



## **2011 Outcomes Congress**

### **Participant Success Stories**

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*Stratis Health, based in Bloomington, Minnesota, is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.*

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## **Introduction**

Beginning in 2008, 43 nursing homes and 27 hospitals joined in collaboration with Stratis Health to improve quality of care and quality of care in Minnesota nursing homes and hospitals. As we conclude this collaborative and embark on a new one, it's time to recognize the successes achieved.

This booklet contains success stories of some of the Minnesota nursing homes and hospitals that participated with Stratis Health in this resident and patient safety collaborative. The stories describe how nursing homes have improved pressure ulcer prevention and care, and physical restraint reduction, and how hospitals have improved surgical care and organizational culture and prevented hospital-acquired MRSA infections.

The improvements that have been made and the work that went on behind the scenes to ensure quality of life and quality of care in these organizations is admirable and worth noting. Congratulations to everyone on a job well-done.



## Table of Contents

CentraCare Health System - Long Prairie Develops Successful Surgical Improvement Processes.....	6
Patient Safety Culture Change at Chippewa County Montevideo Hospital .....	8
Courage Center: Clients as Partners .....	10
Cuyuna Regional Medical Center: Decrease High-Risk Pressure Ulcers.....	12
Evansville Care Campus: Avoid Physical Restraints .....	13
Good Samaritan Battle Lake: There's No Place Like Home .....	14
Good Samaritan University Specialty Care: Lead by Example .....	15
Collaborative Effort at Grand Itasca Improves SCIP Rates .....	17
HCMC: Surgical Care Improvements .....	18
Heritage Living Center: Reducing Chemical and Physical Restraints .....	20
Mala Strana: Journey to an Alarm-Free Culture .....	21
Mille Lacs Health System: Improving Safety Measures .....	22
Oak Hills Living Center: Pressure Ulcer Reduction.....	24
Pipestone County Medical Center: Smart Changes; Big Results .....	26
St. Anne of Winona: Reducing Pressure Ulcers, Awareness and Education Make the Grade .....	27
St. Michael's Health and Rehab: Remove Physical Restraints, Improve Resident Safety .....	28
The Village at Mountain Lake: Pressure Ulcer Success Story.....	30
Tri-County Hospital: Safety First .....	31
Villa Health Care Center: Education and Teamwork, Powerful Partners .....	33
Virginia Regional Medical Center: A Job Well-Done.....	34



## CentraCare Health System - Long Prairie Develops Successful Surgical Improvement Processes

CentraCare, a Long Prairie hospital in central Minnesota, has been participating with Stratis Health in the national surgical care improvement project (SCIP) to improve health care quality around surgical processes. Its team approach to solving problems and improving processes has well exceeded expectations.

Rona Bless, quality improvement director, described how the team tackled its major issues related to surgery: pre-surgery antibiotic administration and deep vein thrombosis (DVT) prevention.

It became apparent that the hospital needed to form a team to take a comprehensive look at all processes and measures around surgical procedures.

The multidisciplinary team included the operating room manager, a pharmacist, core measure abstractor, post-op nurses, and two physicians. Bless says, “We weren’t doing as well as we would have liked with our core measures, so the team sat down and looked at each of the indicators to decide how we could improve.” Many discussions took place, with input from all members of the team.

The team began by implementing consistent pre-op orders—a change from the various pre-op orders they usually received from a variety of physicians.

The team then concentrated on correct timing for antibiotic administration. The most consistent person in the whole process, the anesthetist, was designated to administer the antibiotic. The anesthetist takes the patient history, starts the IV, and knows exactly when surgery will take place. Staff no longer has to worry if the surgeon will arrive within the one-hour window between antibiotic administration and surgery. Preprinted orders with standards for when and how long antibiotics would be given were established.

To prevent DVT, the team looked at use of support stockings, pumps, medication, and patient education. A process was developed to determine the needs of high-risk patients (e.g., patients over age 60, patients with diabetes, cardiopulmonary disease, etc.) as part of the hospital’s new electronic health record system.

Bless says, “Getting everyone to review and agree to the new procedure was a big process. Many discussions took place. Changes took a while to

implement—and this was all taking place *at the same time we were implementing our new electronic health record system!* But by the end of the process, everyone knew what we were doing and why.”

Because Long Prairie has so few eligible cases for the core measures, the team often wondered how they measured up. So they are especially proud of achieving 100 percent for all the SCIP measures in the project, and of the great surgery and DVT protocols they now have in place.

Bless says, “People have changed their practices and how they look at the whole surgical process. It has become a new way of life. “





## Patient Safety Culture Change at Chippewa County Montevideo Hospital

As part of the Stratis Health 2008-2011 Patient Safety Collaborative, Chippewa County Montevideo Hospital (CCMH) focused on reducing hospital-acquired MRSA infections, which included implementing evidence-based practices and entering infection data into the Centers for Disease Control and Prevention National Healthcare Safety Network database. In addition, the hospital worked on its patient safety culture. Staff took the Agency for Healthcare and Research Quality (AHRQ) Patient Safety Culture Survey in July 2010 to assess its patient safety strengths and weaknesses.

A busy 25-bed critical access hospital located in western Minnesota, CCMH has a staff of 250, a surgery department, oncology infusion service, and cardiac rehab, as well as a clinic and home care service. In September, staff reviewed the results of the AHRQ Patient Safety Culture Survey and began to determine the areas of patient safety to focus on. In November, Stratis Health provided TeamSTEPPS™ training to staff to help initiate a framework for improving care processes. More than 40 people took part in the training, with all departments represented.



TeamSTEPPS™, an evidence-based teamwork system designed to improve communication and teamwork skills helps clarify team roles, resolve conflicts, and produce effective medical teams for improving hospital patient safety. Results of the survey showed that patient handoffs presented significant patient safety issues, with multiple opportunities for errors. The initial quality improvement team formed subgroups that represented each department, e.g., X-ray, lab, cardiology. Team members then took the work of the group back to their departments to implement the changes and improve communication processes.

Anita Zelenka, RN, infection prevention practitioner, described how the team initiated improvements in communication and patient handoffs. “We have used the SBAR model on and off for years, but it was not embraced as a standard protocol until now,” says Zelenka. “We use it to let the hospital or clinic know the patient is on the way, and we placed SBAR cheat sheets by the telephones to remind people to use it.”

### **SBAR (situation, background, assessment, recommendation)**

- Situation: Identify yourself, patient, and reason for call
- Background: Patient's presenting complaint, relevant medical history
- Assessment: Vital signs, vital signs outside clinical impression, severity, additional concerns
- Recommendation: State the actions you expect to take place, when, and how urgently

“Staff also developed a hand-off communication tool—like a hall pass. (See sample at left.) The tool travels with the patients and provides pertinent information about their status. It lists details, such as current vital signs, cognition, the patient’s ability to stand alone, and whether they have recently received narcotics.” The hand-off tool has numbered check-off areas that staff in the lab or X-ray initial before the patient is directed to the next department. The form helps ensure that patients receive the tests they need before surgery or before they leave the hospital.

Zelenka says, “Although there may be several things you could work on to improve patient safety, you can’t do it all. You have to select one or two things, get staff input and buy-in, and make it a standard process before you can tackle another issue.” The hospital also is instituting its MRSA policy in phases, in keeping with Minnesota Statutes. CCMH has a low MRSA hospital-acquired infection rate.

Obstetrics Clinical Leader Melissa McGinty-Thompson, RN, is now the main contact who continues to facilitate TeamSTEPPS™ monthly meetings. The hospital will conduct a remeasurement Patient Safety Culture Survey in the spring. Zelenka says, “Although it was a lot of work, with mutual support, and a common goal of making sure the patient is safe and the staff is respected, the whole hospital is on board with the changes. Nobody can do it alone. It was a total team effort.”

## **Courage Center: Clients as Partners**

Courage Center in Golden Valley, MN, has established a precedent for person-centered care. The 40-bed skilled nursing facility offers a transitional rehabilitation program (TRP) to individuals who have had a stroke, brain or spinal cord injuries, etc. Individuals in the TRP, whom Courage Center refers to as clients, are treated as partners. Kathie Nichols, nursing services director, explains that because clients receive care consistently from specific team members, trust builds among staff, clients, and families. As a result of this consistency, staff members gain in-depth understanding of clients' preferences and needs and notice when there is a change in condition. This knowledge allows them to make additions to clients' plans of care that can hasten their recovery.

"Everything we do centers on what we need to accomplish for that client," says Nichols. "Clients are asked to take responsibility for what they can do for themselves. Then staff, often with the inclusion of family members, helps them accomplish the goal, whether it's a activities of daily living, therapy, or adjusting to lifestyle changes. We accept clients as they are, respecting their values, beliefs, and life experiences."

### **Uniquely Person-Centered**

Nichols regularly calls on traditional resources from Stratis Health to educate staff. She says the Webinars and Web site links have provided valuable information. The learning initiatives allow facilities to come together and share best-practices; all valuable tools.

At the same time, Courage Center has combined business as usual with innovation. One distinctive means of empowering clients and staff to collaborate on making choices and setting and achieving goals is mind-body awareness. For 18 years, Matt Sanford, a yoga instructor who has paraplegia, has taught adaptive yoga classes to clients and staff.

"They learn simple yoga poses, breathing exercises, and focus techniques to better connect to their own mind-body awareness, enhance relaxation, and reduce stress. Staff uses these tools to enhance interactions with clients," Nichols says. "The nursing department has incorporated mind-body approaches into client range-of-motion, positioning, and setting their morning and evening routines.

"We can pay attention to what our bodies tell us and use that awareness to help deal with stress and our interactions with others," she adds. "Likewise, clients learn to use mind-body awareness to enhance overall rehabilitation and integration of mind, body, and spirit."

The mind-body approach is only one way to empower staff and clients. Nichols explains that person-centered care can be adapted to fit any health care setting. Doing so requires that, "You clearly define your vision of person-centered care and how it will be visible in your organization," she says. "Then educate the staff, so that each person can identify what it is and how it is reflected in their job responsibilities."



To that end, Courage Center has been able to blend hard work with a homelike, comfortable, and therapeutic environment; designed to give residents optimum control. The goal is to improve individuals' self-reliance.

Open communication actively engages staff, clients, and families. They listen to and learn from each other, while they share responsibility for setting goals, designing services, and attaining desired outcomes.

Person-centered care is not static, and Nichols believes it will always be a work in progress. “We’ve had a person-centered environment for many years and the emphasis [being placed on it] in long-term care isn’t new to us. There was a client-centered care model when I came to Courage 19 years ago and though it’s changed with the times, it’s still in place. It takes new forms with each situation and requires constant reflection to identify what we can do better,” Nichols says. “If staff is engaged, we will continue to be successful.”

## Cuyuna Regional Medical Center: Decrease High-Risk Pressure Ulcers

*Interview with Julie Holmquist, director of nursing, Cuyuna Regional Medical Center, Crosby, MN*

### **Q: What has helped to improve skin care at Cuyuna?**

**Julie:** Education has been key to our success; especially education geared toward our nursing assistants. We've done in-services, a skills fair in partnership with the hospital and with our wound nurse, and we've tapped into our product vendor. Skin care education is continuous and we stay on top of it with quality improvement and our auditing process. We are doing wound rounds with our staff development person once a week, and have a wound team that meets regularly to continually improve processes. We use our audit process as a way to identify educational needs. For example, if we see that someone is calling a venous leg ulcer a pressure ulcer, it's an opportunity for education. Our auditing processes have also helped us to identify and improve coding errors.

Nursing assistants at Cuyuna are active and integral team members in skin integrity. They believe that keeping residents' skin healthy is their job. The leadership team truly appreciates the nursing assistants, and tells them exactly that, often.

### **Q: What are you most proud of?**

**Julie:** That our residents are well taken care of. When you're looking at overall quality of care—if things are being done right, if residents are regularly assisted with toileting, if they have proper nutrition intake, if they are moving and being assisted with positioning—skin should not break down.

### **Q: What advice would you give to others working to improve pressure ulcer prevention and skin care?**

**Julie:** Our work needs to have a team approach. You have to get people to the point where they want to do the right thing for the residents and their coworkers. It's integral that leadership is telling staff members that they are doing a good job and that things are improving *because* of what they are doing; it motivates people.

Get to know your staff—their strengths and opportunities for growth—and empower strong staff members to mentor others. Build that into your culture. Encourage staff to support and educate each other daily.

### **Q: Are there any resources you'd recommend to others?**

**Julie:** There are so many great tools online and available through Stratis Health. Start with a basic tool and then work on making it fit your home. There is not a one-size fits all solution, and it's important to work together and plan what works for your team.

### **Q: What would you like to leave people with?**

**Julie:** I know it's a cliché, but *team, team, team*. I have such a wonderful team. I enjoy coming to work and so does my team. In addition, interdisciplinary teams are a huge part of a success, the dietician, PT, OT, all come together to serve the resident, first and foremost.



## Evansville Care Campus: Avoid Physical Restraints

For years, nursing home caregivers believed a common misperception: restraints ensured residents' safety. Restraints would eliminate falls, and residents would be safe, right? Not necessarily.

Restraints—belts, vests, bed rails, and specialized chairs—are just what the name implies; devices that can restrict freedom of movement.



In addition, research shows that the risks of using restraints can be greater than not using them. Without restraints, there is the potential for falls. With restraints, there is the potential for falls, strangulation, loss of muscle tone, pressure sores, decreased mobility, reduced bone mass—the list goes on.

Sandy Hovland, RN, assistant administrator at Evansville Care Campus, Evansville, MN, has watched the use of restraints diminish over the past few years. Hovland and Pam Wilson, director of nurses, are pleased with the way staff has stepped up to the plate.

“Residents tend to be more agitated when placed in a restraint, which then increases behavior problems,” says Hovland. “Eliminating restraints has been an ongoing project over the past few years. Changes in long-term care and advances in equipment allow us to use other methods to prevent falls for those at risk.”

Hovland notes that the Stratis Health Web site is a resource that staff refers to often. Information on alternative methods of fall prevention from Stratis Health also has been helpful in reducing falls at the campus.

Assessment is the first step to eliminating restraints. Everyone—residents, family members, doctors, nurses, and the interdisciplinary team—collaborates on establishing a care plan for new residents. The plan is reviewed quarterly and when an individual's condition changes. Hovland notes that family members who believe a resident needs a restraint are provided with information on the risks vs. the benefits of restraints.

“If a resident is found to be at high risk for falls, interventions are put in place to prevent them,” explains Hovland. “I’m not saying there may never be a need for a restraint if other interventions fail, but at this point a restraint is not considered at our nursing home.”

Interventions based on each resident's history and risk may include frequent monitoring by staff, exercise programs, positioning devices, body pillows, concave mattresses, low beds, and mats on the floor next to the bed. Scheduling regular trips to the toilet helps staff assist residents before urgency requires them to hurry and possibly slip and fall. Bed noodles define the sleeping area for those who tend to roll out of bed.

Sensor alarms are used for some residents to alert staff that they need assistance, according to Hovland. Now that Evansville Campus is restraint-free, staff is working to reduce the use of alarms, too.

Staff is proud of its restraint-free status. It didn't occur overnight, but they persevered and now it's a way of life. Hovland is pleased with the nursing home's status and says emphatically, “Using restraints is a last resort.”

## **Good Samaritan Battle Lake: There's No Place Like Home**

A homelike setting is one way Good Samaritan hopes to improve the quality of life for residents at the Battle Lake nursing home. Shelly Sagerhorn, assistant director of nursing and quality assurance coordinator says, "We are converting our 55-bed home to mostly private rooms with a shower and bath. Our goal is to provide a home that meets residents' individual needs and enhances their lives." The purpose of this concept is to continue to move away from a medical model of care toward resident-centered care in a homelike atmosphere.

### **Pressure Ulcer Reduction**

Another component of person-centered care is consistent staffing, which, "has been key to such a model and has improved many areas of care," Sagerhorn says. "The staff knows the residents and their routines, so they can care for them more efficiently. If we had different staff all the time, repositioning and other aspects of care would be inconsistent. We'd see more skin issues." Sagerhorn and her team believe consistent staffing has helped reduce instances of pressure ulcers in the past four years. She outlines other practices she believes have made a difference in reducing pressure ulcers.

"Residents receive a thorough health assessment when they arrive. We provide appropriate equipment to staff with training on how to use it. A registered nurse assesses skin issues weekly. Training on skin care is ongoing and we take advantage of Stratis Health Webinars and workshops when we are able to travel." Sagerhorn says that the staff works hard for the residents; always willing to learn new ways to make residents' lives better.



Also, since 2006, an interdisciplinary risk committee meets regularly to evaluate resident care and exchange ideas about weight loss/gain, skin issues, restraints, falls, and other information. "We have met for six years and find it beneficial."

### **Tools of the Trade**

Staff has become adept at integrating education and using tools to efficiently deliver individualized care. Each resident at risk for skin breakdown has a positioning data collection form that aides use to follow a schedule of bed and chair repositioning. They monitor the person's skin at intervals throughout the day. "We start at two-hour intervals and increase or decrease based on skin redness and time it takes to resolve," she explains. "From there, information is reviewed by the case manager, who develops a plan of care based on the data. This process is reviewed every three months with changes made as necessary."

Another effective tool is an electronic device about the size of a cell phone. Nursing assistants can access care plans and enter information into the device. As a result, "the handheld device allows nursing assistants to pull up information on the move, instead of leaving a resident's room to find a paper document," she says. "It's a time-saver, and it provides accurate information." Consistent staffing, an interdisciplinary risk committee, education, devices that provide accurate information about residents, and positioning data collection have changed the way the nursing home delivers care. Remodeling to create a homey setting is the next step in raising the quality of life for residents. "We are excited about our building remodel," says Sagerhorn. "I can't imagine how it will change residents' lives."

## Good Samaritan University Specialty Care: Lead by Example

In 2010, Gwen Johnson won the Minnesota Care Providers Leadership Award and reflected on how her team has contributed to making the Huntington unit at Good Samaritan-University Specialty Care, Minneapolis, a nationally respected care center. As nurse manager for this unit since 1996, Johnson has learned that to promote quality of life for residents and to deliver optimal care, staff is the key element. “People living with Huntington’s disease need a coordinated care team that works together.”

She took the time to observe how the unit operated before suggesting any action. She noticed there were opportunities to improve team communication in order to work with the residents more effectively. Missed or fragmented communication can cause an escalation in a resident’s frustration, which can lead to confrontations or behaviors that can contribute to injuries. After one situation that led to a resident becoming upset, Johnson, “realized we had to work as a team and discuss interventions.” As an example, she describes an instance where a resident was not sleeping at night. The nurse called the doctor to get medication to help that resident sleep. What that nurse didn’t realize was that this resident slept all day, unless at a meal, and therefore didn’t want or need anything to help him sleep. “That is why we set up a team that includes the resident,” she explains. “We need complete and accurate information to ensure the best possible care.” The team wants to provide the best care for each resident, with the resident directing that care as much as possible.

### Restraint Reduction

As the first step in enhancing team work, Johnson solicited staff members’ opinions and suggestions. To her, it’s all good information that can lead to trying different methods and solutions. “The nursing staff is involved and proactive. They really care, and together we come up with ideas to improve the residents’ lives,” says Johnson. “We have tried to create an environment that lets them know their feedback is valued and welcomed.”



Using, reducing, or avoiding the use of physical restraints particularly requires teamwork. The nature of Huntington’s requires careful consideration to identify safe solutions. For instance, seat belts may seem to solve the problem of keeping people from falling out of the chair. However, because people with Huntington’s disease often have movements they cannot control, a seat belt may be dangerous. People can scoot down in the chair and hang in the chair by their armpits. So, each individual situation must be reviewed and treated appropriately. “One of [our priorities] is having a

conversation about whether a restraint could help or cause more problems,” she says. “It needs to be a conversation with some depth and thought, with input from staff, residents, and families. When they feel like a vital part of the team, they are more willing to work together.”

Johnson believes front-line staff provides a wealth of information. She recalls her early days in long-term care. “When I was a nursing assistant, the managers would meet, make decisions and come back to tell us what to do,” she recalls. “If they had just asked us, we could have given them really valuable information. I learned from those experiences.” Including staff in decision-making has improved morale and contributed to

low staff turnover. As a result, quality of life for the residents has improved and news has traveled far. The unit is respected around the country as one that can offer excellent care to people living with the disease.

The unit's success, according to Johnson, rests on excellent communication and staff dedication. The team assesses each situation rather than jumping to conclusions. "As a team, we have worked together a long time and are comfortable talking openly," she says. "We are willing to discuss situations and look at the best solution."

Successes like these are no accident; they take strong leadership, teamwork, hard work and persistence.

## Collaborative Effort at Grand Itasca Improves SCIP Rates

As a participant in the national Surgical Care Improvement Program (SCIP), which aims to improve surgical care by reducing surgical complications, Grand Itasca Clinic and Hospital in Grand Rapids, MN, has worked to improve its SCIP rates. The 74-bed hospital, with five operating rooms and a high-volume, multispecialty clinic, has focused on improving documentation on discontinuing antibiotics within 24 hours after surgery—one of seven SCIP measures.

Gloria Holcomb, senior director of quality and risk management, describes Grand Itasca's process for improving this measure as a multi-disciplinary effort, using a combination of approaches that includes use of order sets, improved documentation, one-on-one coaching, and concurrent chart review. She says, "Using order sets is one way we can standardize the care we deliver and reduce the potential for variation. Rather than having to make a decision every time, best practices defined by core measures are embedded into the order set."

Doug Roberts, nursing director of surgical services, says, "One of the most important parts of the process is that our order sets have been developed by multidisciplinary teams, with input from anesthesia, a pharmacy and therapeutics committee—anyone whose clinical practice would be affected by the order set." For example, pharmacy has had the biggest impact by implementing a hard stop—discontinuing antibiotics 24 hours post surgery. The physician has to document in the chart why the antibiotic should be continued.

When the hospital wasn't doing as well on the SCIP measure as they wanted to, staff conducted a root cause analysis and found that documentation was one of the main issues. Holcomb says, "It was as simple as completing the documentation. You have to document all three elements—the name, dosage, and route of the antibiotic."

The name and dosage of the anesthesia were always documented, but not the route. "Even if everyone knows that it is our practice to only use IV, we now know that we can't leave that box blank." The coder knew that the route was IV, but it was missing from the form. To pass this core measure, you have to pass all the criteria. "Our biggest learning was that now we all know what the coder knows. It changed the way physicians, nurses, coders, and quality staff work together to ensure complete documentation."

In addition to documentation, conducting concurrent, rather than retrospective, chart review has helped resolve issues before the patient or chart leaves the area. One-on-one coaching also contributed to Grand Itasca's improvement. If there was a documentation failure because something wasn't documented in the operating room, the nursing supervisor would give immediate, direct feedback to the care provider who was involved in the situation. Roberts says, "Making a general statement to everyone is not effective because most people feel they are always doing it correctly. Dealing with a real situation at the time versus a hypothetical example has more meaning to the care provider. People want to do the right thing."

Holcomb and Roberts attributed a great share of Grand Itasca's success to the collaboration of multiple disciplines and the contributions of a supportive physician champion John Kole, MD. "We had to have the support of nurses, physicians, and staff from pharmacy, anesthesia, coding, and quality to get to where we are today," says Roberts.



## HCMC: Surgical Care Improvements

Hennepin County Medical Center (HCMC), Minneapolis, has taken a big-picture approach to addressing surgical care improvement project (SCIP) core measures. Rather than focus on individual measure scores, according to Kathleen Ganter, medical staff quality and safety coordinator, a core measure team “looks at SCIP composite scores, allowing HCMC to respond to new measures as they are added.” The purpose of addressing the measures this way is to address SCIP measures that fail to meet the HCMC target of 95 percent achievement in 2011.

### Core Measure Team

Initially, in 2005, a core measure team was established to focus on individual SCIP measures, using scorecards to monitor current and long-term performance. The team used the score cards to analyze



performance, action, and accountability action planning. Using data gathered from the score cards, the team educated staff on SCIP measure expectations and communicated regularly whether they were being met. Paper and electronic medical records were modified to include specific information that would allow the team to track which measures improved.

Roles and procedures were standardized and more education was implemented to ensure that all staff knew and understood the expectations. By 2008, the team had refined procedures. “Relevant SCIP team members reviewed all cases failing to meet measures to determine how to improve systems or practices,” says Ganter. “They used the information to focus on the system or service unit until the gap was significantly addressed.”

One gap the team addressed was why prophylactic surgical antibiotic targets were not being met. Prophylactic antibiotics must be given within one hour prior to surgery and discontinued within 24 hours after surgery is completed.

The questions the team addressed were:

- Are we giving antibiotics too early? Too late?
- Are we giving antibiotics according to guidelines?
- Do post-op antibiotic order sets have a time limit?
- What can we change to deliver the correct antibiotic in a timely manner?

### Process Modifications

The outcome was “a process where relevant SCIP core measure team members review cases failing to meet a measure and determine how to improve the system and practices,” says Ganter. After review, the team placed a time limit on antibiotics in the order sets (Xmg of X antibiotic x 2 doses) to ensure they were discontinued within 24 hours. They also standardized pre- and post-op order sets to include a section for appropriate prophylaxis for specific procedures.

In 2009, procedures were further modified “to remove the focus from improving individual measures to improving the composite score, the percent of patients receiving all recommended cares they are eligible for,” says Ganter.

Roles of surgery department staff were clarified to include assessment and documentation of whether identified patients take a beta blocker prior to arrival. The electronic medical record was also modified to ensure that staff included documentation of beta blocker administration prior to hospital arrival.

Setting targets and educating individuals are how to make change effectively. Ganter believes that having key stakeholders involved and specific individuals to monitor actions and identify issues early helps to ensure that procedures are administered properly. The score card is instrumental in assisting to monitor and track procedures and practices. All work hand in hand to improve composite scores and accommodate new measures as they are added.

## Heritage Living Center: Reducing Chemical and Physical Restraints

The mission of Heritage Living Center, Park Rapids, MN, is to create a home for the people they serve. But, how can people feel at home with chemical or physical restraints? That question spawned the Awakenings program piloted by Sunrise Home in Two Harbors, MN, in 2009. The focus of the project was to eliminate the use of antipsychotic and other potentially unnecessary medications. The program was so successful, parent company Ecumen decided to establish it among all of its care centers.

Heritage embraced the program and watched residents change when antipsychotics were removed from their medications. “Residents have become more aware of their surroundings and are joining in games and activities,” says Cheryl Olson, LPN, Awakenings lead program manager. “Among these residents, some have become more alert, are able to feed themselves, and have improved bladder control.”

Instead of using medication to calm a resident, staff has learned to interpret their needs. As Olson says, “There are no medications that will stop residents from wandering or calling out unless you want them to be drugged. I’d rather have them be awake.” Nurses and other staff quickly recognized the value in the program and became involved in identifying the needs of each resident. Everyone was encouraged to interact with the residents to help them improve physical and cognitive function. Olson says the nursing home eliminated physical restraints around 1993, and went to using alarms instead. Now they are being eliminated, too. “We are slowly getting rid of alarms,” says Olson, “because when they go off, they cause too much noise and agitate the residents.” They agitate staff, too, she notes. So removing alarms is good for everyone.



In order to eliminate alarms, staff uses an alarm tracking tool. This tool allows them to monitor the time an alarm goes off, what the resident was doing that set it off, and the reason it went off. This information is used to individualize resident care. “For instance, if an alarm goes off at 2 a.m. because a resident needs to use the bathroom,” Olson says, “maybe we need to wake that person at 1 a.m. go to the bathroom.” It’s important to first find out what the residents need, rather than just to tell them to sit down, according to Olson.

One way to understand the residents is to have nurses and front-line staff consistently care for the same individuals. As a result, staff members have learned likes and dislikes and wants and needs of the residents they care for. Staff can anticipate when a bathroom break is imminent, a resident needs to be repositioned, or just wants to go for a walk. “For awhile, the alarms went off quite often, but now we check on residents more frequently and it’s a lot quieter,” says Olson. “It’s more peaceful and residents enjoy that.”

Although these changes are impressive, Olson points out that they didn’t occur overnight. Education is ongoing. When there is resistance, education is done one-on-one to clarify why residents are better off without alarms and chemical or physical restraints. But the rewards of watching residents become attuned to their surroundings and interact with each other and staff far outweighs any resistance.

Even though residents may call out or wander from time to time, Olson says the best thing to do is, “Talk to them; find out what they want, what they need. Pay attention to them. It makes a big difference.”

Paying attention has made all the difference at Heritage Living Center.

## **Mala Strana: Journey to an Alarm-Free Culture**

*By: Morgan Hinkley, administrator, Mala Strana Health Care Center*

If you've ever walked through a department store entry and an alarm sounded, you may have thought: Did I do something wrong? Everyone's looking at me. Turn that annoying noise off already.

Certainly, that situation is not parallel to residents having alarms attached to or under them, but it strikes a chord. We, as an industry, have made strides in reducing and eliminating physical restraints; however, we have replaced them with psychological restraints. You may know them as tab alarms, chair or bed pad alarms, mobility monitors, etc. Humans move for a reason. So, do personal alarms prevent a fall or inhibit purposeful movement?

Adopting a no-personal-alarm culture has been shown to decrease residents' agitation, difficult behaviors, and dependency on activities of daily living; reduce pressure ulcers, and often, reduce falls. As an administrator, I was inspired by this concept.

In 2009, Mala Strana Health Care, New Prague, MN, began to eliminate personal alarms and restraints. One count noted upwards of 64 alarms for our 90-bed skilled nursing facility. It took about a year to educate staff, residents, and families and offer alternative interventions for fall prevention. We stood on the premise that alarms do not prevent falls. We need a more proactive approach to meet the residents' needs, while maintaining efforts to prevent falls.



We started slowly and focused on one unit at a time. Our dementia care unit was first. We decreased alarms for those with multiple alarms by meeting with the interdisciplinary team monthly and educating family. As alarms were removed, we provided additional education and used alternative interventions. Staff gained a clear understanding of purposeful movement; the root of the movement. Are residents hungry, thirsty, bored, anxious; do they need to use the bathroom or reposition?

Once we eliminated alarms, we noticed a decline in agitation and problem behaviors; a calmer environment. After achieving our first goal, we moved on to other units. The interdisciplinary team eliminated one alarm a week. By January our facility was alarm- and restraint-free.

I am also pleased that we have seen a decline in falls, greater staff awareness of proactively meeting residents' needs and attention to fall prevention, and most important, a higher quality of life for our residents.

I hope this synopsis of our success inspires others to do the same in their health care settings. We have turned the corner on our journey and will not return to the days of personal alarms.

## Mille Lacs Health System: Improving Safety Measures

When Del Yurick, utilization review nurse, and Greg Larson, quality manager for Mille Lacs Health System, Mille Lacs, MN, noted discrepancies with a couple of surgical care improvement project measures, they had a mission: Improve all the measures. Within six months of concerted effort, the hospital maintains 90 percent to 100 percent achievement on all measures, including heart failure, pneumonia, and acute myocardial infarction.

However, the team is especially proud of progress on surgical site preparation and administration of prophylactic antibiotics prior to surgery.

Although Mille Lacs Health System didn't have a problem with infections at surgical sites, Yurick says, "We merely were trying to prevent infections." Because change doesn't always come easily, getting everyone to comply with using clippers instead of razors took a little maneuvering. "With a razor there are microabrasions, and there's more risk of infection," says Larson. "Clear data show that clipping is a better way to go." So, armed with data derived from other hospitals' procedures and the subsequent results, plus the backing of the Mille Lacs hospital CEO, razors were removed from surgery. Within a couple of months, the hospital no longer used razors and is in compliance 100 percent of the time.



With that success under their belt, the team was ready improve the measures on administering prophylactic antibiotics.

Although nurses always administered the medication before surgery, as is required, they didn't always meet the one-hour limit. Timing could be off anywhere from three to five minutes or more, according to Larson. Yurick did her best to "educate the nursing staff, but changes in scheduling, work load, patient arrivals, change in surgery times, cancellations, etc., made it impossible to achieve 100 percent compliance," she says.

The team went to work problem-solving and came up with a simple, yet effective method: Have the anesthetist administer the antibiotic. With just three meetings, the process was altered.

First, the operating room (OR) staff was consulted and agreed that administering the medication in the OR was the most practical solution. Next, the medical-surgical nursing manager was included in the strategy. "We then went to a nursing staff meeting and discussed the issue," says Yurick. "Since we already had been working on the timing with them, nurses were accepting of setting up the antibiotic, bringing it to pre-op and having the certified registered nurse anesthetist (CRNA) administer it." The CRNA, according to Larson, was willing to administer the antibiotic as long as it was set up, labeled, and ready to go.

Next, the team met with pharmacy to eliminate any issues there might be with billing and obtaining the drug in one department and administering in another. Once everyone was in agreement and with administrative backing, the system was changed and the timing for prophylactic antibiotic administration has been accurate ever since.

Larson and Yurick agree that once the right people supported their mission, change happened naturally and effectively. Larson explains that the staff's first concern is for the patients and that is the key to making changes. "Once we showed staff the data, they could see that our outcomes could be better, he says. "They asked, 'How can we make this work?'"

Teamwork, persistence, ingenuity, and the right resources have put this hospital's achievement at 100 percent for the past several quarters.

## Oak Hills Living Center: Pressure Ulcer Reduction

When it comes to pressure ulcers, it's better to prevent than to heal. That's how Christie Gallagher, director of nursing, Oak Hills Living Center, New Ulm, MN, sees it; apparently so does her staff. Incidence of pressure ulcers are at an all-time low because, she says, everyone is accountable for wound care. Oak Hills is fortunate to have a wound-care specialist who comes in monthly to work with the team to ensure that pressure ulcer prevention and care is a priority all day, every day. Everyone takes responsibility, according to Gallagher. "I believe the changes we have made have helped to make in-house-acquired pressure ulcers rare," she says.

### Focus on Prevention

Pressure ulcer prevention starts on admission. Assessing pressure ulcer risks on admission is critical to initiating resident-specific preventive measures. "You need processes in place to address an existing skin issue so you can treat it immediately and effectively."

"Tissue tolerance tests are also a big focus to individualize care plans for each resident," says Gallagher. "It took awhile to tweak the process, but I believe we have it down now." Although it isn't a new tool, using the test has helped prevent pressure ulcers. "Some residents can sit for three hours; others have skin that begins to deteriorate quickly," she explains. "Those individuals may need to be repositioned every 45 minutes. It's not the tool; it's thinking about individualization that really helped us."

Good communication is also important in pressure ulcer prevention. Gallagher emphasizes the importance of communicating with staff about expectations, and making sure they feel safe reporting skin issues without fear of being blamed. Consistent staffing is another tool that effectively improved communication. "I didn't realize how much consistent staffing and reducing pressure ulcers are linked," says Gallagher. "The consistency of seeing the same residents allows staff to see exactly what's new or what's old on their skin. Staff is attentive to resident condition changes and good at reporting it quickly. You can't beat consistent staffing."



Communication with the interdisciplinary team helps to provide an overall picture of residents' needs. "It helps to have the administrator at our weekly meetings," says Gallagher. "She can and does approve special equipment, such as mattresses, wheelchairs, dressing services, etc., without memos and red tape."

### Focus on Assessment

Guidance and education from Stratis Health were instrumental in providing resources for the new standards on staging pressure ulcers. She encourages educating everyone in the difference between stasis ulcers and pressure ulcers. "They can be miscoded pretty easily," she explains. "Especially, make sure the front-line staff is trained to recognize the difference, not just the nurses."

Tracking existing skin issues also needed to be improved. "Initially, skin issues were tracked using a flow sheet," she explains. "But, Easy Graphs were put into place. Easy Graphs look like a target that surrounds the

wound and staff can draw the outline of the wound making measuring pressure ulcers more accurate.” The new procedure helped to catch and treat skin issues earlier. Measuring occurs weekly and when there is an issue, a new plan is immediately put in place by the nurse manager. Everyone is educated on this plan through formal and informal updates.

Education regarding current pressure ulcer care and prevention strategies is provided regularly. She also notes that the Advancing Excellence in America’s Nursing Homes Campaign helps them monitor their progress, provides initiatives and resources, and generally helps keep the nursing home initiatives on track.

Finally, Gallagher notes, making change is a process. She advises anyone undertaking change to “take it one step at a time.” The results will be worth it.

## Pipestone County Medical Center: Smart Changes; Big Results

Pipestone County Medical Center and Family Clinic, Pipestone, MN, recently tackled improving safety culture and infection prevention, and came out ahead of the curve. In fact, between 2009 and 2010, the organization's overall grade on patient safety on the Agency for Healthcare and Research Quality Patient Safety Culture Survey went from 15 percent excellent to 30 percent excellent, a 50 percent increase.

As a critical access hospital and full-service family clinic in southwestern Minnesota, Pipestone Medical Center offers inpatient care that includes surgery and maternity, outpatient services, emergency department, home care and hospice, swing beds, and various specialties.

### Positive Change

Nancy Johnson, director of quality initiatives, says the medical center already had an alliance with Avera Health in Sioux Falls, SD, to maintain excellence in health care. In addition, education and resources from



Stratis Health were instrumental in helping to achieve such admirable results. Add to that a transformation from a culture of blame to learning opportunity and the atmosphere was fertile for positive change.

The initial results of the patient safety culture survey taken in 2009 were shared with staff, and the management team pinpointed specific areas to focus on. “Janelle Shearer, from Stratis Health, presented a day-long program for managers, educating us on teamwork strategies and using the tools to help us assess where we were a little weak according to the survey,” says Johnson. “I continue to revisit the tools to provide ongoing education to departments regularly.” The following year, Johnson again shared the results of the survey. Staff was thrilled to see how much improvement occurred because of their efforts.

The medical center also installed event reporting software that gives a clearer picture of safety occurrences. “The software takes a bit longer to fill out because all the blanks must be filled in order to send it. So the report is more complete,” Johnson explains. “When they were just handwritten, we could get sketchy reports that needed follow-up.”

### Consistent Progress

The discharge planner stepped up to take on the role of the infection control nurse. Her consistent presence helped to decrease the number of health care-acquired infections. “She started monitoring diagnosis and symptoms for prompt isolation with appropriate precautions,” says Johnson. “She is able to train on the spot. So when she isn't there, staff members know what she's looking for and are more alert to the fine points of starting isolation quickly. Health care-acquired infections have decreased by 50 percent at the hospital.

To ensure that staff members wash their hands regularly, posters have been displayed that say “It's OK to Ask” about hand hygiene. Staff appreciates the reminder from patients, and alcohol-based gel dispensers are situated at the door of each room. Staff is encouraged to use it before entering a room. “We told people to enter the room working the gel into their hands so patients would know they are using it,” says Johnson. Hospital staff consistently maintains 98 percent compliance in hand washing.

## St. Anne of Winona: Reducing Pressure Ulcers, Awareness and Education Make the Grade

Helping residents to keep their skin healthy is a top priority at St. Anne of Winona. Jo Hassinger, director of nursing, attributes staff awareness and education as the two factors that have helped most to improve skin care over the past 20 months. Education has been ongoing and regular.

“A lot of our staff members are students, which means there is frequent turnover and new staff,” she says. “We continually need to make sure staff has the information and education necessary to take care of our residents.”

Leadership took notice of the need for a change in skin care beginning in 2009. “We noticed that we had triggered on the quality indicators on pressure sores, and our numbers of acquired ulcers had increased,” she explains. “We were *red* on dashboard data that we receive from Benedictine Health System on acquired pressure ulcers. We wanted to provide good nursing care and make sure our residents had healthy and intact skin. It is important to us to make sure they have good quality of care and life.”

### Change in Skin Care

When we reviewed our pressure ulcer data, leadership worked with staff to outline procedures for care with specific expectations for the staff to follow. The biggest hurdle was change. “Change can be a barrier. It is difficult for people to make changes,” says Hassinger. “We have overcome the barrier with education and ongoing support in explaining our expectations. Our leadership believes this issue is important and has showed support and follow-through with the staff.”

Change doesn’t happen overnight, Hassinger admits. “It was a process with ongoing education,” she



explains. The team’s perseverance and patience paid off; patience and a little help from Stratis Health Webinars and training sessions. The team reviewed the basic nursing care standards that work best in preventing pressure ulcers. Helping residents with individualized positioning, nutrition, and toileting were revisited and subtle changes were made. One tool, a toileting/positioning document, was developed to help “guide aides in the care they give our residents,” says Hassinger. The team also explored the most current wound care protocols and trained staff on the most effective use of dressings.

Equipment that prevents pressure ulcers—beds, air mattresses, and ROHO cushions—were purchased and put into service.

Consistent staffing is the next ideal on which the nursing home has set its sights. The four-floor building generally has the same staff working on each floor, but not always for the same residents. “Consistent staffing is a goal we are definitely working toward,” says Hassinger. As St. Anne of Winona fosters a strong relationship between caregivers and residents, the quality of care, including a reduction in pressure ulcers, should follow.” As the director of nursing, Hassinger is proud of the improvements staff has made in reducing pressure ulcers, and notes that consistent staffing will become a reality as well.

## **St. Michael's Health and Rehab: Remove Physical Restraints, Improve Resident Safety**

A move into a nursing home can be unsettling. For residents at risk for falls, use of physical restraints can add distress. But such distress can be avoided. Jane Ouke, director of nursing at St. Michael's Health and Rehab, Virginia, MN, says, educating family and staff about alternatives to physical restraints has been a boon to reducing restraint use and improved resident contentment.

A review of quality measures a couple of years ago showed a high use of physical restraints at the nursing home. "Through our participation with Stratis Health, we learned it was best for residents not to be restrained," says Ouke. "We strive to provide the best quality care and service possible and always are looking at ways to improve." Stratis Health was the source for education that helped staff see restraint use from the perspective of freedom.

### **Removing Barriers**

Barriers to making changes were lack of knowledge and fear for patients' safety on the part of families and staff members. Families' fears were allayed when they received information regarding the dangers of restraints and about alternatives that would be used to keep loved ones safe. Follow-up about alternative measures is offered to family members during care conferences, which helps to further reduce concern.

Staff, too, received education. "Leadership sought the knowledge and tools to increase staff awareness of the negative outcomes restraints could have," says Ouke. "We invested time and effort in training staff, listening to their suggestions and gradually reduced the use of restraints. Once staff understood the negatives restraints can cause, they were more open to suggest and try alternatives."



As nursing staff began to eliminate restraints, they realized that falls were often triggered by an unmet need or want. As staff began to anticipate residents' needs, incidents further declined. They visited higher-risk residents more frequently to assist with toileting, to check on needs, to see if they are hungry, which helped avoid an accident. "When you fulfill that unmet need, you reduce the necessity for interventions," says Ouke, "and both residents and staff are happy and safe."

### **Tools for Reducing Restraints**

Weekly risk meetings allow staff to discuss possible alternatives to restraints. Floor nurses then put the suggestions into practice. The following week, staff members assess the merits of the alternatives. A fall investigation tool was developed to help nursing staff understand what caused a fall; when it occurred, and what a resident was doing when he or she fell. Using this tool, nurses can discern the best alternatives to put in place to avoid falls. "Although there is no guarantee no one will ever fall again, those who do fall are less prone to injury, because residents who are mobile maintain stronger bones to ward off injury as well as balance and strength, an innate skill to reduce falls," says Ouke. "The key is to enhance freedom of mobility, while maintaining safety."

The elimination of physical restraints provided an added benefit. Staff noticed fewer behavioral issues and the environment was quieter overall, creating an atmosphere of contentment and serenity.

Ouke is proud of the results staff and leadership have achieved in removing physical restraints. The next step is to reduce alarms using similar methods.

## The Village at Mountain Lake: Pressure Ulcer Success Story

Deb Kremmin is thrilled about the work her nurses and nursing assistants have done to lower the rate of pressure ulcer incidents at The Village at Mountain Lake. Director of nursing there since April 1991, Kremmin is proud that occurrences of pressure ulcers are down 50 percent over the past year compared with the previous year.

Awareness and teamwork are the reasons for the change, she says. Everyone from nursing assistants to charge nurses is aware of the potential for pressure ulcers.

### Awareness

“We discuss skin care at each staff meeting,” says Kremmin. “It’s a standard topic on our agenda every time. Skin care is often brought up in conversations at the nurses’ station.” Constant education has everyone on the lookout to ensure that pressure ulcers don’t become a problem.

If nursing assistants see any redness on the skin, they report it immediately. A skin barrier wipe is applied as a preventive measure. Similar to a tissue-like swab, the barrier wipe adds a film of protection to skin that is at risk of developing pressure ulcers. “We use it as a preventive

measure, especially around the heels and coccyx,” Kremmin explains. “We routinely rub it on those areas to give residents a little more of what they have lost due to age or illness.”



### Teamwork

Education has paid off. Staff instinctively notes residents’ movement or lack of it. “We keep a close eye on residents to ensure that they turn and move regularly,” she says. “For those who are unable to turn in their sleep, due to a hip fracture or something similar, an overlay mattress is provided to them immediately.”

Turning schedules and residents’ conditions are as close as the private hand-held devices in nurses’ pockets. If someone hasn’t moved for too long, a quick look at the hand-held for a resident’s schedule tells the nurse whether it’s time to remind him or her to turn or move.

Charge nurses conduct another skin check at bedtime. “They make sure everyone is positioned comfortably and the wrinkles are out of the linens,” says Kremmin. “It’s the little things that make a big difference.”

Nutrition is also important. Kremmin and staff nutritionists work together to find supplements or foods that residents like and will ingest regularly. “If nutrition is good, the resident is healthy and the skin is stronger,” she explains. Helping maintain the integrity of the skin is vital to helping prevent pressure ulcers.

Success in preventing pressure ulcers isn’t a secret; it simply takes awareness and teamwork. “Educate your staff; make them aware of how important it is to prevent pressure ulcers,” she says. “You have to make it a priority.”

## Tri-County Health Care: Safety First

In west central Minnesota, Tri-County Health Care (TCHC), Wadena, MN, is responsible to provide quality health care to more than 25,000 residents of Wadena and Todd counties. TCHC takes that responsibility seriously. Patient safety and quality care are No. 1 priorities.

Kathy Kleen, chief nursing officer, says that a team of individuals looked at and improved several safety measures over the past 18 months.

Antibiotic administration within one hour of surgery, a Centers for Medicare & Medicaid Services measure, was high on the list.

The Tri-Care team noticed that although antibiotics were always delivered to the surgery center before a patient's surgery, they weren't always administered within the required time frame. "There wasn't anyone who was responsible, so patients often didn't receive the medication until it was too late," says Kleen. "We decided that accountability was the first step for this process."

Because the certified registered nurse anesthetist (CRNA) has all the information regarding surgery timing, that person was the most natural choice to administer the antibiotic. Now, when the physician orders the medication, pharmacy delivers it directly to the CRNA, who administers it prior to surgery. "That seems like a simple thing," says Kleen. "But it corrected that step in the process, and for the past two quarters we have administered antibiotics on time 100 percent of the time."



Once it became clear that the CRNA was the most practical choice for administering antibiotics, the quality management team figured a similar process would work to ensure that identified patients received beta blocker medication within the perioperative period. Again, a system was put in place for the CRNA to administer and document the beta blocker in EPIC, the hospital's new electronic medical record (EMR) system. EPIC alerts the CRNA to administer the beta blocker.

One tool that Kleen is particularly pleased with is a core measure pocket guide, developed by the quality team. Among other things, the pocket guide helps nurses, pharmacy, and physicians determine which medications to use. "Every physician working on any core measure, including the surgical care improvement project (SCIP) now has a pocket guide to show the indicators that we have to achieve," says Kleen. "As the core measures change we will update the pocket guide to ensure staff and physicians have current information."

It has proven especially useful in administering antibiotics. For instance, if an individual is having surgery for X, the physician can use the pocket guide to find the proper antibiotic. In addition, if a patient is allergic to that antibiotic, the pocket guide offers alternatives that meet the requirements to prevent infection. "Within the new EMR, protocols also guide the providers to know the most recent indicators," says Kleen.

She notes that having the processes in place helps everyone because it isn't possible to rely on memory. "Everyone is human, and having checklists and processes in place provides a safety net for patients that is invaluable," says Kleen. "I pull my pocket guide out frequently. It's a great tool."

Take venous thromboembolism (VTE) prophylaxis, for instance. Physicians cannot admit anyone to surgery or the hospital without screening for and administering measures that prevent VTE. The EMR cannot proceed if the field is empty; therefore a patient cannot be admitted.

Kleen is proud of the progress her staff has made, and how they have accepted responsibility to ensure the changes are sustained. Now, the surgery committee and board meetings include information and improvements on SCIP measures. "Prior to 18 months ago, the whole discussion of SCIP measures didn't get much attention at meetings. Now, it's a standing agenda item," says Kleen. "We are all aware of the goals and keying the data at the forefront helps us meet those goals."

## **Villa Health Care Center: Education and Teamwork, Powerful Partners**

Wound care and skin health are hot topics at Villa Health Care Center in Mora, MN. Those topics have been the buzz since 2009, when the idea of a wound team was discussed with the staff. Debra Ohman, director of nursing, arrived on the scene in July and introduced the wound team idea because, “I had been involved with a wound team in another nursing home,” she says. “I thought that a team approach was more effective than one person trying to make decisions and monitor wounds.”

She recalls that, at first, the staff had reservations about the approach, as is often the case when introducing something new. But, those reservations soon became exuberance as everyone—nursing assistants, bath aides, trained medication aides, dietitians, therapists, physicians, nurses, nurse practitioners—got involved.

The wound team includes Ohman, three nurse managers, the MDS nurse, dietary manager, and staff development director. The team focused on educating the staff about what to look for and new procedures to treat and prevent pressure ulcers. As awareness grew, a new wound tracking process and documentation system was born. “The system has enabled us to track wounds per unit, wounds from month to month, improvements, etc,” she explains. “Our incidence dropped from approximately nine or 10 wounds a month to zero on our last quality indicator report.”

Education was the wound team’s first order of business, and education is everywhere. At least, that’s how Ohman sees it. She advocates attending as many wound seminars as time allows. “We also use resources, such as the local wound clinic; a wound nurse available for consultation through our supply vendor, McKesson; and education and hand-outs from the Stratis Health seminars we’ve attended,” she says. “Most important, line staff members are a wonderful resource. They know the residents better than anyone, and often have ideas for prevention or specific care.”

Without teamwork, education only goes so far. “There are no easy answers in wound prevention and healing,” Ohman says. “Prevention is huge, and a team approach works best.” She is thrilled with how the Villa Health Center staff grabbed hold, and as a group, put their education to work. “I am most proud of the staff’s response. There is a renewed focus on skin care, wound care, and prevention,” she explains. “All members of the nursing staff alert a member of the wound team about a skin problem, and offer suggestions and ideas.” The wound team routinely receives requests to consult on residents. These exchanges among team members are essential, she believes.

Ohman is proud of the wound team’s commonsense approach to preventing pressure ulcers. “Involve your staff, and lead by example,” she says. “Thank and compliment them when they bring a skin concern to you. Congratulate them when an area is healed.” The key to Villa Health Care’s success boils down to those simple components.



## Virginia Regional Medical Center: A Job Well-Done

Since 1936, the Virginia Regional Medical Center has been a mainstay for health care in the Iron Range in northern Minnesota. Hospital staff takes pride in providing patient safety and high-quality care. So, when Linda Pogorelec, manager of surgical services became aware of sporadic administration and documentation of perioperative beta blocker therapy, she took action.

Beta blocker therapy is a Centers for Medicare and Medicaid core measure to ensure that surgery patients on beta blocker medication receive it during the perioperative period.

### Systems and Procedures

Pogorelec spoke with Brenda Skorich and Doris Parenteau, quality management department, about her concerns. Together they methodically reviewed their data and procedures to learn what changes needed to be made. During the first quarter of 2009, they noticed 60 percent compliance of administering beta blockers within 24 hours of the perioperative period. The second quarter dropped even lower. With a bit more research they were shocked to find there wasn't a space on the electronic medical record (EMR) to note whether it was administered, the time, or by whom.



“We were surprised that there wasn't a place on the EMR to document the information,” says Pogorelec. “We expected people to do it, but didn't supply a place for documentation. So it didn't seem important to the staff, and the EMR didn't prompt them to remember to include the information every time.”

The quality team began by creating a section on the EMR where nurses could enter information about the administration of beta blockers. “We made this new spot on the EMR a required field so [nurses] have to document

it,” says Pogorelec. “So now, people don't forget.” The other section missing from the EMR was a space where the anesthesiologist could include the reason a beta blocker was not administered. This information was equally as important, so a section was added for this documentation, as well

### Educate for Results

Once the form had all the requisite information, the team moved on to education. Nurses were apprised of information they needed to know and understand the guidelines for administering the beta blocker. The importance of doing so could not be overstated. They also needed to follow up with patients to ensure they had received it within the specified 24-hour time period. Once they understood the significance of these procedures, nurses were committed to tracking them.

Anesthesiologists were educated one-on-one about their part in administering the medication. “We discussed with individual anesthesiologists the guidelines, what we needed to do, and how we could make it happen,” says Pogorelec. “Generally, beta blocker is administered after surgery. Once the anesthesiologists understood and embraced the necessity, they ensured that patients received it before they left the recovery room.”

Education is ongoing, and staff involvement is key to the hospital achieving 94 percent compliance in administering and documenting beta blockers in the third quarter 2010.

“I think getting the staff involved is what it took to make the change,” says Skorich. “Then, once we implemented changes, our outcomes have become consistently better.”