Clinical Huddle and Patient Safety
MountainView Regional Medical Center

SETTING THE STAGE

How is this project consistent with strategic plan?

Harm event reduction is a key initiative of hospital leadership. It is a part of daily communication with the Chief Executive Officer, Chief Nursing Officer, and Hospital Leadership during the morning safety huddle. It is recognized as a high priority patient care initiative by our Board of Directors and President & CEO, allowing us to be the regional healthcare leader of choice for excellence, innovation, and quality.

Why was this project selected and what was the goal?

A review of 2017 data showed our overall AHRQ Patient Safety Indicator Event (PSI) rate was above benchmark goals and our leadership expectations. To achieve zero harm it became evident we needed a multidisciplinary approach to understand the pathway of harm. Our goal was to implement a process to impact change reducing overall PSI and CMS Hospital Acquired Condition Events (HAC) and to achieve zero events in 2019.

PROJECT DESIGN

Who was involved in the improvement effort?

The weekly Clinical Huddle Process Improvement Program is a focused, multi-disciplinary group championed by the Chief Quality Officer and Patient Safety Coach Champion. It is comprised of Clinical Documentation Improvement specialists, nursing leadership, non-clinical leaders, our coding team, and frontline staff. During the Clinical Huddle the multi-disciplinary team discusses both at-risk and potential PSI events allowing for real-time reviews, giving an opportunity for immediate improvement with clinical care, clinical process, and documentation.

What methodology was used and how?

The weekly Clinical Huddle Performance Improvement Program employs the IHI Model for Improvement following Plan-Do-Study-Act (PDSA). The Clinical Huddle Process Improvement Pathway was created to allow for a very fluid process for collaboration and communication. The pathway is utilized to steer the immediate evaluation and direction of the Clinical Huddle, as indicated through lessons learned. The initial steps were a training process to efficiently identify at-risk and potential PSI events in real-time. As real-time identification became more concrete the focus shifted to determining whether the event hospital acquired or hospital identified. We felt both instances were representative of a potential process breakdown and an opportunity to evaluate clinical practices.

How was data collected?

Data was collected through coding software 3M/160 for real-time analysis of at-risk and potential events, and premier data warehouse for finalized events.

How was the data used for improvement?

Total PSI events were tracked monthly in each PSI category prior to implementation of Clinical Huddle and was too far in areas to impact change. Daily review of at-risk and potential PSI events gave us the ability to identify opportunities for a process change in real-time. The PSI categories with the largest number of total events were the initial focus; PSI-9: Postoperative Hemorrhage/Hematoma, PSI-11: Postoperative Failure, PSI-12: Postoperative VTE, and PSI-17: Birth Trauma. We have seen a decrease in events in these major PSI categories, as well as overall PSI events since the implementation of the Weekly Clinical Huddle Process Improvement Program.

PROCESS IMPROVEMENT METHODS

Plan:

The process of establishing Clinical Huddle had to be very fluid due to the need for rapid change implementation. The process, as with the strategy plan, to deliver high-quality reviews. Identifying the events in real-time, allowing for meaningful review and opportunity for change, ideally as the patients still had inpatient status, was the critical step in establishing the process. We identified the core group who had an ability to identify a potential event, Quality Department, Infection Prevention, Nursing Leadership, Clinical Documentation Improvement Specialists (CDI), Coding Team, Collaboration and ease of communication among this multidisciplinary team was imperative for success.

Do:

The Clinical Huddle Process Improvement Pathway started to determine two major questions. The real-time analysis of identified and potential events includes an initial review by the Quality Department to determine if the event met AHRQ, CMS, and/or NHSN criteria for a qualifying event. The initial event analysis is conducted within 24 hours of identification to determine whether the qualifying event is hospital acquired or hospital identified. Once the determination is made, the event is forwarded to the Clinical Leadership of the unit where the event occurred for a Root Cause Analysis (RCA).

Study:

If the event was determined to be a true hospital acquired/hospital onset event, the RCA is focused on clinical process opportunities. If the event was determined to be hospital identified, the event is focused on immediate re-education of the involved staff for process compliance and failure impact. If the event was determined to not meet AHRQ, CMS, and/or NHSN criteria for a qualifying event, the Quality Department, Infection Preventionist, CDI, and Coding Team work together to either clarify the physician documentation through queries, clarify the inclusion/exclusion criteria, and/or clarify the DRG Code and coding clinic rules that triggered the event.

Act:

The results of the RCAs are reviewed at Clinical Huddle and each director submits to the team what was implemented on their unit based on the results. Often, this process change is incorporated house wide.

RESULTS

There are 15 PSI categories; 4 were identified as major focus areas for improvement. Reduction of PSI events after the Weekly Clinical Huddle Process Improvement program implementation in the 3rd quarter of 2018 by PSI; PSI 9 = 50%, PSI 11 = 80%, PSI 12 = 60%, PSI 17 = 80%. Overall event reduction, after implementation is hovering around 65%, and 7 of the 15 PSI categories have zero events. According to the American Data Network Data Analysis on Excess Cost and Length of Stay of Adverse Patient Safety Events, the estimated excess cost of care for patients with a PSI 9 = $14,973; PSI 11= $24,659; PSI 12= $22,888. Using these values, the total savings in the focus PSI categories after Clinical Huddle Implementation was $280,134 and year to date is $280,883 with total lives impacted = 17.

Relevance:

ANOVA test was run to determine statistical relevance of the data sets with the P-Value set at 0.05. The Null hypothesis can be rejected, and statistical relevance established as the P-Value of the data set is 0.041, less than 0.05. Additionally, the F-Value is 4.67, and greater than the Fcrit of 4.25 indicating the standard deviation of each group as compared to the overall performance is statistically different. The decrease in events is not random and does correlate to the implementation of Clinical Huddle, with the greatest statistical impact in the Jan-Jun 2019 subgroup.

Lessons learned:

A multidisciplinary approach to involve all interested parties is necessary to ensure each event is looked at in real-time, with maximum opportunity.

• Real-time review of at-risk and potential events is the best way to truly understand the events and impact change.

• Reviewing each qualifying event for inclusion/exclusion criteria is an imperative part of the process.

• Physician documentation accuracy in documentation describing the full clinical picture of the patient is critical to outcomes. Our physician CDI says, “Documentation must be codeable documentation. It is no longer ‘If it wasn’t documented, it didn’t happen’, it is now ‘If it isn’t codeable documentation, it didn’t happen’.”

LESSONS LEARNED/SUSTAINABILITY

A focused RCA, on an instance of aspiration complication event, lead to an identified need for a process change of patients at high risk of Postoperative respiratory failure, due to aspiration. A PDSA was implemented for all high-risk patients, and was focused on positioning high risk patients in high fowlers, rather than 30 degrees. To-date we have seen a reduction in aspiration complications after this process improvement implementation, based on lessons learned.

We identified documentation opportunities with PSI 17, birth trauma. The delivery nurse’s documentation described a normal occurrence of birth called a “suck blister” on a neonate’s hand. This documentation was utilized in the final coding of the chart and triggered the assignment of a DRG, which included a PSI event. Review of the coding practices and coding clinic rules indicated this was not best practice. Quick identification, training and education of the coding team, and our collaborative approach, allowed for a secondary coding review and removal of the DRG, triggering the event.

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<th>Hospital Identified</th>
<th>Criteria Met?</th>
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<th>RCA for clinical care</th>
<th>RCA for clinical process</th>
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