method used for analysis of “Never” Event data.
• Understand how the “Never” Event programs are linked to Financial Considerations and Value Based Purchasing.
• Discover how the “Never” Event programs integrate with initiatives to reduce Rehospitalizations & ED outcomes.

Objective:
Learn the history of how the “Never” Event programs were initiated and developed

Kathleen Glendening

FACT:
Adverse events in healthcare are one of the leading causes of death in the United States today.

What the Final Rule Says

The final rule addresses non-payment for hospital-acquired conditions by:

- Explaining the criteria used to adopt a policy of nonpayment for reasonably preventable hospital-acquired conditions.
- Suggesting currently available standards and guidelines that hospitals can adopt to help prevent hospital-acquired conditions.
- Creating a new coding process that will indicate to CMS that a hospital-acquired condition was present on admission (POA).
- Defining circumstances under which CMS will continue to pay for treatment of hospital-acquired conditions.

The Affordable Care Act - 2010

The Affordable Care Act (ACA) required the Secretary of Health and Human Services to "establish a national strategy to improve the delivery of healthcare services, patient health outcomes, and population health.

HR 3590 & 3011, amending the Public Health Service Act (PHSA) by adding 399HH(a)(1)

The principles of the National Quality Strategy are:

What is a “Never” Event?

The National Quality Forum, a non-profit national coalition of physicians, hospitals, businesses, and policy-makers, has identified 28 events as occurrences that should never happen in a hospital and can be prevented.

“Never” Events are PREVENTABLE medical errors.
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HHS 2011 National Quality Strategy: Six National Priorities
1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family are engaged as partners in their care.
3. Promoting effective communication and coordination of care through the continuum of care.
4. Promoting the most successful prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to support wide use of best practices to enable health living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Where did we start?
Recommendations for our Long Term Care “Never” Events

FACILITY-ACQUIRED ONLY
1. High-risk pressure ulcers
2. Falls with injury
3. Medication errors that require additional monitoring due to potential side effects and beyond (actual harm)
4. Infection resulting in unit and/or facility outbreak
   - Acute care readmissions within 30 days
   - ED visits within 30 days without hospitalization

What will make us successful?

Plan

Jan 2011:
- Begin data collection, education for prevention strategies

Jan 2011:
- Develop Committees for each “Never” event and associated RHC action plans

Ongoing:
- Ongoing support for, education/implementation, monitoring, evaluation, feedback, and strategic plans
- Educate to ensure contractors, associations, and stakeholders are aware

March 2011:
- Begin reporting to internal and external audiences

Ongoing:
- Use data to make improvements
- Ongoing feedback, education, monitoring, evaluation, feedback, and strategic plans

Annually:
- Revisit tools, definitions, constructs, what else needs to be added?
Never Events - 2012 Plans

Falls with Injury

Education
- Dr Quigley Series of Conference Calls
- Risk Assessments
- Risk Fall Huddles / After Action Reviews
- Staff Compliance

Best Practices
- Implement Culture of Function
- Focus Philosophy
- Risk / Safety Rounds Audited by Team
- Communication with Staff Involving Changes
- Interdisciplinary Rounds at the “Scene”

Infection Control - Outbreak

Education

Learning Sessions Topics:
- Preventative Measures to Avoid Outbreaks
- How to Read and Interpret Monthly Lab Reports & Summaries
- Getting Ready for End of Month Report and Quality Assurance Meetings

Best Practices
- Excellent Speech Pathologist: early identification prevent aspiration pneumonia

Infection Control - Outbreak

Learning Sessions Topics:
- Preventative Measures to Avoid Outbreaks
- How to Read and Interpret Monthly Lab Reports & Summaries
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Best Practices
- Excellent Speech Pathologist: early identification prevent aspiration pneumonia

Bundle for Medication Errors Prevention

Right patient
- Check, double check, re-check before administering the medication to make sure it is the right patient
- Check patient’s chart
- Check bed side chart
- Check patient’s face
- Check patient’s voice

Right medication
- Check the bottom of the medication bottle
- Check the label
- Check the order
- Check the medication
- Check the physician’s order
- Check the physician’s name on the medication
- Check the medication’s expiration date

Right dose
- Check the right dose for the medication
- Check the dose in the order
- Check the dose on the medication
- Check the dose in the PAM

Right route
- Compare the route on the label to the PAM
- Compare the route on the label to the order
- Compare the route on the label to the physician’s order
- Compare the route on the label to the pharmacy

Right frequency
- Compare the frequency in the PAM to the order
- Review the frequency in the PAM
- Review the frequency in the medication
- Review the frequency in the order

Right documentation
- Check the chart at the time the medication is given
- Check the chart at the time the medication is given
- Check the chart at the time the medication is given
- Check the chart at the time the medication is given

Due to the importance of accurate medication administration, it is crucial to follow the bundle for medication errors prevention to ensure patient safety and adherence to treatment protocols.
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Indicator Data Collection Form

Clear identification of each of the 4 “NEVER” Events Care Dimensions
Defined definitions involving measurement of the 4 areas
Development of Constructs using Evidence Based Criteria:

- Falls – Resident Assessment Instrument, RAI Manual
- Medication Errors – American Pharmacist Associate, APA
- & Victorian Consultant Pharmacist, VCP
- Infections Outbreak – CDC Definitions, Mc Geer’s Criteria
- PUs – Resident Assessment Instrument, RAI Manual & Braden Scale

System-wide communication and education on indicator tools, process and collection of the data

Falls with Injury

Major Injury

Construct: Falls with Injury

Total # Resident Days for the Month

X 1000

Long Term Care Clinical Indicator Data Collection Form

CARE DIMENSION: Resident Falls with Major Injury

INTENT:
Consistent with our values of providing a full range of services that support healthy individuals and to improve the quality of care in our facilities, we are committed to fall prevention. To improve the overall quality of life for residents, we need to measure the outcome of fall prevention efforts.

RULES/DATA COLLECTION INSTRUCTIONS:

NUMERATOR – DEFINED AS:

Total # of Documented Falls which Resulted in Major Injury

Total # Resident Days for the Month

DENOMINATOR – Major Injury:

Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma. Injury related to a fall – Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

DEFINITIONS FALL:

RAI Manual

Unwitnessed Fall: either self-reported or when a resident is found on the floor or other object but no one knows how he/she got there.

Documented Fall: a fall that is noted in an official facility document, e.g., medical record, incident report, risk management report, etc.

Treatment: a resident that is sent to an ED or physician office for evaluation and/or treatment (in that setting). It does not include first-aid.

General Considerations:

Falls that resulted in evaluation out of the facility (e.g., emergency room, physician’s office) with the evaluation indicating no major injury and the resident being transferred back to the facility would be classified Level1 or Level 2 as appropriate for injury sustained.

A fall should only be counted once, at the highest level of injury, e.g., a fall in which a resident fractures a hip and sustains a skin tear would be counted once and at a Level 3 fall.

Exclusions:

Unanticipated Physiological

- Sudden Myocardial Infarction, Seizures (sudden attack)
- Unexpected CVA
- Syncope Episode

Intended Falls:

- Specialty Unit and/or documented behaviors problems - psychotropic medications (example: threatening self on the floor)
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High Risk Pressure Ulcers

Overall Rate
Stage II
Stage III
Stage IV
Unstageable
Deep Tissue Injury

Construct: Facility-acquired Pressure Ulcer (by stage) X 1000

Medication Errors

Categories
- Overall Rate
- Category A
- Category B
- Category C
- Category D
- Category E
- Category F
- Category G
- Category H
- Category I

Types
- Wrong dose
- Wrong route
- Wrong resident
- Wrong frequency
- Wrong time
- Wrong medication
- Omission
- Transcription

Construct: Med Error by Category and Type X 1000

Medication Error Index for Categorizing Errors

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<thead>
<tr>
<th>TYPE OF ERROR</th>
<th>CATEGORY</th>
<th>RESULT</th>
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<tr>
<td>ERROR, HARM</td>
<td>Category E</td>
<td>An error occurred that resulted in the need for treatment or intervention and caused temporary patient harm</td>
</tr>
<tr>
<td></td>
<td>Category F</td>
<td>An error occurred that resulted in initial or prolonged hospitalization and caused temporary patient harm</td>
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<tr>
<td></td>
<td>Category G</td>
<td>An error occurred that resulted in permanent patient harm</td>
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<td></td>
<td>Category I</td>
<td>An error occurred that resulted in a near-death event (e.g., anaphylaxis, cardiac arrest)</td>
</tr>
<tr>
<td></td>
<td>Category J</td>
<td>An error occurred that resulted in patient death</td>
</tr>
<tr>
<td>NO ERROR</td>
<td>Category A</td>
<td>Circumstances or events that have the capacity to cause error</td>
</tr>
<tr>
<td>ERROR, NO HARM</td>
<td>Category B</td>
<td>An error occurred but the medication did not reach the patient</td>
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<tr>
<td></td>
<td>Category C</td>
<td>An error occurred that reached the patient but did not cause patient harm</td>
</tr>
<tr>
<td></td>
<td>Category D</td>
<td>An error occurred that resulted in the need for increased patient monitoring but no patient harm</td>
</tr>
</tbody>
</table>
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Infection Control

By unit (cluster) and facility (outbreak)
- Overall Rate
- Pneumonia
- Influenza
- GI
- UTI – with and w/o Foley
- MRSA
- VRE
- C Diff
- General

Construct: Infection by Unit (cluster) or Facility (outbreak) by Type

Total # Resident Days for the Month

Avoidable Readmissions

Kathleen Glendening

Objective: Discover how the “Never” Event programs integrate with initiatives to reduce Rehospitalizations & ED outcomes

Reasons Skilled Nursing Facilities Should Focus on “Never” Events

- Key referral source (Hospitals) will be penalized if the rate of readmissions from nursing homes does not improve – Referrals will decline.
- Payors will not pay for additional costs of care which will impact Skilled Nursing on Medicare side via Bundled Payments and ACOs.
- Consumers (patients/families) will become increasingly aware of providers rate of readmissions in relation to competitors – Hospital compare -> Nursing home compare.
Primary Reason for Nursing Home Readmissions to Hospital

By Order of Magnitude:
- Pneumonia
- Urinary Tract Infections
- Heart Failure
- Dehydration
- Pressure Ulcers
- Falls
- In addition, it is noted that a significant portion of readmissions occur at the end-of-life thereby making SNF-based Palliative care programs and Advanced Directives increasingly important!

Acute Care Readmissions W/1 30 Days

Construct:

\[
\frac{\text{Total # of Residents Who Were Readmitted to Acute Care Hospital Within 30 days Admission to the NF}}{\text{All Admissions from the Hospital Within 30 days}} \times 100
\]

ED Visits

Construct:

\[
\frac{\text{# of Emergency Visits in the Month Within 30 Days Discharge from the Hospital}}{\text{Resident days for the month}} \times 1000
\]
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Goals
EVERY PERSON. EVERY PLACE. EVERY TIME
0% Tolerance to substandard practice for
“Never” Events

Targets for 2012
- ED visits
  - CHE Target = 2.67%
  - If <2.67% maintain or improve if >2.67% decrease by 25%
- Acute Care Rehospitalizations
  - CHE Target = 22%
  - If <22% maintain or improve if >22% decrease by 25%

“NEVER” EVENTS: Just Culture
Aysha Kuhlor

Objectives: Learn the characteristics of a
Culture of Safety

AHRQ Patient Safety Culture Focus Areas

- Openness
- Feedback about error
- Handoffs/Transitions
- Across units
- Within units
- Supervisor/manager expectations and action promoting safety
- Management support for patient safety
- Non-punitive response to errors
- Frequency of errors
- Learning - continuous improvement
- Staffing
- Of resident safety

Culture of Safety

Comparison of Safety in Various Industries

- Healthcare
- Aviation
- Chemical Industry
- Nuclear Industry

Very Unsafe
Extremely Safe

Culture of Safety

Reward Reporting:
- Implement incentives to increase reporting.
  - Reward buttons
  - Staff breakfasts
  - Contests between units
- Create incentives for safe behavior and increased awareness; remove incentives for at-risk behaviors.
- Ensure staff are educated about data use to examine systems not people.

Culture of Safety

Questions to Ask Regarding Just Culture and Open Communication

- Are errors used to measure system performance?
- Is value, respect, appreciate, and reward all contributions to safety?
- Is meaningful feedback provided and memorable stories told?
- Are managers taught blame-free management style? Are they mentored?
- Are leaders visible where staff work to learn about barriers to safe practice?
- Is the culture just?
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“NEVER” EVENTS in a LONG TERM CARE SETTING: A Director of Nurse’s Perspective

Aysha Kuhlor

Objective: Learn the “5 why” method used to analyze “Never” Event data

Saint Mary Home (Background)
256 bed facility located in West Hartford, CT
2 sub-acute units
1 secured unit
5 long term care units
Focus on Falls - Monitoring

<table>
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<th></th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
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<td>1</td>
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Data Collection
January 2011 – May 2011

Unit Fall Totals Jan - May 2011
Utilizing the 5 Why's

The subsequent discussion focused on why falls were occurring on Fitzgerald unit.

**WHY?**

**Issue:** The majority of residents on this unit are rehab. These residents are trying to do too much without calling staff.

**WHY?**

**Issue:** Residents feel they can do for themselves.

Discussed frequency of rounding by RNs and CNAs: No set time for rounding.

Initial rounding after report, then for those residents with specified q15 minute checks, then on frequent fallers.

Frequent fallers identified via risk assessment.

**WHY?**

**Issue:** Residents feel they can do for themselves because they have a level of confidence and want to show staff that they are ready to go home.

**WHY?**

**Issue:** Residents are basing this level of confidence and ability on past experience.

**WHY?**

**Issue:** Residents not understanding that past experience is not equal to current abilities and there are limitations to what they can currently do without assistance.

**Opportunities for improvement:**

Review falls for additional data to further inform improvement plan:

- Time of fall (e.g., during change of shift, meal time, toileting)
- Resident engaged in a particular activity (i.e., transferring, ambulating, toileting)
- Location of fall
- Was staff or family assisting?
- Were any resident comments, i.e., why they think they fell.

Ensure multidisciplinary review of plan of care with resident and family, i.e., provide education using teach-back, ensure thorough understanding by all involved.

Based on data dive, if occurring during change of shift, opportunity to refocus rounding.

### Improvement Plan

**Goal setting for reducing falls (share goals with staff)**

**Computerized tracking system for falls (gather specific information)**

- Time, unit, location, use of restraint, ambulatory status, shift, staff involved etc.

**Interdisciplinary approach**

- Choosing Assessment Tools
- Staff Education
- Policy/Procedure revision
- Boredom (Recreation)

### Action Plan for 5 Why Analysis

**Name of Facility:**

**Issue:** Falls with Injury

<table>
<thead>
<tr>
<th>Item #</th>
<th>Action Step</th>
<th>Responsible Party</th>
<th>Status for Completion</th>
<th>Other (including how measuring progress)</th>
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<tbody>
<tr>
<td></td>
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</table>
System Change

Medical Staff Training
- Review of Medical Factors (e.g., DM, weakness, dizziness, visual impairment etc)

Medical Review
- Cardiac
- Analgesics

Individualize toileting needs and care plans

Challenges

Staff compliance with plan of care

Physicians/Pharmacists reviewing medication for reductions

Family members

Avoidable Readmissions

Aysha Kuhlor

Objective: A plan to reduce Avoidable Rehospitalizations & ED outcomes
Saint Mary Home Preparation Plan

- Re-evaluate clinical competency of the staff (assessment skills, admissions assessments, etc.)
- Establish relationship with hospitals
- Evaluation of services provided by providers
  - Labs
  - X-rays
  - Pharmacy Services
  - Care Transitions
    - E.g. Patient from Hospital with ileus

Diagnosis of Focus

- COPD
- CHF
- PNA (Respiratory)

Respiratory Unit - October 1, 2011

New Steps

- Education of the staff (Discharge Summaries)
- Introduction of Interact II Tool (Interventions to Reduce Acute Care Transfers)
- Assessing in-house equipment
- Rounding by Physician/Clinical Staff
- Monthly meeting at local hospital (meeting with SNFs, VNAs and other community organizations involved in care of heart failure population)
- Culture Change for patients and families re: hospital transfers
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“NEVER” EVENTS:
CHE Outcomes to Date
Next Steps for 2012

Objectives:
- Explain the “Never” Event programs data collection reporting process
- Understand how the “Never” Event programs are linked to Financial Considerations and Value-Based Purchasing

Outcomes: Medication Errors

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<tr>
<th>Facility</th>
<th>Metric</th>
<th>2011 Target</th>
<th>2011 YTD</th>
<th>2012 Target</th>
<th>1Q12</th>
<th>% of Meeting 2012 Target</th>
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<td>CHE</td>
<td>Ed Vis</td>
<td>0.06</td>
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<td></td>
<td>Falls</td>
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<td>PCN</td>
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<td></td>
<td>C. Outbreak</td>
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<td>0.00</td>
<td>100%</td>
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CHE Long Term Care Never Events
2012 Rates

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<tr>
<th>Facility</th>
<th>Metric</th>
<th>2011 Target</th>
<th>2011 YTD</th>
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<th>% of Meeting 2012 Target</th>
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<td>CHE</td>
<td>Acute Care Hospitalizations</td>
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<td>22.00</td>
<td>12.24</td>
<td>28.57%</td>
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Overall Medication Errors

Financial Cost of Never Events

Pressure Ulcers

Infectious Diseases

Medication Errors

Our Savings – Cost Avoidance Events

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Cases</th>
<th>Residents</th>
<th>Multiplier</th>
<th>Cost</th>
<th>Dollars Saved</th>
<th>Difference in Number of Cases</th>
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<td>327,419</td>
<td>9.113</td>
<td>$9,113</td>
<td>$1,658,566</td>
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Partnership for Patient Goals

By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients, with more than 60,000 lives saved over the next three years.

Help patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 12% compared to 2010. Achieving this goal would mean more than 1.6 million patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.


Top Ten Never Events

10. Never ask your administrator for assistance with your Nursing policies.
9. Never take the cap of a syringe off with your teeth.
8. Never write your wishes on a resident's care plan or "Ditto" for another resident.
7. Never give a resident or family your contact information - always give them your Administrator's home and cell phone number.
6. Never have your residents drink their IV fluids for hydration.
5. Never hook an IV to a compressor.
4. Never use crazy glue to re-approximate a skin tear.
3. Never suction your residents with the hose of a vacuum cleaner.
2. Never ask a surveyor "Am I giving the right medication?".
1. Never miss a NADONA Conference.