

# Proceedings from the 2007 Wisconsin Quality and Safety Forum

The Wisconsin Medical Society, Wisconsin Hospital Association, MetaStar, Wisconsin Collaborative for Healthcare Quality, and the Wisconsin Health Information Organization partnered on the 2007 Wisconsin Quality and Safety Forum held October 22-23 in Waukesha. A highlight of the forum was the showcase of quality and safety projects from health care organizations around the state. We are pleased to publish shortened versions of these projects in this issue of the *Wisconsin Medical Journal*.

## **A Comparison of 2 Methods to Improve HgbA1c Testing: "Pay for Performance" versus a "Chronic Care Collaborative"**

*Geoffrey C Lamb, MD; Medical College of Wisconsin, Milwaukee, Wis*

Motivated to improve HgbA1c testing reported to Wisconsin Collaborative for Healthcare Quality, 2 Medical College of Milwaukee clinics took different approaches, creating a natural experiment comparing pay for performance (P4P) to a chronic care collaborative model (DITTO). DITTO was piloted at 1 clinic. Non-participating providers received only simple feedback. In the other clinic, bonuses were directly linked to testing (P4P). The proportion of patients tested and median HgbA1c were calculated at baseline and 14 months later. Median HgbA1c was reduced 0.4% in the DITTO pilot while the feedback and P4P groups were unchanged ( $p < 0.001$ ). Resources may be better spent supporting multidisciplinary interventions than providing financial incentives.

## **A Comprehensive, Coordinated, Community-Wide Quality Improvement Project to Decrease the Prevalence and Transmission of MRSA in a Rural, Regional-Referral Health Care Setting**

*Jeanine Bresnahan; Aspirus Wausau Hospital, Wausau, Wis*

Within our organization, the number of patients with a positive Methicillin Resistant *Staphylococcus Aureus* (MRSA) culture, including patients with health care-associated MRSA, in-

creased annually. Inpatient admissions for which Contact Precautions were utilized also increased. Our goal was to reduce the prevalence of MRSA in our rural, geographical circumscribed area through a concerted, collaborative effort between the hospital and 5 local skilled nursing facilities. This collaborative effort utilized active surveillance, decolonization, and centralized follow-up to attain long-term clearance of MRSA colonization.

## **Annual Quality and Safety Review Fair**

*Karen Grasse, RN, BSN; St. Mary's Hospital Medical Center, Green Bay, Wis*

St. Mary's Hospital Medical Center (SMH) was due for its first Unannounced Accreditation Survey from Joint Commission sometime in the year of 2006. As SMH Joint Commission Specialist, I decided to create a way for staff to participate in a review fair as part of ongoing survey readiness. The main objective was to have fun while reviewing quality and safety topics. Thus "The Joint Commission Review Fair/Christmas Carnival" was created. The holiday-themed carnival was held for 2 days in December of 2005, 11 AM – 5 PM on the first day and 7 AM – 1 PM on the second day. This gave the greatest opportunity for all shifts to participate. It was such a success that it has become an annual event. The second review fair was in October of 2006, "The Haunted House of Quality and Safety." Plans for the third annual review fair are underway, "A Tailgate Party Review" in early November of 2007.

## **Blood Culture Utilization**

*Carol A. Spiegel, PhD; University of Wisconsin Hospital and Clinics, Madison, Wis*

Blood cultures are the only reliable means for laboratory diagnosis of sepsis. They are over used at University of Wisconsin Hospital and Clinics compared to peer institutions. In addition to the excess cost of these cultures, false positive cultures lead to additional laboratory testing, unnecessary antibiotic use, and extended length of stay; a mean excess of \$6000 (2005 dollars) per false positive. Excess single (rather than paired) blood cultures are likely to under diagnose sepsis and lead to unnecessary treatment of patients whose single culture grows a common skin contaminant. Blood culture guidelines were updated in November 2006 and monitors instituted to determine compliance.

## **Chest Pain Accreditation**

*Mary Nickel; Saint Clare's Hospital, Weston, Wis*

Saint Clare's Hospital began an interventional heart program in the fall of 2006 and received full Cycle II Accreditation with PCI (Percutaneous Coronary Intervention) from the Accreditation Review Committee on May 25, 2007. Saint Clare's Hospital is the 355th accredited chest pain center in the nation, the 16th Wisconsin hospital to earn certification and only the second to earn it with PCI. Less than 10% of all US hospitals have accredited chest pain programs. No other local or regional hospitals in central Wisconsin currently are accredited.

Heart attacks are the leading cause of death in the United States, with 600,000 dying annually of heart disease. More than 5 million Americans visit hospitals each year with chest pain. The goal of the Society of Chest Pain Centers is to significantly reduce the mortality rate of these patients by teaching the public to recognize and react to the early

symptoms of a possible heart attack, reduce the time that it takes to receive treatment, and increase the accuracy and effectiveness of treatment.

### **Chronic Care Model Implementation for Diabetes**

*Mary Walker; Advanced Healthcare, Milwaukee, Wis*

Providing excellence in clinical care is an important part of the Quality and Value Strategy for Advanced Healthcare (AH). In 2004, AH joined the Wisconsin Collaborative for Healthcare Quality (WCHQ). Our performance on the initial WCHQ diabetes measurements was generally below average. Via a "Diabetes Taskforce," we took a variety of steps to improve our measures. While improvements in our some of our process measures were seen, AH continued to lag WCHQ leaders in other process measures and outcome measures. A more comprehensive, system-wide solution was needed to improve the quality of care at AH for diabetes and other chronic illnesses. Thus, we formed a Chronic Care Model Team. This team has been successful in implementing system and workflow changes in various AH primary care practices, which has improved the quality and accountability for care for our diabetes population.

### **Decreasing Ventilator Associated Pneumonia: A Collaborative Approach**

*Rachael Boehning-Anderson; Saint Joseph's Hospital, Marshfield, Wis*

Ventilator Associated Pneumonia (VAP) is associated with significant morbidity and mortality. A multidisciplinary team implemented a process to track VAP rates and recommended improvement strategies. Prior to this, St. Joseph's Hospital (SJH) did not track VAP rates.

Baseline rates were measured, strategies selected and implemented. Strategies included elevation of head of bed, cuff pressure measurements, daily weaning assessments, oral care, suctioning technique, and hand hygiene. After implementation rates decreased from 6.79 to 2.30 per 1000 ventilator days ( $p=.035$ ) with over 300 vent days per month.

We continue to work toward a goal of 0 VAP through continued education and monitoring.

### **Development of a Safe Patient Handling Program**

*Mary Hughes, OTR; Fort HealthCare, Fort Atkinson, Wis*

An opportunity existed to improve the safety of employees and patients during patient transfer and handling tasks. In April 2006, the Safe Patient Handling Program was started at Fort HealthCare. The program started with formation of a committee with representatives from patient care areas. To increase staff awareness of the program we held Safety Fairs with vendors demonstrating equipment, and provided training in the use of the equipment as well as opportunities to trial it in actual patient handling situations prior to purchase. Our Safe Patient Handling policy and procedure was formally introduced in March 2007. There were 77 employee reports of back or shoulder pain related to patient handling in the 5 years preceding implementation of the Safe Patient Handling Program; from January to June 2007 there have been no reports.

### **Diabetic Labs**

*Mary Beth Dickinson; Marshfield Clinic, Marshfield, Wis*

An investigation into the process for drawing diabetic labs that measure A1C, LDL, and urine for microalbuminuria was done to determine the number of patients having the recommended test frequency with desired clinical outcome measures. One regional Marshfield Clinic center was chosen since initially 16% of its patients with diabetes did not have lab results available for the patients' health care professional at point of care. A process to change the timing of lab work was implemented so results would be available to the health care professional at the office visit to enable collaboration on a plan of care.

### **DVT Prevention: Not Just for the Surgical Patient**

*Danny Loosemore; Good Samaritan Health Center, Merrill, Wis*

Good Samaritan Health Center this year developed a protocol to help prevent deep vein thrombosis/venous thromboembolism (DVT/VTE) in the general inpatient population. This project was instituted in response to a review of the Agency for Healthcare Research and Quality Patient Safety Indicators as

well as information from the Surgical Care Improvement Project. While the risk and indications for DVT/VTE prophylaxis in the surgical patient is well understood, the risk associated with the general inpatient population required a concerted effort to collect the data necessary to create clear and concise risk assessment protocol.

### **Embedding the National Patient Safety Goals Into Day-to-Day Practice**

*Kim Weber Chandler; Gundersen Lutheran, La Crosse, Wis*

Gundersen Lutheran chose a "layering" system with multiple methods of education and measurement to embed the National Patient Safety Goals into day-to-day practice and raise the staff's comfort level in conversing about how the goals are implemented in patient care. This was done using observation and dialogue around the goals through safety walk-throughs and tracers and patient surveys of demonstrated behaviors. Tracer results have shown at least 10% improvement in all goals over the last 3 months and, according to survey results, patients see staff meeting 5 specific goals consistently at least 93%-100% of the time.

### **Empowering Patient Escorts to Change Culture; Eliminating Omissions of Patient Identification Bracelets**

*Diane Batten; Aurora Sinai Medical Center, Milwaukee, Wis*

Aurora Sinai Medical Center recognized that a small number of patients improperly identified could lead to poor patient outcome. Patients were being transported throughout the facility for procedures without identification (ID) bracelets. While the incidence was occasional, concern was raised. The ability to positively identify confused patients caused a delay in care while identification was verified. The goal was to have all patients wear ID bracelets when transported for procedures. The Patient Escort Team was empowered to refuse to transport patients who were not wearing ID bracelets. This "hard stop" approach to a complex process was successful in eliminating the problem of patients arriving for a treatment or procedure without identification.

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## **Finding Better and Safer Ways Together: The Development and Implementation of a Patient Safety Council**

*Deborah Bonin; Aurora Health Care, Elm Grove, Wis*

The implementation of a patient safety council improved medication safety in Walworth County, Wisconsin. The council, consisting of health care professionals and patients, developed and implemented patient and professional tools to increase communication about medications. The patients and health care professionals developed a medication bag for patients to carry medications to their health care appointments and a personal medication list for the patient to complete. The use of these tools, as well as health care professional education, improved the accuracy of the clinic medication lists in the Walworth County Clinics 17% (69% to 81%) ( $p < .0001$ ).

## **Franciscan Health Care System Has Gone Lean**

*Kris Arney; Franciscan Health Care System, La Crosse, Wis*

Franciscan Health Care System (FSH) has gone Lean—a way of viewing the world. Lean is about focus, removing waste, and increasing patient/customer value. Lean is a systems approach to designing processes that improve patient safety. Lean is about smooth process flows, doing only those activities that add customer value and improving patient safety, and eliminating all other activities that don't. FSH formed 7 teams that used "Lean" techniques to improve processes. Each team applied the 5 S Method within their process improvement activities and the Solution/Suggestion Boards to obtain and maintain improvement ideas from staff members. The Lean initiative helped FSH to improve the organization from a strategic perspective. In addition, the initiative helped the organization develop capabilities to maintain the improvements that led to improved quality and patient safety.

## **Getting Organized...and Integrating Quality**

*Sally Rosemeyer; Boscobel Area Health Care, Boscobel, Wis*

In our small, rural hospital, as in all hospitals, we continually review how and

what we are doing to meet the ever increasing demands of the "quality movement." Over the past year and a half it became obvious that we are inundated with data collection and data analysis. However, it also became apparent that we were doing more data collection than data analysis.

We began by asking 3 questions about the data we collect. We then asked a second set of questions to determine if the data collected is relevant and reflective of the mission and vision of Boscobel Area Health Care. Our next step was to align the organizational goals with departmental and individual performance measures.

We next developed an "online quality clearinghouse" so all staff has access to all data collected and so staff are not independently collecting data that is already being collected or is available through the computer system.

## **Hand-Off Communications**

*Heather Willner, Saint Joseph's Hospital, Marshfield, Wis*

Communication problems in health care continue to be the number 1 cause of sentinel events. Because hand-off communications are high-risk, offer opportunities for error, and are important for the continuity of patient care, a multidisciplinary team was formed at Saint Joseph's Hospital to develop a standardized process to assure that high quality hand-off communication with the opportunity for interaction occurs with patient hand-offs.

Baseline information, including trends in processes, content and gaps related to hand-off communication, was obtained. Facility to facility transfers, unit to department transfers and unit-to-unit transfers were chosen as key opportunities for improvement with hand-off communication. Strategies have been implemented that result in a standardized, more efficient, and improved communication process.

## **Health Literacy: The Importance of Education for Health Professionals**

*Doris A. Doherty; Franciscan Skemp Healthcare, La Crosse, Wis*

Franciscan Skemp's mission is to put patients first and improve our communities' health. Determining the staff

development and clinical competency needs of our licensed nursing staff as it relates to patient and family education is imperative to this mission. An expert team of nurses was formed from the hospitals and clinics within the Franciscan Skemp Healthcare system. A survey was designed to rank personal skill level and nurse's perception of the skill's importance. Ability to determine patient's health literacy and adjust their teaching methods accordingly was identified by nurses. System-wide implementation of a learner-driven nursing education module commenced in 2007.

## **How to Create and Maintain an Effective Skin Care Program to Prevent Pressure Ulcers**

*Patti Anderson, RN; Gundersen Lutheran, La Crosse, Wis*

In 1995 Gundersen Lutheran established a comprehensive program to decrease the prevalence of pressure ulcers by 50%. We achieved this aim in 8 years decreasing from 32% to 14% and have decreased prevalence since then to <2%. In addition, our incidence rate (skin breakdown acquired while we were caring for the patient) decreased from 6% to 0 and has remained so 4 of the last 5 measurement periods. Our approach is also cost effective and demonstrates cost savings of approximately \$90,000.

## **Identifying Barriers to Achieving Discharge Medication Teaching Outcomes**

*Jennifer Burfeind; Aurora Sinai Medical Center, Milwaukee, Wis*

The quality improvement project started with a hospital-wide retrospective chart audit (n=33) that showed a high percentage of incomplete medication reconciliation forms on admission and discharge, which resulted in failure to meet established regulatory discharge outcomes. Concurrent chart review (n=16) provided further evidence that barriers exist that make it difficult for nursing staff to accurately complete medication history during the admission process. Staff (n=12) survey reported barriers to gathering medication history. Post educational intervention data (n=57) included follow-up audits of those forms initiated on our unit at 2, 4, 6, 8, 10, and 12 weeks post intervention that showed a 98% accuracy rate.

**Why the project was undertaken?** The home medication reconciliation was found to be incomplete, which greatly influenced the nurse's ability to effectively provide adequate discharge teaching.

**How this project improved quality or safety?** Our literature review supported that this is a global problem within all diverse populations and is not unique to our urban medical center. If unresolved, the incomplete medication history issues carry over and limit the effectiveness of discharge teaching. Improving this process has provided vital patient information for nurses to use in achieving proactive, individualized discharge instructions that will enhance self-management after discharge.

### **Improving Cancer Screening Rates—Medical Associates Health Centers**

*Vicki Fehrenbach; Medical Associates Health Centers, Menomonee Falls, Wis*

In 2006, Medical Associates publicly reported on screening rates for breast, cervical, and colorectal cancer as a member of the Wisconsin Collaborative for Healthcare Quality (WCHQ). From our data, we learned that our performance was among the lowest of 14 participating WCHQ clinics. As a result, a team was formed to improve cancer screening at Medical Associates. One year later, our cancer screening rates have improved by 8% for both breast and cervical cancer, which equates to approximately 600 additional women receiving screening mammography and 1000 more getting Pap smears.

### **Improving Health Care Worker Hand Hygiene Compliance**

*Nancy M. Lorenzoni; St. Vincent Hospital, Green Bay, Wis*

The Hand Hygiene Project evolved to address implementation of the updated Centers for Disease Control and Prevention (CDC) guideline for hand hygiene practices in health care settings and compliance with The Joint Commission national patient safety goal that health care facilities reduce the risk of health care associated infection by complying with the CDC Hand Hygiene Guideline. Hand hygiene is an expected practice for health care professionals to protect their patients from infection. Historically, the level of compliance has been low. We embarked

on our project to determine the behavior of our health care professionals, to bring the information to them, and to work on ways to improve compliance and enhance patient safety.

### **Improving IV Starts Using Simulation**

*Kendra Jacobsen; Madison Patient Safety Collaborative, Madison, Wis*

The Madison Patient Safety Collaborative (MPSC) formed a team to investigate improving IV start skills among nurses working in Madison, Wis. The team created a city-wide standard for IV start competency and also purchased an IV skills simulator to improve skills. Data analysis shows a decrease in nurse anxiety and an increase in nurse confidence with IV starts. Change is most dramatic for nurses who have little opportunity to start IVs. The MPSC team is using the IV simulator in new nursing orientation classes and in-services at clinic. Feedback of the simulator is being monitored through evaluations.

### **Improving Patient Care Through Increased Pneumococcal Immunization**

*Ellen Gianoli; Gundersen Lutheran, La Crosse, Wis*

Gundersen Lutheran, Inc. initiated a proactive approach in 2006 to increase the pneumococcal immunization rate for patients older than 65 in our multiple primary care clinics to prevent community-acquired pneumonia (CAP). A standardized patient flow process and standing orders for administration of pneumococcal vaccine were developed and piloted in the regional clinics. The 2007 goal is to hardwire this process regionally, and implement it in the La Crosse primary and urgent care departments. There will also be a process to immunize patients who come into specialty departments that do not have a primary care provider in our system.

### **The Initiation of a Scripting Program in a Rural Community Hospital**

*Stephanie Wanek, RN, BSN; Richland Hospital, Richland Center, Wis*

The project that was initiated was a scripting program at a 25-bed critical access facility. Scripting is the process of developing a specific script for staff

to utilize and rely on in certain patient contact situations and can help give patients a clear and consistent message. When devising the plan, areas in which we had opportunity for improvement were identified via Press-Ganey scores. Targeting these areas with a script was the foundation for the program, and it has blossomed from there. Described are the goals, identified challenges, method of communication, method of implementation, and results from our facility.

### **It's OK to Ask**

*Mary Nickel; Saint Clare's Hospital, Weston, Wis*

The purpose of the project is to encourage and empower the Family Birth Center's (FBC) patients of Saint Clare's Hospital (SCH) to be active participants in their care by completing hand hygiene and observing or asking staff and physicians to complete hand hygiene before delivering their care. On January 1, 2007, the Joint Commission implemented a new National Patient Safety Goal. The new goal was set forth to encourage patients and their families to become more active in their care. As a way to help become compliant with the new National Patient Safety Goal and to further enhance the quality and safety of their patient care, Saint Clare's Hospital adopted the "It's OK to Ask" Campaign.

### **Journey to Perioperative Safety**

*Greg Bruder; Columbia St. Mary's, Milwaukee, Wis*

As part of its "Healthcare That Is Safe" strategy, Ascension Health identified Priorities for Action and adopted a goal of clinically excellent care with no preventable injuries or deaths by July 2008. Alpha sites developed and deployed initiatives to implement evidence-based practices to undertake the Priorities for Action. Both teams participated in the Institute for Healthcare Improvement Impact Group to enhance Perioperative Safety. Sacred Heart Hospital (SHH) and Columbia St. Mary's (CSM) accepted the invitation to serve as Alpha sites to develop strategies to eliminate perioperative adverse events.

### **Level 1 Cardiac Care Program**

*Audrey Schlund, RN, BSN; Aspirus*

Wausau Hospital, Wausau, Wis

Aspirus Wausau Hospital's Heart and Vascular Institute implemented the Level 1 Cardiac Care Program in January 2007 with the intended goal to provide timely reperfusion for all acute myocardial infarction (AMI) patients being transferred from outlying facilities. This effort complements our already existing internal D2B (Door to Balloon) process that successfully manages STEMI patients coming to our emergency department with an average door to reperfusion time of 68.9 minutes.

### **Listen. The Patient is in the Room**

*Sue Gaard; Gaard & Associates, Madison, Wis*

This project presents the findings of a qualitative study designed to measure patient perceptions about the quality and safety of their health care, the extent to which patients are proactive in communication with their providers, and their reactions to message concepts about patient safety. Although participants were very concerned about the quality and safety of their health care, they had difficulty defining and evaluating health care quality. All participants agreed they should be proactive in their care, but did not express confidence in their ability to do so. Results were used to develop a communication campaign to increase awareness of patient safety and promote proactive communication between patients and providers.

### **MRI Safety**

*Nancy Dufek; Memorial Medical Center, Ashland, Wis*

Memorial Medical Center experienced a near miss when a staff member attempted to bring a non-compatible piece of equipment into the strong magnetic environment of the MRI suite. National statistics indicate that once every 5 years a MRI facility experiences an accident resulting in patient/staff injury or destruction of equipment. Memorial Medical Center's first MRI magnet was installed in 1994 and to this point, no incidents have occurred.

Every MRI facility has safety policies and procedures in place. Can we do better? Memorial Medical Center formed a team to beat the odds rather than play them.

### **Our IHI Journey to Excellence**

*Barb Rogness; Wheaton Franciscan Healthcare – St. Joseph, Milwaukee*

Wheaton Franciscan Healthcare (WFH)—St. Joseph has been an active member working with the Institute for Healthcare Improvement (IHI) since 2002 as IMPACT member and an active participant on a number of innovative test teams. The IHI has been a leader in improving the quality and safety of patients. Our commitment to remain active shows a true commitment to be a leader and tester of innovative ideas. From 2002 to present, there have been many identified improvement opportunities, some of which take years to fully implement. In the end our 2005 HSMR mortality data lists us below the national average. A number of these key initiatives remain a focus of improvement within our organization.

### **Patient Satisfaction in 21st Century Medicine: Revolution or Evolution?**

*Paul Sommers, PhD; Hudson Hospital, Hudson, Wis*

A patient satisfaction system has been designed that is revolutionizing the delivery of health care services by making the patient the "center" of the delivery system at "the-point-of-service." The patient-provider interaction is accomplished through a Moment-of-Truth (MOT<sup>®</sup>) patient satisfaction system. Patient needs are aligned with the required health care resources when the patient enters the health care system. The unique advantage of the MOT approach is that it collects patient information in real-time and simultaneously acts on the information collected to correct less-than-excellent patient care and service experiences before the patient leaves the facility.

### **PeriData.Net—Wisconsin's Comprehensive Perinatal Data System: A New Tool for Perinatal Care**

*Ann Conway, RN, MS, MPA; Wisconsin Association for Perinatal Care, Madison, Wis*

PeriData.Net<sup>™</sup> was developed and implemented through the leadership of the Wisconsin Association for Perinatal Care (WAPC) to be Wisconsin's comprehensive perinatal database. Operational in April 2006, its

Web-based system provides Wisconsin birth hospitals with a portal for collection and submission of birth vital record data and additional patient-level data for quality monitoring, reporting, and improvement efforts. Immediate access to secure perinatal data through the case retrieval, standard reporting, and on-line querying functionality support timely evaluation of perinatal care. An aggregate reporting function currently in development will provide hospitals with comparison data and will support statewide perinatal quality initiatives.

### **Prevention of Catheter Associated Urinary Tract Infections**

*Eileen Scalise; Aurora Medical Center, Oshkosh, Wis*

Health care acquired infections (HAIs) cause an increase in morbidity/mortality and costs. It is our hospital's vision to provide better results; Preventing an HAI for a patient is providing quality care and keeping the patient safe.

Even though the utilization of indwelling urinary catheters and infection rate in our hospitalized patients remains below the National Nosocomial Infections Surveillance benchmark, we believed to provide better results we needed to prevent the catheter associated urinary tract infections (CAUTIs) that were occurring. The urinary tract is the most common site of HAIs according to the literature. Although not all CAUTIs can be prevented, it is believed that a large number could be avoided by the proper care of the patients with indwelling urethral catheters.

If we could institute a successful CAUTI prevention bundle strategy, we would be finding a better way to provide quality care while keeping the patient safe from infection and its sequelae.

### **Prevention of Post-operative Atrial Fibrillation in the Cardiac Surgery Patient**

*Kelly Galler; Bellin Health, Green Bay, Wis*

*Background:* Post-operative atrial fibrillation (AF) in the cardiac surgery patient is a common, costly, and potentially devastating complication. Literature reveals no proven methods to reduce this. Comparison of hospital, like group and national rates of post-

operative AF from the STS National Database revealed room for improvement. A new prevention of post-operative AF protocol was developed.

*Conclusion:* The implementation of this prevention protocol has significantly reduced the post-operative AF rate, which is resulting in improved patient safety and outcomes. Loading the cardiac surgery patient with amiodarone prior to undergoing surgery proves to be beneficial at preventing post-operative AF.

### **Rapid Response Team**

*Crystal Kirschling; Saint Michael's Hospital, Stevens Point, Wis*

The Institute for Healthcare Improvement and Joint Commission on the Accreditation of Healthcare Organizations recognize the incidence of failure to rescue and have focused on the Rapid Response Team as an initiative to prevent these occurrences.

Developing a Rapid Response Team in a community hospital can be a challenge with available resources.

### **Reducing Employee Injuries From Patient Handling**

*Marge McFarlane; Sacred Heart Hospital, Eau Claire, Wis*

The analysis of Sacred Heart's employee injury log from 2002-2006 identified an opportunity to reduce employee injuries due to patient handling. The project was selected because reducing employee injuries increases productivity, staff and patient satisfaction, and reduces operating costs both directly and indirectly.

The goal was to decrease the number of employee repositioning injuries and costs due to patient repositioning by 10%.

The Failure Modes and Effects Analysis identified the 3 primary reasons for potential injury as:

1. Equipment not available
2. Staff not waiting for assistance or equipment
3. Staff not using available equipment.

### **Reducing Harm from Falls**

*Kendra Jacobsen; Madison Patient Safety Collaborative, Madison, Wis*

The Madison Patient Safety Collaborative (MPSC) participated in an Innovation Project with the

Institute for Healthcare Improvement (IHI) on Reducing Harm from Falls. Nationally, 12 hospitals participated in this project and collected monthly measures on harm from falls and fall rates. Participants used the PDSA improvement method. Madison hospitals tested post-fall huddles, patient teach back, high fall risk assessment, prompted toileting, and patient safety rounds.

The MPSC team concluded that to reduce harm from falls you must prevent the fall from occurring. The best strategies for reducing harm may be those that are for fall prevention.

### **Strict Glycemic Control in the SICU**

*Jennifer Neubauer, RN; Froedtert Hospital, Milwaukee, Wis*

To achieve strict glycemic control in an open surgical intensive care unit, a multidisciplinary team used process improvement methods to lower average monthly glucose. Strategies employed included (1) use of virtual ICU data reported monthly to leadership, staff intensivists, and nurses, (2) improving accuracy of virtual ICU data by reporting glucose values, and (3) linking glucose values to physician orders. Orders included no action, use of insulin drips, and use of 3 increasingly aggressive subcutaneous insulin regimens. Average daily glucose fell from 141 in October, 2006 to 130 in May, 2007. This correlated with increased use of more aggressive insulin therapy.

### **Successful Implementation of the Surgical Care Improvement Project: A Charter Team Approach to Making Surgery Safer**

*Jeanne Feldman; West Allis Memorial Hospital, West Allis, Wis*

An innovative partnership composed of the Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, American Cancer Society, Agency for Healthcare Research and Quality (AHRQ), American Heart Association, American Surgical Association, Association of Perioperative Registered Nurses, Veteran Affairs, Institute for Healthcare Improvement and The Joint Commission have developed guidelines for hospitals to follow in order to make surgical procedures safer for all patients. This project is titled Surgical Care Improvement

Project (SCIP). It is up to the individual hospitals to implement the guidelines in their setting. This charge has been taken by West Allis Memorial Hospital. An interdisciplinary "Charter Team" was formed in order to successfully comply with all aspects of SCIP, regardless of whether components are mandatory or voluntary. Members of the team include nursing from inpatient and surgery areas, physician, pharmacy, infection control, anesthesiology, and quality management. Stages of implementation of measures were conducted using the "rapid cycle" PDSA method. Study period includes April-December 2007. All surgical cases were included in the data versus a random sampling.

### **Tracheostomy Service—Improving Care and Outcomes**

*Richard Kansteiner; Gunderson Lutheran Health System, La Crosse, Wis*

Advancements in critical care and demand for earlier placement of tracheostomies has resulted in an increased rate of tracheostomy at Gunderson Lutheran. It was hypothesized that a system of specially trained people and specific protocols would improve continuity of care across medical service lines, while rapidly moving toward decannulation of tracheostomy patients. Having a team of experts at hand to help in decision-making would also assure proper use of tracheostomies. By implementing the Tracheostomy Service, average time to decannulation was reduced and average length-of-stay positively impacted.

### **VTE Project**

*Mary Nickel; Saint Clare's Hospital, Weston, Wis*

Evidenced-based medicine practices were incorporated to many of Saint Clare's Hospital processes to promote excellence in patient outcomes. Specifically, Saint Clare's Hospital was selected as 1 of 50 hospitals as a pilot test site for the Joint Commission on Accreditation of Healthcare Organizations' National Consensus Standard for the Care and Prevention of Venous Thromboembolism (VTE) Project from January 2007-June 2007. The pilot study is designed to evaluate a standardized set of performance measures for adult inpatient discharges and has great potential to positively impact quality improvements in health care.

# Wisconsin Medical Journal

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