Proceedings from the 2008 Wisconsin Quality and Safety Forum, Part I

In 2008, quality and safety improvement initiatives in Wisconsin focused on developing an organization-wide culture of quality, and implementing processes to improve patient care and satisfaction. Below are descriptions of improvement projects undertaken by hospitals and other health care organizations, and showcased at the Wisconsin Hospital Association's 2008 Wisconsin Quality & Safety Forum. The projects are broken into 6 categories; clinical improvement, infection control, customer service, medications, performance improvement, and safety. The last 3 categories will be published in the next issue of the *Journal*.

CLINICAL IMPROVEMENT

Development of a Therapeutic Hypothermia Protocol

Kevin Jacoby, MSN, RN; Wheaton Franciscan Healthcare-St. Joseph, Milwaukee, Wis

The development of the therapeutic hypothermia protocol at Wheaton Franciscan Healthcare–St. Joseph has been a continuous work in progress, with initial planning and order set creation in February 2007 and nurse/physician in-servicing/education and go-live (or patient enrollment) in March 2007. From inception to the present, both the protocol and orders have been through numerous changes to accommodate patient, pharmacologic, logistic, and multidisciplinary practitioner needs. Each revision was recommended and supported with requirement needs developed from enrolled patient data, evidence-based practice in current therapeutic hypothermia treatment modalities, and reviewed benchmark trends from over 20 other hospitals that have developed hypothermia protocols. Our institution's Initiative for Healthcare Improvement (IHI) Committee oversees and guides the initiative and consists of members from our Quality, Advanced Practice Nursing, Nursing Education, Management, Care Management, Respiratory Therapy, and Intensive Care departments. In May 2008, we approved a working, sub-final order set with plans for its inclusion as a final, official document.

One of our staff hospitalists, Rajesh Bhargava, MD brought the idea for development of the hypothermia protocol to our IHI Committee. Dr Bhargava who spent a summer working in New Zealand. During that time he learned that they were using a lesser-known protocol that had promising potential for resuscitated cardiac arrest patients. Feeling our institution potentially could use a hypothermia protocol with its neuroprotective benefits to improve the quality of lives in our frequent cardiac arrest population, Dr Bhargava drafted a trial order set. As 1 of the few hospitals in the Metro-Milwaukee area with a protocol, especially in its infant stages, we utilized national and international literature to support our development.

Encouraged by therapeutic hypothermia's potential benefits, we agreed on a relatively short timeframe for our first enrollment—1 month. From a nursing perspective, this meant we had to draft education materials on the protocol itself (inclusion and exclusion criteria), the order set, and provide in-services on the logistics of the initiative to the nurses of the emergency department and intensive care unit, while Dr Bhargava gave informational in-servicing to the medical staff and the resident physician teaching service teams.

To accomplish this, we enlisted the assistance of the clinical educators of the Emergency Department and Intensive Care Unit as well as a few staff nurses to disseminate the information. In-services were held prior to shifts, unit practice council, and shared governance meetings for staff nurses who would be caring for the enrolled patients. Initially after rollout, logistical concerns regarding the availability of equipment, the ordering of serial lab work, and the unfamiliarity of the protocol became apparent through staff confusion, frustration, and delays in getting patients cooled down to goal range within the goal timeframe. To alleviate these issues, tip sheets were made for the lab schedules and the protocol's cooling and rewarming phases, as well as conversations with department supervisors regarding smooth and timely accessibility of supplies and equipment. Overall, despite over a year to streamline the process, each hurdle was overcome with minimal effort and unequivocal staff support and participation.

ED Nurse Driven Pneumonia Care Protocol: It Made a Difference!

Sue Baird Holmes, RN, CNS; Wheaton Franciscan Healthcare-St. Joseph Milwaukee, Wis

In January 2007, the Pneumonia Outcomes Team (Team) assessed trend pneumonia measure data. Door-to-drug times remained inconsistent. It was identified that timely Emergency Department (ED) nurse triage of possible pneumonia patients could be improved to decrease the time it took for patients to receive their first antibiotic. One strategy discussed was the use of a nurse-driven protocol that would assist with timely nurse assessment of possible pneumonia patients and lead to a reduction in the time it took for a patient to receive their first antibiotic.

The ED nurse representative to the team investigated the potential for a nurse-driven protocol, conducted a literature search for evidence-based respiratory assessment cures, and developed

an initial ED nurse-driven pneumonia protocol. The ED Nursing Practice and Development Councils, ED Medical Director, and Emergency Medicine Departments reviewed, finalized, and approved the evidence-based content.

After nursing staff education, the ED Pneumonia Protocol was implemented in April 2007. Positive nursing feedback concerning use of the protocol included ease of use and helpful cues for timely respiratory assessment. Door-to-drug times improved from 130 minutes to 95 minutes and compliance to antibiotic initiated within 4 hours improved from 86.2% to 95% for the first month after protocol implementation.

Methods used to support the protocol implementation included ongoing collaboration with emergency medicine physicians and the ED medical director. The ED nurse pneumonia team member continued to serve as a major nurse champion and collaborated with the nurse educator for nursing staff education.

The ED Pneumonia Protocol has been revised to reflect the most current evidence-based antibiotic recommendations. Protocol use is driven by the nurse, supported by physicians, and remains ongoing. ED nursing use of other patient population-based protocols contributed to the successful implementation of the pneumonia protocol.

Improving Colorectal Cancer Screening Rates Using Colonoscopy through Motivational Interviewing

Jackie Bearwald; Gundersen Lutheran, La Crosse, Wis

Motivational interviewing has been successful in programs helping patients with obesity, suffering from addictions, and smoking cessation. It has also been used to try to improve mammography screening rates. Motivational interviewing is a person-centered directive method of communication for enhancing intrinsic motivation to change by exploring and resolving ambivalence, anger, and fear. The intent is to determine at what stage in the Transtheoretical Model of Change the patient is and move them to the action stage using motivational interviewing.

Based on barriers to screening identified in the literature, a survey for providers at Gundersen Lutheran was developed to determine their impressions on this topic and how a nurse might help improve this process of care. Surveys were mailed to 154 of our family medicine and internal medicine providers at the main campus and our regional clinics with 72% of providers responding. Fifty-eight percent supported face-to-face nurse-patient education and 61% supported follow-up phone contact with patients. Training in motivational interviewing was completed by nursing staff testing this change. This test of change was to do motivational interviewing by phone for patients who had not scheduled their colonoscopy within 6 months after being referred by their primary care provider and receiving a letter from the gastroenterology department to call and schedule their procedure.

Post-operative Pain in Urologic Day Surgery Patients: Oxycontin versus No Oxycontin at Discharge

David Grinder, MS, RPh; Mark Thompson, MD; Monroe Clinic, Monroe, Wis

Urologic surgery patients discharged from the Acute Care Unit (ACU) between June 12 and August 30, 2007, were instructed how to complete a pain assessment at least 4 times in the 24 hours post-operative. The form provided the Wong faces scale and a descriptive scale to assist the patient in determining a numerical pain score. The ACU nurse recorded the procedure, time of post-op arrival to ACU, surgeon, date and time of discharge from ACU, and the pain score at discharge. The patient was to indicate the time of pain assessment and what was done to relieve the pain. The patient was given a self-addressed stamped envelope to return the survey to the Monroe Clinic Pain Committee. The urologic patients were part of a larger survey of all ambulatory surgery patients.

Results were shared with the urologist and post-operative ambulatory pain management literature was reviewed. It was agreed that a dose of 10mg or 20mg of Oxycontin would be given to patients at discharge in an attempt to achieve better post-discharge pain control. The self assessment form was provided to all urologic day surgery patients between February 22 and May 12, 2008.

Results: A total of 30 assessments were received, 17 patients reveived no Oxycontin at discharge and 13 patients received Oxycontin at discharge.

The average pain score at discharge and at specified time intervals up to 24 hours after discharge was calculated for both groups. The maximum average pain score for patients not receiving Oxycontin was 3.2 between 4 to 8 hours after discharge. The maximum pain score for patients receiving Oxycontin at discharge was 1.5 between 12 and 20 hours after discharge.

Use of Oxycontin prior to discharge of day surgical patients has been reported with mixed results. Our data suggests that in urologic day surgery patients use of Oxycontin prior to discharge can help reduce pain scores in the immediate 24 hour period post-discharge.

Project Move

Nancy Whitfield, RN, MSN, CNS; St. Mary's Hospital Medical Center, Green Bay, Wis

Problem: Inconsistent patterns of addressing mobility and functional care needs of hospitalized patients can result in significant deterioration and deconditioning. Nursing is responsible for baseline assessment of functional and activity status and initiation of basic activity regimens. The nurse's attention to this important aspect of care is often overshadowed by other patient needs. Mobility regimens may be initiated too late, and role responsibility confusion may exist between caregivers.

*Purpose: (*1) Develop and implement interventions to enhance activity and mobility levels among adult hospitalized patients. (2) Conduct literature review to identify hazards of immobility and practice standards for improved mobilization.

Findings: (1) Baseline documentation data on 120 patients found 83% had a mobility activity order. Forty-two percent received minimum activity to the chair or bathroom and 5%

received ambulation outside the room or for any specified distance. (2) Lack of clarity and consistency by nurses in documenting activity. (3) Lack of readily available equipment and assistive devices for ambulating patients. (4) Limited means of communicating activity levels between disciplines. (5) Literature identified need to have patient out of bed 3 times daily and ambulating 3 times daily.

Rapid Response Team Implementation

Danny Loosemore, Good Samaritan Health Center, Merrill, Wis

Rapid Response Teams (RRTs) have been shown be an integral part of patient safety through responding to recognized signs and symptoms of patients who have the potential to code. While RRTs are important to implement in all hospitals, the logistics of establishing a team in a small rural hospital had its own set of challenges. Good Samaritan Health Center's approach to RRTs had to be created in such a way to meet our needs as well as perform as expected. The results of the implementation showed our hospital took a step in the right direction to improve patient safety.

According to the Institute for Healthcare Improvement (IHI), cardiac arrests can often be predicted 6 to 8 hours prior to the event occurring through the patient displaying signs and symptoms of the upcoming event. After review of code blue data and evaluating it against the early warning signs, a determination was made that a rapid response team would be an important addition to patient care practices.

A multidisciplinary group of physician, nursing, and support staff was formed to review literature and resources to create the rapid response team model that would both best suit the needs of patients and be feasible with the available hospital resources. Our methods included creation of a documentation tool to aid patient care staff in performing assessments in addition to staff education to make the changes permanent.

The documentation tool created was modeled around Situation, Background, Assessment, and Recommendation (SBAR). This model was used to enable the nursing staff to communicate with the physicians in a clear and consistent manner. Information from the literature review in addition to the framework provided by the IHI was incorporated into the assessment tool.

Situation: The patient's current situation is assessed for early warning signs of decline using the criteria that evaluates cardiac status, respiratory status, level of consciousness, pain assessment, genitourinary problems, temperature increase/decrease, abnormal labs, and patient care provider perceptions.

Background: The patient's background includes current diagnosis, any comorbidities that exist, vital signs taken within 4 hours of RRT call along with vital signs after the call, and any procedures the patient had during the stay.

Assessment: The assessment piece provides an area to record current vital signs and areas of concern that lead to the rapid response team call.

Recommendations: This area of the form is completed with recommended interventions to help alleviate the symptoms the patient is experiencing to bring them out of their deteriorating state. After report is given to the responsible physician, other recommendations are recorded here as well.

Finally, outcomes are recorded to determine if the intervention was successful in bringing about a positive change in the patient's status.

Project Implementation: Execution of the RRT program came through development of the policy and procedure to educate the patient care staff on how it works and what steps to take to call a rapid response team into action.

The house supervisor designates staff members to carry the RRT pager for every shift. The RRT members include available patient care staff such as the house supervisor, respiratory therapy, and Emergency Department physicians or mid-level providers.

Once nursing or other patient care staff recognizes the signs of the potential for a patient to decline, the staff member pages the RRT who then respond to the room listed on the pager. For those times respiratory therapy is not available in-house, the nursing supervisor completes a respiratory care assessment form and, if it is deemed necessary, the respiratory therapist is paged to consult. The patient's nurse completes the assessment form along with any interventions completed and communicates all information to the responsible physician. Additional interventions are carried out as ordered and the patient is continuously monitored for improvement or decline. Communication is maintained between all team members and physician until the condition resolves or further intervention is needed.

The RRT calls are initiated when necessary and reviewed for possible improvement opportunities to the process.

Reducing Risky Drinking and Drug Use

Joan Fischer; Wisconsin Initiative to Promote Healthy Lifestyles, Madison, Wis

Wisconsin leads the nation in binge drinking and drunk driving. Diseases and injuries related to alcohol and drug misuse make it the fourth most common cause of death and hospitalization in this state. In response to this need, the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) is implementing evidence-based screening, brief intervention, and referral-to-treatment (SBIRT) services at 23 primary care clinics around the state, with more to be added in coming years. SBIRT's proven efficacy in more than 50 clinical trials has led it to be endorsed by a number of leading medical and health care associations, including the National Institutes of Health and the National Quality Forum. The Joint Commission is presently considering whether to make SBIRT services mandatory in all hospitals. Such services must be administered by Level I and II trauma centers. WIPHL began offering SBIRT services in spring 2007, with the goal of establishing SBIRT as a long-term, sustainable component of basic health care in Wisconsin.

For the patient, the process begins with a brief screen—a few questions about alcohol and drug use and other health behaviors—that is administered to all

patients 18 and older, once a year. The carefully designed questions have been shown to identify substance misuse at even an early stage. Patients scoring positive meet with WIPHL-trained health educators at the clinic to discuss options for change. Numerous studies show that these brief interventions (1 to 4 sessions of 15-30 minutes) are enough to help many patients greatly reduce or eliminate substance misuse. The health educator and patient may agree that a referral to treatment for more intensive care (residential or outpatient) is needed. Costs may be covered by WIPHL.

Wisconsin Rural Hospital Stroke Improvement Group

Michelle Gardner; WHA, American Stroke Association, Office of Rural Health, Milwaukee, Wis

In the state of Wisconsin, approximately half of hospitals are critical access hospitals and rural hospitals. It is important when establishing a stroke system of care that all hospitals in Wisconsin understand guidelines and best practices in the area of acute stroke care and secondary prevention. It is vital that every hospital in Wisconsin can accurately treat, transfer in a timely fashion if necessary, and provide evidence-based interventions to those stroke patients that complete their stay in the rural hospital. It is critical to the system that all hospitals have appropriate protocols and availability of stroke guidelines.

The goal of this project is to improve each rural hospital's infrastructure to ensure that a process is in place for acute and secondary prevention measures for stroke patients at every hospital in Wisconsin regardless of location or size.

The Wisconsin Hospital Association (WHA), the Office of Rural Health (ORH), and the American Stroke Association (ASA) are providing rural hospitals the opportunity to improve stroke care by inviting hospitals to participate in a stroke quality improvement project. Each participating hospital can use the on-line patient management tool through "Get with the Guidelines." In addition to access to all guidelines, point of care tools, and patient education, each hospital will be able to participate in teleconferences to target best practices and areas in need of improvement.

In Wisconsin, many hospitals have small numbers of stroke patients, but collectively stroke patients that present at rural locations are numerous. Most rural hospitals initiate tPA, the only FDA approved "clot-busting" drug, and ship the patient to a Primary Stroke Center. Stroke patients that are not eligible for tPA often stay at the rural hospital and need the appropriate interventions, education, and follow-up to help prevent another stroke in the future.

The current areas of focus in the Wisconsin Rural Stroke Improvement Project have been the improvement of transfer protocols, adminstering tPA to appropriate patients, performing dysphagia screenings in a timely manner, and meeting the 5 components of educating the stroke patient. Learning sessions have also included the National Institutes of Health (NIH) stroke scale and establishing a stroke system of care in the state of Wisconsin.

The change has been significant. In June 2008, the group of rural hospitals met for its second in-person meeting. Most had established and implemented stroke protocols within their hospitals, had been training staff on the NIH Stroke Scale and had created other tools, such as dysphagia screening tools. Most hospitals have been looking at stroke data and sharing with the appropriate team members within their facility.

The WHA, ASA, and ORH will continue to establish learning sessions for the group based on the guidelines, data, and discussion around stroke quality improvement and best practices in stroke care.

INFECTION CONTROL

Antibiotic Stewardship: Putting Evidence to Work to Improve Outcomes

Chris Baker RN, PhD; St. Mary's Hospital, Madison, Wis

Antibiotic stewardship promotes appropriate selection, dosing, timing, and choice of route for antimicrobial agents. The primary goal of antibiotic stewardship is to optimize clinical outcomes while minimizing the unintended consequences of antimicrobial use including toxicity and the emergence and transmission of resistant organisms. A secondary goal is the reduction of health care costs associated with the use of antibiotics.

In the fourth quarter of 2007, St. Mary's Hospital in Madison, Wis, implemented a clinical antibiotic stewardship pilot program to evaluate the clinical, operational, and economic implications of antibiotic stewardship. Program resources included (1) 1 full-time clinical pharmacist practicing in the role of stewardship pharmacist, (2) 2 Infectious Diseases (ID) physicians providing 1-to-1 scheduled, clinical consultations for the stewardship pharmacist, (3) operational support from the pharmacy's administrative director and clinical supervisor, and (4) a dedicated data analyst. The pilot population was comprised of patients diagnosed with community acquired pneumonia (CAP).

Using electronic case finding, as well as provider referrals, the stewardship pharmacist reviewed clinical, medication, and immunization records for CAP patients on a daily basis. The stewardship pharmacist then consulted with the ID hospitalist to review findings and to develop recommendations. Recommendations were then discussed with the attending physician. If the attending physician concurred, the stewardship pharmacist wrote necessary change orders. In addition, the stewardship pharmacist would order immunizations to be administered based on the hospital's screening protocols. The most frequent interventions were suggesting alternate antibiotics based on national guidelines, making an IV to oral switch, and educating providers about evidence-based care for CAP. Additional interventions noted were avoiding significant adverse reactions, avoiding drug interactions, and discontinuing the antibiotic when CAP was ruled out.

Heightened Surgical Site Infection Surveillance

Paul Thomas RN, BSN, CIC; Saint Clare's Hospital, Weston, Wis

After a large quality improvement project was undertaken in the Surgical Service department among the total joint

replacement subspeciality, it was vital to know our current surgical site infection (SSI) rate. The Infection Prevention and Control Department at Saint Clare's Hospital created an overlapping, multi-resource SSI surveillance program that includes but is not limited to:

- Resource utilization via monitoring daily records; emergency department visits, the hospital's admissions, discharges and transfers
- Attending interdisciplinary inpatient rounds
- Reviewing microbiology department culture result reports
- Encouraging surgeons to self report SSIs
- Patient post-operative SSI screening calls by Saint Clare's Hospital volunteers
- Soliciting feedback via surgeon specific cumulative procedures surveys
- Rounding with purpose in the inpatient units

It is paramount for a hospital to accurately know its SSI rate. This is the starting point that guides process improvement activities that prevent HAI and eliminate sentinel events and/or unanticipated death.

Implementation of Guidelines to Reduce Catheter-Related Bloodstream Infections

Dena Jarog, CNS; Saint Joseph's Hospital, Marshfield, Wis

In 2006 the catheter-related bloodstream infections (CRBSI) rate for the units being studied was reported as 4.6 per 1000 catheter days. This was a 68% increase from 2004. Central venous catheters (CVC) provide much-needed access in the sickest patients, although they may place critical care patients at increased risk for bloodstream infections due to the frequency of CVC access and the severity of the patient's illness.

To address new mandates from Centers for Medicare & Medicaid Services (CMS), critical care patients within the facility, having a non-tunneled CVC in place for greater than 24 hours, were part of a program implementing the Institute for Healthcare Improvement (IHI) insertion and maintenance bundles created using evidence-based guidelines developed by the Centers for Disease Control and Prevention (CDC).

Using computerized tracking mechanisms, the infection control department observed nosocomial CRBSI rates higher than the National Healthcare Safety Network (NHSN) benchmark mean in the critical care units for the last several quarters. In the past, follow-up action has been unit specific education on proper line care techniques, and while the rates have dropped briefly, they have remained stubbornly high overall. The mean CVC infection rate for the surgical intensive care unit in 2006 was 3.1 infections per 1000 line days, the medical intensive care unit (MICU/CCU) had 2.7 infections per 1000 line days, and pediatric intensive care unit had 6.4 infections per 1000 line days.

During rounds, the physician staff, advanced practice nurse, and nursing staff assessed CVC dressings each day. Observations revealed that some of the dressings were not in optimal condition. Some of the occlusive dressings had old blood under them and others were loose due to patient diaphoresis or other skin conditions experienced by the patient. As part of this project, this issue was addressed during the roll out of the central line maintenance bundle. During a brainstorming session of the central line infection action group, it became apparent that there were assumptions being made about the knowledge of the nurses and physicians placing lines and maintaining the sites.

Using direct observation during daily morning rounds and informal bedside interview of staff nurses and physicians, gaps were identified. They were non-compliance with the use of the CDC recommended insertion bundle, poor compliance with hand hygiene, poor technique with changing dressings, and misuse of the swabs due to inexperience and misunderstanding of education provided. Other gaps were non-compliance with the CDC recommended daily assessment of need for continued CVC use, and poor technique when accessing ports for medication administration or when drawing from the ports of a central venous catheter. Following discussion regarding the gaps, the action group decided to begin the focus on the insertion and dressing practices as they relate to the CVC in order to reduce migration of bacteria through the site.

In April 2008, education for the use of the CDC guidelines and CHG patch was implemented. Infection rates for April, May, and June 2008 are at 0 for all units involved. Staff will continue to audit compliance with dressing maintenance and insertion technique. We will also continue to gather data to determine sustainability of the rates over the next year.

Pre-Operative MRSA Screening Program for Patients Undergoing Elective Implanted Surgery

Karen Peterson, RN, MSM; Wheaton Franciscan Healthcare All Saints, Racine, Wis

Surgical site infections (SSIs) account for 38% of health care acquired infections in the surgical patient population. A post-operative surgical site infection can lengthen a patient's anticipated length of stay by an average of 7.5 days and add thousands of dollars to the care cost and result in significant patient morbidity and mortality. A Methicillin Resistant Staphylococcus aureus (MRSA) post-operative SSI can add additional care costs as the infection is more difficult to treat with usual antibiotics.

A review of surgical site infections from July 1, 2006, to July 31, 2007, identified a total of 9, or 6.7% of post-operative SSIs developed following implanted surgery, ie, total hip, hernia repair with mesh, peripheral vascular bypass surgery with graft, implanted shoulder, or pacemaker surgery.

A long-standing MRSA screening program is in place for known previously positive cultured patients upon readmission to Wheaton Franciscan Healthcare All-Saints, but a process was not in place for MRSA screening of patients scheduled for elective surgery.

To improve quality outcomes by reducing the risk of MRSA post-operative

SSIs, a program for screening select elective surgical patients was proposed and approved by all general, vascular, orthopedic, urological, and plastic surgeons. In collaboration with surgeons and infectious disease physicians, patient populations identified include those undergoing a total hip, knee, shoulder, or spinal fusion; hernia repair with mesh; peripheral vascular bypass; and cardiac rhythm management implant, ie, pacemaker, as well as penile prosthesis, artificial urinary sphincters, and breast implants.

Methods: A multidisciplinary team developed a process that is utilized by patient care staff in the physician office setting. Physician office staff are responsible for identifying and following patients who are scheduled for a MRSA-screened operative procedure.

The screening process implemented focuses on an initial MRSA screening culture of the bilateral anterior nares prior to surgery. The timing of the culture is based on the date of surgery and/or history of previous MRSA in the select patient population.

A positive MRSA screening culture is followed by implementation of a decolonization protocol. The patient is re-cultured 2 days following completion of decolonization. A repeat positive MRSA culture is followed by a second decolonization and the patient's fluid is re-cultured 2 days following completion. In the event that the bilateral anterior nares remain MRSA positive following the second decolonization, the surgeon is encouraged to use Vancomycin as the pre-incision antibiotic.

Surviving Sepsis Campaign

Lori Harmon, RRT, MBA; Society of Critical Care Medicine and Aurora St. Luke's Medical Center Milwaukee, Mount Prospect, Ill

Rationale: More people die in 1 year in North America from severe sepsis than from breast cancer, lung cancer, and colon cancer combined. The incidence of sepsis is strikingly high and significantly underestimated. Data suggest that the prevalence of severe sepsis may double over the next 25 or 30 years; so the implications for resource allocation and utilization in North America are enormous. Hospitals across the United States and some countries internationally are having success by organizing multiprofessional task forces dedicated to working through the challenges associated with early patient identification and implementation of the sepsis bundles. The Surviving Sepsis Campaign (SSC) evidence-based bundles target rapid intervention in the emergency departments (EDs), floors, and intensive care units (ICUs) much like treatment of stroke and myocardial infarction. Annually, severe sepsis strikes an estimated 750,000 people in the United States with associated costs being borne by insurers, government, patients, and hospitals. Early intervention in the ED and hospital wards can mitigate increased morbidity and mortality. Since approximately 55-60% of all septic patients present to the ED, Aurora St. Luke's Medical Center (ASLMC) selected the ED to launch the bundles. ASLMC also implemented the SSC at another site location-Aurora St. Luke's South Shore (ASLSS).

In June 2006, after a hospital-wide educational program, physicians and nurses began using the sepsis screening tool provided by Institute for Healthcare Improvement (IHI) to screen patients for sepsis upon arrival to the ED with an annual volume of 63,000 patients. The educational program and the sepsis committee is known as the LIFE Campaign (St. Luke's Initiative for the Implementation of Early Goal Directed Therapy and the IHI bundle). Patients were risk stratified into severe sepsis, septic shock, and cryptic shock based on the IHI definitions and with point of care lactate. They were then admitted to the ICU with a standard order set containing all the IHI bundle elements as well as an antibiotic appendix.

Early Goal Directed Therapy (EGDT) and the resuscitation component of the IHI bundles were started in the ED on patients in septic shock or cryptic shock and continued in the ICU under supervision of the electronic ICU physician. Individualized feedback to emergency physicians was provided by committee chart review to ensure compliance of bundle elements.

Data for bundle compliance was compiled 1 month before the formation of the committee and 2 months after the rollout date.

Ongoing data collection and feedback to physicians and staff is given on a routine basis. Any case not meeting the bundle elements is reviewed by the Sepsis Physician Co-chairs with feedback given to those staff involved.

CUSTOMER SERVICE

Real Time Feedback for Real Time Care: The Use of Retired RN Volunteers in Patient Centered Quality Improvement

Sherri Waid; Saint Clare's Hospital, Weston, Wis

Saint Clare's Hospital wanted to go above and beyond in patient care. To learn more than would be available in the typical survey tool, we undertook a hospitalist survey to help us identify potential patient concerns after discharge. Patient concerns are frequently in the area of follow-up appointments with providers, follow-up testing, and medication compliance. Ultimately we wanted to increase patients' comprehension of care after hospitalization to prevent readmission, and to support the healing process.

We adhered to the **plan, do, study, act** methodology.

Planning involved selecting volunteers with a clinical background, developing training materials, role playing phone calls, shadowing staff through the call back process, and developing survey and tracking tools and relationships with clinical staff.

For implementation (**do**), volunteers conducted call backs within 72 hours for each inpatient who was seen by our hospitalists. The results were entered in a tracking tool. Any patient care concerns were entered into an electronic incident reporting system for follow up.

In **studying** the data, the tool was thoroughly completed and patient concerns were mapped and shared with the hospitalists for process improvement.

Some of the lessons learned (**act**) were adjusting callers' schedules to accommodate high census, revising the survey tool to make it more patient centered,

and knowing when to refer the patient to their patient care provider or back to the hospitalists' nurse practitioner. To validate the program, we have tracked the patient response to the call. Most are very appreciative of the extra attention. Readmission data is shared on a quarterly basis at the Performance Improvement committee.

The survey tool and its results continue to evolve over time to improve the care and quality of services provided to our patients.

Resident-Centered Care

Joan Bahr; Southwest Health Center, Platteville, Wis

The Resident-Centered Care initiative was undertaken to improve resident satisfaction. The process for change initially included a multidisciplinary team, including the nursing home administrator, the director of nursing, activity manager, food/nutrition services manager, and social worker. The initial process to implement the change included attending various conferences across the various disciplines, teleconferencing with facilities that had implemented resident-centered care and asking questions, and visiting a facility that had implemented resident-centered care.

To measure the program's success, the following goals were established for 2007:

- Implement consistent assignment of a core group of staff to the same residents 80% of the time.
- Change the dining experience from tray service to restaurant style dining.
- Offer greater resident choice in when to get up, when to eat, and when to go to bed.
- Offer greater resident choice in bathing.

As plans progressed, the interdisciplinary team increased to include 2 certified nursing assistants, 2 food service workers, maintenance, and housekeeping. Resident-Centered Care involved a culture change within the facility. To prepare the staff for the change to Resident-Centered Care, an inservice was prepared for all departments. The 4-hour inservice was attended by the entire nursing home staff.

Prior to the March 28, 2007, implementation date, residents or their POA-HC were interviewed regarding the preferred time to get up in the morning; how often, and how they would like to bathe. Also, prior to the implementation date, the food service department tested the meals by working with the food items and staff to determine the best possible method of service. The building was divided into 4 communities with each employee also included in a designated community. The employees were able to choose the community and/or were part of the community based on their position. The only 2 employees not assigned to a community were the director of nursing and the nursing home administrator.

As the Resident-Centered Care project progressed, adjustments were made. Also, the value statement for Resident Centered Care was approved as:

We will….

C*ommunicate with residents in order to strengthen bonds and*

A*cknowledge the importance of relationships. Through available*

R*esources we will create an atmosphere that promotes community*

I*dentity, while simultaneously addressing each person's unique*

N*eeds. We will honor the values and standards set by their*

G*oals with respect and love.*

The 1 year anniversary was celebrated April 5, 2008 with a party off-site. Changes over the first year were massive. The process continues with new emphases: the physicians have approved the use of alcohol by all residents (with only minor exclusions), the purchase of a portable bar for monthly "happy hours," the purchase and implementation of 3 raised garden plots, and the development of the communities by holding meetings with the residents and staff to determine activities for the community. Each community has a bulletin board that is decorated on a monthly basis by members of the community.

Volunteer Patient Advocate

Sister Sharee Hurtgen; Saint Clare's Hospital, Weston, Wis

Volunteer Patient Representatives (VPRs) make frequent patient rounds to welcome the patient to the hospital, to increase patient satisfaction, address immediate patient concerns, and ensure patients are aware of the patient advocate services. The role is to enhance quality of care and quality customer service.

Prior to becoming a VPR, an individual needs to have served as a volunteer at Saint Clare's Hospital for 1 year.

The VPR visits patients on the assigned unit. They greet patients and assess the patient satisfaction, explain hospital systems such as call light, how to use the TV, how to order food, and assure that the patient has received Saint Clare Hospital Patient and Visitor Guide.

The VPR listens to concerns and either resolves them or brings them to the attention of the charge nurse. If the charge nurse is unable to resolve the concern, the VPR will inform the patient/family that their concern is being forwarded to the Patient Advocate.

The VPR also notes any compliments from the patient and records them. If patient has family at a distance the VPR may give patient a long distance phone card to contact family members.

During patient visits, the VPR asks questions regarding patient care, such as the following:

- Do you know how to use your call light?
- Has anyone gone over your patient booklet with you?
- Do you know how and when to order your meals?
- How have they been taking care of you?

advancing the art & science of medicine in the midwest

WMJ

WMJ (ISSN 1098-1861) is published through a collaboration between The Medical College of Wisconsin and The University of Wisconsin School of Medicine and Public Health. The mission of *WMJ* is to provide an opportunity to publish original research, case reports, review articles, and essays about current medical and public health issues.

Visit www.wmjonline.org to learn more.