The American Hospital
Quest for Quality Prize
2003

American Hospital Association
Founded 1898

The American Hospital
Quest for Quality Prize

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Dear Health Care Leader:

The American Hospital Quest for Quality Prize, now in its second year, continues to honor the commitment of hospitals and health care systems to leadership and innovation in patient care quality and safety. And this year’s honorees exemplify this passion and dedication to the patients they serve in their communities.

In 2003, the American Hospital Quest for Quality honors a 508-bed suburban community, teaching hospital; a two-hospital system; an academic medical center; and a small, rural hospital. Each is devoted to patient safety and quality throughout the organizations.

Through their leadership and example, these hospitals and health care systems demonstrate how to incorporate a culture of safety into all areas of their services, and how health care can provide the safest, most appropriate care to the patients and communities they serve.

Hospital and health systems across the country submitted applications for this year’s honors. And while we weren't able to recognize all of them for their outstanding achievements, they shared with us their programs and ideas, and demonstrated their commitment to patient quality and safety.

On behalf of the AHA Board of Trustees and its members, I’d like to thank the American Hospital Quest for Quality Prize Committee for giving its time and expertise, as well as the McKesson Corporation and the McKesson Foundation for their program support and commitment and leadership in this critical area.

Take a look at what your colleagues around the country have accomplished this year. And if you’d like to learn about last year’s winning programs, visit the Web site at www.aha.org/questforquality. You’ll also find information on the 2004 awards.

While America has the best health care system in the world, we must continually strive to improve patient care, quality and safety—and this prize is one way of recognizing programs for their incredible efforts.

Sincerely,

Dick Davidson
President
American Hospital Association
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SAFE SYSTEMS: About 99 percent of prescriptions at Abington are ordered through its computerized physician order entry system. Jack Kelly, M.D., chief patient safety officer, and Vcg McGoldrick, executive vice president and COO, present a mobile CPOE unit in the ICU.
Recognizing that health care delivery will never be 100 percent error-free, Abington (Pa.) Memorial Hospital’s patient safety program aims to head off errors before they cause harm. If an error does occur, redundant processes and systems are to contain it. This philosophy is featured in the preface of Abington’s Patient Safety Plan, which every employee must sign: “We, as human beings, in our roles as health professionals, will always make mistakes. We cannot change the human condition but we can change the systems within which we work.”

Patient safety has long been a priority at Abington. Leaders of the 508-bed community teaching hospital in suburban Philadelphia believe safety is part of the hospital’s obligation to provide quality care.

But, like most health care organizations, the Institute of Medicine’s reports on medical errors led the hospital to formalize its efforts. “The IOM reports galvanized us to review our approach to care,” says chief patient safety officer Jack Kelly, M.D., chair of Abington’s Department of Medicine. “Currently in health care, we hold people to a standard of perfection. That’s not the right standard because errors will occur. We need to place enough redundancies in the system, enough barriers to prevent errors from causing harm.” One key feature: the patient safety effort has strong support from the top. The chief executive officer and other executives engage staff on safety issues. “It’s got to involve more than just lip service and a mission statement,” Kelly says. “The staff knows we are very serious about this.”

A critical step is to establish open communication and a non-punitive environment. “We have a very rigorous structure that supports our philosophy of preventing harm from reaching the patient,” says Meg McGoldrick, executive vice president and chief operating officer. “We’ve created policies that put into writing what we need to do. Our staff feel supported on their end to improve patient safety.”

Abington educates employees on its safety policies and initiatives and encourages them to examine every process for potential error. “We continue to iterate this through safety education and the science of safety,” Kelly says. “Communication and safety science is not something we’ve been trained in.” To improve communication, Abington established multiple avenues for reporting near misses and safety ideas. Twenty-six suggestion boxes throughout the hospital encourage staff, families and patients to comment. Reporting can be anonymous; if a name is provided, a thank-you note is sent as follow-up.

Other means of reporting include a 24-hour hot line and direct reporting to management. “We take every opportunity to talk about patient safety,” McGoldrick says. Patient safety is on the agenda on nearly all meetings, from the board to individual units. A quarterly patient safety newsletter updates staff on the hospital’s efforts and bulletin boards on patient floors.
help spread the message. "This is not a top-down effort," Kelly says. "It's very grassroots."

Continual reinforcement of the nonpunitive policy and the importance of reporting hazards has paid off: "People are much more willing to come forward," says Barbara Wadsworth, administrative nurse director. "We've seen a big increase in suggestions. Before, people did not have a way to report them." Once a suggestion is made, the hospital prioritizes and tracks it. The Integrated Patient Safety Working Document, maintained by the the Patient Safety Working Group, is updated weekly to note new additions and track efforts. New items are assigned to members to evaluate for the group, which meets weekly to discuss ongoing projects and new suggestions. Projects are prioritized based on variables including likelihood of occurrence, potential severity and availability of solutions to correct it.

The Patient Safety Working Group is multidisciplinary, consisting of Kelly, the vice president of professional services, staff from the department of patient safety and performance improvement, and nurses. Members serve as patient safety liaisons, reporting to and from their departments. The group reports to a Patient Safety Committee, which Kelly chairs, and includes two representatives from the community. Also reporting to the Patient Safety Committee is a Patient Safety Employee Committee, comprising nonphysician employees representing various hospital departments.

A separate Patient Safety Oversight Committee, which consists of board members, the chief operating officer, chief medical officer and physician and nurse leaders, allocates money and other resources to enhance safety.

Because of the large volume of patient safety improvement suggestions and the number of projects, the IPS Working Document is reviewed each year to prioritize projects. Clinical department chiefs, nursing and administration are polled to determine which projects deserve attention and resources. Kelly addresses urgent clinical matters immediately.

Technology plays a central role in Abington's patient safety program. Computerized physician order entry has been available for about eight years; the hospital mandated it when it made patient safety a formal organizational priority. CPOE is credited with reducing errors during ordering and transcription by more than 50 percent and has virtually eliminated the need for the pharmacy to ask for orders to be clarified. "We've realized a lot of improvement through technology," McGoldrick says. "CPOE provided a phenomenal running start." Abington is investing $10 million to $15 million for software upgrades for CPOE to provide physicians with speedy access to clinical information.

Investment in safety technology is one way the organization demonstrates its commitment. "Whatever is in the marketplace that is tried and true, we will bring to our organization to improve patient safety," McGoldrick says. "We have a long list of patient safety goals that drives the allocation of resources. We fund good patient safety ideas. It's our No. 1 priority." A bar coding pilot is slated to begin in July 2004, she says.

When good technology is not available, Abington finds its own solutions. The hospital developed a Web-based anticoagulation clinic to monitor patients on Coumadin. The system provides physician offices a list of all their patients on it, identifies patients past due for testing and notifies the physician when the patient should stop taking the medication. The result has been a significant improvement in appropriate anticoagulation treatment.

One challenge: gauging the success of the patient safety program. Measuring response and reporting is difficult because the organization has no baseline with which to compare. "We are doing things we weren't doing before," McGoldrick says. The hospital has expanded its performance report to reflect patient safety and clinical measures.

Abington leaders believe in sharing its experiences. "We are ethically obligated to share information, whether errors or system improvements, with other health care organizations," Kelly says. Much of that occurs through Abington's participation in the Delaware Valley Healthcare Council and VHA. Kelly also strongly urges hospitals to advocate for adequate resources from the government. "Mandates for safety are well intended, but need to be accompanied by appropriate resources to achieve the intended goal," he says.
Cooperation among facilities, staff is key

William Beaumont Hospital, Royal Oak, Mich.

Ask hospital administrators about the challenges of their patient safety program and you'll likely hear about the difficulties of implementing culture change and establishing consistent processes across all areas and levels of the organization. William Beaumont Hospital has succeeded at both—establishing a pervasive culture of safety and consistent practices—at its two facilities in southeast Michigan.

About 14 miles apart, William Beaumont, Royal Oak, a 997-bed tertiary care and teaching hospital, and William Beaumont, Troy, a 226-bed community and teaching hospital, share systemic methods for communication and process implementation across the two facilities. "We really believe in collaboration between the two hospitals," says Steve Winokur, M.D., Royal Oak's patient safety officer. Communication is facilitated in part through the hospitals' intranets and shared newsletters.

The two hospitals share a board of directors. Patient safety committees comprise staff from both facilities. The Corporate Patient Safety Council is composed of hospital executives, medical staff, quality leaders and legal affairs representatives. The council works with the Patient Safety Cabinet, comprising patient safety officers, quality managers, and corporate legal council, which works closely with front-line staff.

Collaboration is also encouraged through, among other things, joint analysis and reporting efforts. Failure Mode and Effects Analyses are conducted by representatives from both facilities. Sentinel event and intensive assessment recommendations are shared with all departments, which implement the recommendations.
Process owners—staff champions who develop and implement risk-reduction strategies in specific areas such as patient falls and medication management—meet monthly to share efforts under way at their facilities. Variance reports collected from departments at both hospitals are maintained in a central patient safety database accessible to both facilities.

Education and training are central to the patient safety programs at the two hospitals and also serve as a means to instill consistent policies and practices. Employees at both facilities learn about William Beaumont's patient safety program at orientation. More than 350 administrators, managers, and medical staff leaders have participated in a three-hour Patient Safety Overview course offered through Beaumont University.

A simulation lab uses a mock patient for team training in the operating room and anesthesia. The lab allows staff to prepare patient encounters, developing assessment, communication and treatment skills. But education isn't enough. Both Winokur and his counterpart at William Beaumont, Troy John Tower, M.D., are members of the inaugural class of the Patient Safety Leadership Fellowship, co-sponsored by Health Forum and the National Patient Safety Foundation.

To help maintain a nonpunitive environment for reporting errors and near-misses, the human resources department trains managers so they can support staff involved in errors. Managers get a checklist to assist them in evaluating errors from a process-focused perspective rather than an individual-focused perspective.

The efforts are paying off. "When you walk through our corridors and see staff interact with patients, you see our patient safety program in action," says Kay Beauregard, administrative director at William Beaumont's Royal Oak facility. "It's very concrete and observable. It's not just because our staff thinks it's a great idea, but because we also have strong processes in place."

As an example, Beauregard cites an organization-wide effort to improve patient identification. Variance report and department performance data from the Clinical Pathology Department, along with a sentinel event analysis, identified a systemic breakdown in patient identification, so it became a safety priority.

A task force was charged with ensuring that every patient be identified when an intervention occurs. It standardized wristbands and point-of-care reminders, and called for implementation of bar code technology. Clinicians now ask the patient to verify his or her identity before transfer or service. The results of the policy are promising. Prior to the program, about 72 patients per month were found without wristbands. That number was reduced to zero in 2002 following implementation of the program.

William Beaumont is proactive when it comes to medication errors. The organization is close to a pilot of computerized physician order entry, but decided it couldn't wait for CPOE to make improvements in the medication ordering process. So, it developed a seven-step process for placing medication orders; an order cannot be filled if all steps are not followed. All patient orders must:

- Have complete and legible patient name
- Have prescriber name and ID number
- Use no unapproved abbreviations
- Use "units," not "u"
- Use zeros before a decimal point, but not after
- Write out micrograms or use the abbreviation "mcg"
- Follow the metric system.

Since the program was launched, the organization has seen a 24 percent improvement in completeness of medication orders.

Beauregard is quick to note the importance of leaders' commitment. "Our board is interested in supporting anything we can do to improve safety," she says. Executives maintain a high profile throughout the facility to demonstrate their commitment to patient safety and the importance of shared experiences.

The result is an increased willingness among staff to participate. "We are fortunate that our staff readily brings things to our attention," Beauregard says.
Safety is the driving force
University of Wisconsin Hospital and Clinics, Madison

An early adopter of technology to improve patient safety, the University of Wisconsin Hospital and Clinics recognizes the importance of including error reduction in its return-on-investment analysis. "Patient safety has been a driving force for a long time. It's the reason we are here," says Steve Rough, director of pharmacy. "If a technology is proven to help avoid errors, that must be part of the ROI equation."

Leaders of the 471-bed hospital support the patient safety efforts, particularly when it comes to technology. The board of directors regularly authorizes significant capital and personnel investment when a goal is improving patient safety.

In 1993, UWHC became the second hospital in the United States to install a drug-dispensing robot in its pharmacy. The robot fills about 90 percent of the inpatient medication orders. In 1999, the system introduced medication-dispensing cabinets on patient floors to store bar-coded, unit-dose medications. It implemented scanning of bar codes at the patient's bedside in 2001, allowing nurses to check a medication against a patient's wristband and the nurses' identification badges. Two nursing positions were created to oversee the process. Medication administration errors have been reduced by 87 percent since the scanning system launched.

"We are the most automated hospital in the country when it comes to medication-use systems," Rough says. "These projects are often hard to finance. But we've been able to move forward because our chief executive officer and board made patient safety a top priority within the organization." It's not that the hospital regards technology as a panacea; "but we feel strongly that technology can play a vital role in preventing and detecting errors in care," he says.
Other recent or current technology projects at UWMC with a patient safety focus are:

- In 2000, it replaced all hospital beds with new beds equipped with exit alarms to help prevent falls. Coupled with other fall prevention efforts, UWMC has seen a 21 percent reduction in falls since 2001.
- It will pilot computerized physician order entry in an inpatient unit beginning in October. UWMC plans to roll out CPOE hospitalwide over the next two to three years. It added 13 new multidisciplinary positions to facilitate the transition.
- It installed smart infusion pump technology to combat dosing errors.

The large investment in technology and personnel is one way the hospital demonstrates its commitment to patient safety. The other is by its continual effort to nurture a nonpunitive philosophy for reporting errors. "Unless you get out there and communicate your program thoroughly, you will not succeed with your objective," says David Entwistle, chief operating officer. "Our public affairs department has been very active and effective in getting our message across. The nonpunitive policy is communicated through mandatory Web-based training and through various newsletters and campaigns.

From first quarter of 2002 through the first quarter of 2003, UWMC saw a 44 percent increase in reporting of all events. Near-miss or unsafe circumstances accounted for about 19 percent of reports. According to Myra Enloe, R.N., patient safety officer for nursing and patient care services, these incidents would likely have gone unreported in the past. Although employees may report anonymously, almost all provide their names on the reports.

An online reporting system, Patient Safety Net, is available in all care areas, including outpatient clinics. Paper reports are no longer used. Patient Safety Net immediately notifies managers and quality improvement and risk management staff via e-mail when an incident is reported. Data is compiled in a single database to assist incident analysis.

UWMC participates with the Wisconsin Patient Safety Institute and the Madison Patient Safety Collaborative. It recognizes that other organizations, rural hospitals in particular, do not have the resources to implement costly patient safety programs. So, the hospital provides consulting and management services to rural hospitals on medication safety. "It's a way to work together and share research without having to reinvent the wheel," Rough says.

A quality institute

Olympic Medical Center, Port Angeles, Wash.

Olympic Medical Center in Port Angeles, about three hours from Seattle, was so serious about improving patient safety that it formed its own think tank, the Olympic Medical Quality Institute. With that program and membership in the Boston-based Institute for Healthcare Improvement, OMC, which includes 126-bed Olympic Memorial Hospital, seeks out systemic solutions to reducing errors. "We continually review our practices to see where things may fall through the cracks and seek the best solutions," says Joyce Cardinal, assistant administrator, patient care services. "It's pretty much the way we do business.

The Olympic Medical Quality Institute, comprising physicians, board members, administrative staff and others, oversees cultural re-engineering and system redesign. It meets quarterly to evaluate information technology options and prioritize patient safety initiatives, and works in conjunction with the Quality Coordinating Council, made up of physicians, nurses, board members and others, to establish benchmarks for performance improvement efforts. The Patient Safety Committee, composed of frontline staff, managers and administration, oversees specific safety-related issues, such as patient falls and medication administration errors.

As a public hospital district, OMC is required to release outcomes data. Leaders say the transparency builds community trust and improves communication within the organization. Board meetings are open to the public. Outcomes data, including medication errors, ineligible physician medication orders and patient falls, are presented in report card format, with results reported in the local newspaper and on the radio.

Information technology plays an increasing role at OMC. "We want to incorporate whatever technology we can to improve safety," Cardinal says.
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