Performance Improvement and Patient Safety Matters
The mission of Fox Chase Cancer Center is to prevail over cancer, marshaling heart and mind in bold scientific discovery, pioneering prevention and compassionate care. Fox Chase Cancer Center (FCCC) is dedicated to providing safe, high value cancer care (high quality, cost effective). The Performance Improvement and Patient Safety Program is comprehensive and functionally integrates the components of performance improvement, patient safety, risk management and patient advocacy to improve patient care and its related processes and desired outcomes. The combination of these methods will meet the goals of: 1) systematically assessing the adequacy of systems and processes; 2) identifying and analyzing root causes of process deviations especially when adverse, sentinel, or unexpected events occur; 3) designing and implementing interventions intended to prevent future process deviations; 4) identifying, correcting, and preventing quality and safety problems caused by individual performance; 5) providing ongoing assessment of the effectiveness of interventions; and 6) promoting a learning culture.

Quality of care is measured by several dimensions of performance, which are based on the Institute of Medicine’s Six Quality Aims: safety, effectiveness, patient centeredness, timeliness, efficiency, and equity. Patient safety is measured by several dimensions as well, including adherence to National Patient Safety Goals and measurement of the Patient Safety Culture.

Key components of the Program include:
- Senior-level Leadership and Commitment
- Open Communication
- Just Culture
- Process Management, Safety Design and Technology
- Employee Involvement and Accountability within a Just Culture
- Measurement and Analysis
- Patient-focused Excellence and Patient/Family Involvement

Our Road to Performance Excellence continues with the goal of further application of the Malcolm Baldrige Criteria for Healthcare. FCCC was the recipient of the 2011 Keystone Alliance for Performance Excellence (KAPE) Mastery Award, based on the 50-page application and a multiple-day site visit. The Performance Excellence Team (formally called the KAPE Writing Team) continues to educate themselves by attending KAPE conferences and serving as KAPE examiners. A team of FCCC staff attended KAPE Examiner Training this past year as well: Christine Behr (Performance Improvement), Theresa Lafferty (Infection Prevention & Control), James Nichols (IT), and Olalekan Ogunde (Arcadia BS Student with D. Pendleton). FY 2013 Goals include addressing the opportunities for improvement noted in the KAPE
Feedback Report, strengthening strategic planning efforts, utilizing the SOAR (Strengths, Opportunities, Aspirations, and Results) methodology, and partnering with Jeanes Hospital in this effort to reap the benefits of a campus-wide initiative.

**Just Culture** education for physician leaders and management staff was conducted, led by Bob Beck and Mary Ellen Morba. Principles of Just Culture were incorporated into the Morbidity and Mortality conferences and the RL Solutions Event Reporting program. Managers participated in weekly application sessions where actual events were discussed. FY 2013 plans include education of front-line staff.

Keeping patients and family in the center of performance excellence, the Patient/Family Advisory Council (PFAC) celebrated its 2nd year anniversary in October 2012 with a list of accomplishments:

- development of PFAC website
- production of PFAC video
- participation on hospital-based committees & teams (including Ethics, Infection Prevention & Control, Patient Safety)

PFAC Co-Chairs and Pat Keeley attended the annual intensive training session conference. FY 2013 goals include a recruitment campaign. **PFAC Members:** Robert Beck (Senior Leadership), Abigail Boulden, Marcin Chwistek, Luanne Chynoweth (Social Work), David Cohen, Dyanne Garner, Al Goldstein, Kim Hagerich (Co-Chair), Joanne Hambleton (Senior Leadership), Wendy Heacock, Jay, Hyman, Fran McAdams (Nursing, Infusion Room), Delinda Pendleton (Quality Management), Jeannie Watson, Maddy Weber (Media Relations), Daniel Wolfson (Co-Chair)

In FY2012, FCCC continued utilizing patient safety tools, such as the root cause analysis (RCA) and failure mode effect analysis (FMEA). The Histology staff, under the leadership of Maryanne Carroll-Tapley, participated in a FMEA (Mary Ellen Morba, Project Coordinator) to address specimen process steps that had opportunity for error. As part of the FMEA, observations were made of all steps in the process from accessioning, grossing, processing/embedding, microtomy and assembly / distribution of the case. The process improvement action plan included: enhanced labeling; purchasing segmented specimen containers; added QA check at every point in the process; adding two identifiers (case # and patient initials) on block; making correction in CoPath LIS and reports; keeping only one case at a time at the microtome; processor on automated alarm system which notifies hospital operator if system fails over night; and one case per slide folder. Future state planning includes automation of processes.

**Looking Back on Performance FY 2012**

Each year, we look back on performance, based on goals that were set at the beginning of the year. This year is no different. Goals are based on a combination of prior year performance, external benchmarks, and evidence-based practice. The following data reflect our performance in FY 2012 as it relates to set goals of performance in high risk, high volume, and problem-prone areas. In most cases, multidisciplinary teams worked together to address opportunities of improvement and made incremental, progressive changes utilizing basic PI tools. Proposed changes, including pilot studies, were
proposed, reviewed, and approved at multiple levels of the quality reporting structure, most notably the Infection Prevention & Control, Patient Safety, and Performance Monitoring Committees and the Executive Committee of Staff. Periodic updates were included in the reports made to the Academic and Professional Committee, FCCC’s Board of Overseers.

There are many, more improvement stories at the department and service level that did not make this report. The summary below only represents a few highlights. Next year, our program will reflect a more robust, broader and deeper perspective of quality and patient safety that spans all departments and service lines, both within Fox Chase and across the campus as we integrate our programs with our colleagues at Jeanes Hospital and Temple Health.

**Prevention and Reducing the Rate of Infection Remains a Priority**

*The Infection Prevention & Control Program*, led by Dr. Peter Axelrod (*Infectious Diseases*) and Theresa Lafferty RN, MHA, *Infection Preventionist*, includes an active surveillance system that determines hospital-acquired infections, and conducts comprehensive analysis of trends. The goal of the program this year was to identify opportunities for further reducing the rate of hospital-acquired infections. The data below captures the rates for FY2012, compared to established benchmarks.

*The Surgical Site Infection* rate and hospital-acquired rates for *C-diff* and *MRSA* remained below the internal target. Admissions were screened for MRSA when patients were transferred from Skilled Nursing Facilities and outside ICUs. Patients with *C-diff* were isolated and equipment and rooms disinfected with a bleach-based product. Hand washing was also stressed.
FCCC Clostridium difficile Infections per 1,000 Patient Days

FCCC Methicillin-Resistant Staphylococcus Aureus Infections per 1,000 Patient Days
**Medication Reconciliation Team Holds On to Continuous Improvement Goal**

The Medication Reconciliation Team knows all about continuous cycles of improvement. Over the past year, the team has worked closely with clinicians to move the rate from mid-80s (FY 2011) to sustained performance of 98% and 97%, respectively. Action steps included refining the pre-printed order sheet and reinforcing requirements with staff. Next steps include improvements in the process when patients are transferred in and out of ICU and further enhancing the quality of the program. **Medication Reconciliation Team:** Ken Patrick (Lead, Medicine-Hospitalists), Mary Ellen Morba (Project Coordinator, Patient Safety), Eileen Fagan-Fittery (Nursing), Joanne Gurney (Perioperative Services), Jeanne Held-Warmkessel (Nursing), Anne Jadwin (Nursing), Sharon Kim (Pharmacy), Pavlos Papavasiliou (Surgical Oncology), Linda Regul (Nursing), Linda Schiech (Nursing).

**Fall Prevention Committee’s Continuous Improvement Efforts Lead to Tumbling Patient Fall Rates**

The nurses continue to assess all patients for fall risk within 12 hours of admission. Analysis is conducted on each fall that occurs. The Fall Risk Assessment & Prevention Standard of Practice was revised in 2011 to include a high risk for injury decision tree. Fall rates were monitored quarterly and detailed fall reports were discussed at the Multidisciplinary Fall Prevention Committee and Nursing PI Council. National Fall Prevention Awareness Day was celebrated with awareness activities and treats for patients and staff. The rates of patient falls and patient falls with injury continue to outperform the 50th percentile (median) of the NDNQI comparison group: teaching facilities. In FY 2013, FCCC enrolled in the PA Patient Safety Authority’s Falls Reporting initiative and looks forward to the ability to further drill down our data and to receiving valuable regional benchmark data. **Fall Prevention Committee:** Jenna Balaicius (Rehabilitation), Melissa Corsey (Nursing), Tara Durkin (Nursing), Diane M. Edwards (Nursing), Anne Jadwin (Nursing), Mala Kailasam (Medicine, Hospitalists), Sharon Kim (Pharmacy), Janice Moore
Automation Supports Critical Test Results Reporting

Improving communication among caregivers requires notifying practitioners of critical test results within 30 minutes (FCCC Policy). Rates for complying with this National Patient Safety Goal (as it relates to documentation of the notification) had reached a plateau until Nursing developed the plan to automate
the process of documentation. Working closely with Linda Schiech, RN and the IT Staff, a program was created for RNs to document notification in Soarian. Soarian reports confirm sustained rates of documented physician notification within 30 minutes.

![Graph showing MD/PA/NP notified within 30 minutes for FY12-Q1 to FY12-Q4]

**Hospital-acquired Pressure Ulcer Prevalence: Assessment & Prevention Remain Key**

The Nursing staff continues to assess all patients for skin breakdown and risk of breakdown, using the Braden Scale for Predicting Pressure Sore Risk. Assessment is completed within 12 hours of admission, according to the Nursing Standard of Practice. Assessment for risk of breakdown is also completed daily, every shift, and with any change in the patient’s condition. Nurses are empowered to initiate skin protection efforts without a physician order: utilization of protective ointment, pressure redistribution mattresses and air redistribution overlay mattresses if the nurse determines it is clinically indicated.

The Skin/Wound/Ostomy Resource Nurse Program (led by Pamela Jakubek, RN) is a group of self-selected RNs and LPNs that receives additional classroom and on-line clinical education of wound care, skin care, pressure ulcer prevention and ostomy care. They also participate in meetings where performance data and performance improvement is discussed and learning needs and products are evaluated.
Staff Gets Hooked on Good Catch Reporting and Get Rewarded...Good Catch reports make significant climb in volumes
During FY 2011, 5 hospital departments participated in the Good Catch pilot: *Outpatient Clinical Lab, Infusion Room, ICU, Pharmacy, and Radiation Oncology*. The goals of the pilot were to increase reporting of good catches (near-miss occurrences). Prior to the pilot, initial steps included a brief staff survey, which was conducted among the hospital staff. Over 300 hospital staff responded, confirming that staff were reporting near-misses at a very low rate for multiple reasons, including, “not my job”, “don’t have time”, “didn’t know I needed to report”, “fear of disciplinary action”, and “didn’t want to get anyone in trouble”. The pilot was designed to address these concerns, educate the staff, trial a user-friendly reporting system, and provide feedback to staff. The average number of good catches reported per year prior to the pilot (36), served as the baseline. Staff was educated on the principles and benefits of reporting and the use of the on-line reporting tool designed by Mary Ellen Morba, Patient Safety Coordinator. Results of the pilot were very positive; nearly **400 good catches** were reported! The **Department of Pharmacy** and the **Clinical Lab** were recognized for reporting the majority of reports on a consistent basis. After the pilot, the program was expanded across the hospital with staff education. Reports were reviewed and forwarded to managers for input and analysis. Monthly reports were generated that provided feedback to staff at the department level.

**Good Catch Team** members include Marianne Carroll-Tapley (Pathology), Dawn Elliott (Pharmacy), Crystal Greco (ICU), Margie Kearns (ICU), Kristen Krauss (Anesthesiology), Anne Jadwin (Nursing), Fran McAdams (Infusion Room), Mary Ellen Morba (Patient Safety), Delinda Pendleton (Team Lead, Quality Management), and Robert Price (Radiation Oncology).

At the end of the pilot a recognition program was launched to reward employees for reporting good catches. On a monthly basis, names of staff who reported were randomly drawn and rewarded with a WaWa gift card. Beginning in FY 2013, thanks to an anonymous employee donor, the reward program was broadened to award staff on a weekly basis. Winners included: Danielle Puccio (Clinical Lab), Margie Flaherty (Diagnostic Imaging), Kathy White (Pharmacy), Helga Hollerbach (Clinical Lab), Anne Shelinsky (Diagnostic Imaging), Debbie Grutzmaccher (Pharmacy), Debbie Fitzpatrick (Respiratory Care), Anne Loser (OPD Lab), Debbie O’Neill (Clinical Lab), Nancy Warren (Clinical Lab), Beena Raju (Nursing 3 South), Veronica Carter (Pharmacy), Lindy Gulli (Pathology), Stuart Rubin (Pharmacy), and one group award to Dr. Bleicher’s Clinic Team. Several staff, who were frequent reporters, were winners multiple times; their names are bolded.

Several sub-teams were formed to address common themes, including chemotherapy orders, specimen labeling and patient identification. Based on observations, results from an employee anonymous survey, and data from good catches & incident reports, patient identification became a priority in the 1st Quarter of 2012. A Patient Identification Team was created, and a campaign to address patient identification was launched that included staff education and the production of posters and matching buttons with the theme, “Did We ID You?” Efforts are underway to develop a staff education video in FY 2013 to support the campaign. **Patient Identification Team**: Hope Harrell (Radiation Oncology), Jeanne Held-Warmkessel (Nursing), Janice Moore (Nursing), Mary Ellen Morba (Team Lead), Ken Patrick (Medicine, Hospitalists), Delinda Pendleton (Quality Management).
A Peak at FY 2013 Priorities

FCCC signed a commitment letter to participate with the National Partnership for Patients and State-wide PA Hospital Engagement Network on several regional collaborative projects. Multidisciplinary teams were formed with designated leaders.

- Prevention of Wrong-Site, Wrong Person, Wrong Procedure/Surgery (Joanne Gurney, Perioperative Services)
- Preventing Harmful Adverse Drug Events with Opiods (Pam Kedziera)
- Venous Thromboembolism Prevention (Jeff Farma, Mala Kailasam)
- Surgical Site Infection Prevention (Theresa Lafferty)
- Central Line-Associated Bloodstream Infection Prevention (Theresa Lafferty)

We’re Striving for Straight As!

- Alignment with strategic plan (people, performance, patient experience, prosperity, pursuit of knowledge)
- Assessment/Analysis (right data, resources needed)
- Aims (clearly articulated with roadmaps)
- Accountability (at all levels)
- Agility (identifying and conquering barriers)
- Application (standardization & dissemination)
- Always (every patient...every time)

Next step...High Reliability!

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